



THE FAISON SCHOOL FOR AUTISM
1701 Byrd Avenue
Richmond, VA 23230
804-612-1947
www.thefaisonschool.org

ENROLLMENT APPLICATION

Please Complete and Return This Form to- **Adam Warman**
Director of Curriculum & Training
The Faison School for Autism
804-612-1947
awarman@thefaisonschool.org

Please Complete the Following Application and Provide These Additional Items-
Applications will not be considered complete until all items are received

- 1) Individual's most recent physical or medical evaluation or medical record
- 2) A copy of the most up-to-date immunization history
- 3) The most recent educational and psychological evaluations, including copies of a current IEP
- 4) All protocols (previous and current) designed to treat the individual's target behaviors
- 5) The individual's typical daily schedule
- 6) A videotape sample or photographs of the individual

The team will review this form and accompanying documents. After reviewing this information we will contact you to set up an intake appointment. If you should have any questions or need assistance, please contact us at 804-612-1947 or e-mail to the above address. Thank you very much for your assistance!

Completed By _____ Date Completed _____

Address _____

Telephone _____

PART I - BIOGRAPHICAL INFORMATION

Child's Name _____ Date of Birth _____

Social Security Number _____

Individual Currently Lives at (circle one) - Home Residential/Group Facility Other

Address of Residential/Group Facility _____

Contact Person at Facility _____ Telephone _____

Parents' Names _____

Mother's Maiden Name _____ Telephone _____ Cell _____

Address _____

County of Residence _____

Current School or Institution _____ Telephone _____

Address _____

Type of School Placement _____ Teacher/Therapist Name _____
(Public, Private, Etc.)

In Classroom:

Number of Teachers & Aides _____ Number of Students _____ Does individual have a 1:1 Aide? _____

If Individual is Over 18 Years of Age, Who Has Legal Custody/Who is Legal Guardian (circle one)?
Child Parent Other Not Assigned Yet

Do You Have the Legal Custody Papers/Documentation? _____
Please Bring Copies to Appointment

Does the Child Have Medical Insurance? _____

Name of Insurance _____

Policy# and Holder Name _____

Group# _____

Type _____

Primary Care Physician _____ Telephone _____

Address _____

Other Physician(s) _____ Telephone _____

Address _____

PART II - PSYCHOSOCIAL/DEMOGRAPHICAL BACKGROUND

Caregivers Name	Age	Occupation	Marital Status
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Father _____

Mother _____

Guardian _____

Race/Ethnicity (circle one)

White Black/African American Hispanic/Latino Asian American Indian/Alaskan Native Other

Household Income (circle one)

Less Than \$24,999 \$25,000-\$49,999 \$50,000-\$74,999 \$75,000-\$99,999 \$100,000+

Education Level	Father	Mother
Less than 9th Grade		
9th to 12th Grade - No Diploma		
High School Diploma or GED		
Associate Degree		
Bachelor Degree		
Graduate or Professional Degree		

Who Lives in the Individual's Residence?

Name Age Gender Relationship

What is the Primary Language Spoken in the Home? _____

Who Else, Living Out of the Residence, are Considered Significant Relationships to the Individual?

Name Age Gender Relationship

Please List Community Agencies/Contacts Who Provide Services to Your Child/Family

Agency Contact Name Telephone Nature of Service

PART III - MEDICAL

General Information

List All Previous and Current Psychiatric and/or Developmentally-Related Diagnoses/Problems

Diagnosing Physician or Other Professionals

Instrument, Mechanism, or Manner (Eligibility Team, DSM-IV Diagnosis, ADOS, etc.) in Which Individual was Diagnosed

List All Previous and Current Medical Diagnoses/Problems

List Medical Equipment and/or Treatments (tube feeds & pump, tracheotomy, CPAP, etc)

ALLERGIES

Medication Allergies

Medication	What Symptoms Occur with Allergy	What Treatment is Given for Allergic Reaction

Food Allergies

Food Allergies	What Symptoms Occur with Allergy	What Treatment is Given for Allergic Reaction

List Any Environmental Allergies (dust, grass, etc) _____

Has Your Child Had Any Formal Allergy Testing Done? _____

If So, Please Include Report

Current and Previous Medication

List All Information Below for Each Current Medication

Drug Name	Date Started	Dosage	Purpose	Has It Been Effective

Current Nutritional Supplements

Name	Highest Daily Dose	Has It Been Effective

List Any Topical Medications (creams and ointments) _____

What Other Medications Have Previously Been Prescribed But Are No Longer Being Administered?

Hospitalizations, Testing & Evaluations

Hospitalization

Hospital Name	Month/Year	Reason

Surgeries

Hospital Name	Month/Year	Reason

NEUROLOGICAL

Is There a History of Seizures? _____ Age of Onset _____ Date of Last Seizure _____

How Often Does Seizure Occur Now and How Long Does it Last _____

Describe in Detail Seizure Activity _____

Describe Other Neurological Problems _____

Date of Last EEG, MRI or CT Scan (if applicable) _____

Date of Last Doctor's Visit (attach visit note) _____

Physician's Name _____ Telephone _____

EYES

Are There Any Problems with Vision? _____ If Yes, Explain _____

Glasses _____ Purpose _____ How Often Are Glasses Worn _____

Date of Last Eye Exam (if applicable) _____ Seen By (circle) Ophthalmologist Optometrist

Physician's Name _____ Telephone _____

EARS, NOSE & THROAT

Are There Any Problems with Hearing? _____ If Yes, Explain _____

Hearing Aid _____ Purpose _____ How Often Is Hearing Aid Worn _____

Past Ear Infections _____ If Yes, Explain _____

Date of Last ENT Exam (if applicable) _____

Physician's Name _____ Telephone _____

DENTAL

Are There Any Problems with Current Condition of Teeth? _____ If Yes, Explain _____

Date of Last Dental Exam _____

Past Dental Procedures & Dates _____

ADDITIONAL SPECIALISTS (Cardiology, Urology, Orthopedics, GYN, etc)

Physicians Name	Specialty	Telephone	Reason for Being Seen

OTHER PREVIOUS MEDICAL TESTS & EVALUATIONS (List Type & Date)

Chromosomes _____

Metabolic Studies _____

Feeding/Swallowing _____

Gastrointestinal _____

Other _____

PART IV - NUTRITION

Present Weight _____ Present Height _____

Diet (Circle) - Regular Chopped Pureed Low Fat Other _____

Describe Any Feeding Problems (chewing, swallowing, choking, eating too fast, vomiting, food aversions, etc)

PART V - PROBLEM BEHAVIORS

Record each problem behavior the individual displays and describe it specifically. Include any damage resulting from the problem behavior either to the individual, others and property. Please rank in order of concern to yourself or to other caretakers.

Behavior	Description	Occurs How Often (Daily/Weekly/Monthly)	Damage to Self/Others/Property

Estimate the Severity of the Problem Behavior of Greatest Concern (Circle One)

Moderate Severe Life Threatening

Has the Individual Ever Been Sent to the Hospital to Treat an Injury Resulting from the Behavior?

Yes _____ No _____

If Yes, Describe _____

Has the Individual Ever Injured Someone Else to the Extent That the Individual Had to Be Hospitalized or Treated as a Result of the Behavior?

Yes _____ No _____

If Yes, Describe _____

Has the Individual Ever Been Hospitalized to Develop a Treatment for These Behavior Problems?

Yes _____ No _____

If Yes, Describe _____

In What Setting Do These Behaviors Occur (Circle)

Home School Community Other

If Other, Describe _____

How Long Has the Individual Been Engaging in the Problem Behaviors (circle one)?

Within Past 6 Months More than 3 Years, But Less than 5 Years
 More than 6 Months, But Less than 1 Year More than 5 Years, But Less than 10 Years
 More than 1 Year, But Less than 3 Years More than 10 Years

When is the Problem Behavior(s) Likely to Occur (circle all that apply)

When Individual is Left Alone or Unattended When the Individual Cannot Have Something He/She Wants
 When Lots of People are Around Time of Day
 When Demands are Placed on the Individual Other _____
 Mealtimes, Dressing or Bathing

Are There Any Occasions When the Problem Behavior(s) Rarely or Never Occurs?

How Do People (Parents, Staff, Etc) Typically Respond When the Individual Engages in the Problem Behavior(s)?

Is a Formal Program or Intervention Protocol Currently Being Used? Yes _____ No _____

If Yes, Please Bring a Copy with You to the Appointment

How Long Has the Program Been in Place? _____

Estimate the General Trend of the Problem Behavior(s) During the Past Year (circle one)

Increasing (Behavior Getting Worse)

Decreasing (Behavior Getting Better)

Stable (About the Same)

Does the Individual Display Aggressive Behavior Toward Staff or Peers? Yes _____ No _____

If Yes, Explain _____

Was the Onset of the Problem Behavior(s) Associated with any Specific Event or Series of Events?

Have the Following Procedures Ever Been Used to Treat the Problem Behavior(s)?

Restraint (describe) _____

Which Problem Behavior was the Treatment Indicated for? _____

Start Date _____ Still Used (Yes/No) _____ Stop Date _____

Degree of Success - Poor _____ Fair _____ Good _____ Excellent _____

Protective Equipment (helmet, gloves, etc.) _____

Which Problem Behavior was the Treatment Indicated for? _____

Start Date _____ Still Used (Yes/No) _____ Stop Date _____

Degree of Success - Poor _____ Fair _____ Good _____ Excellent _____

Behavior Modification-Positive Reinforcement (describe) _____

Which Problem Behavior was the Treatment Indicated for? _____

Start Date _____ Still Used (Yes/No) _____ Stop Date _____

Degree of Success - Poor _____ Fair _____ Good _____ Excellent _____

Behavior Modification-Punishment (describe) _____

Which Problem Behavior was the Treatment Indicated for? _____

Start Date _____ Still Used (Yes/No) _____ Stop Date _____

Degree of Success - Poor _____ Fair _____ Good _____ Excellent _____

Other (describe) _____

Which Problem Behavior was the Treatment Indicated for? _____

Start Date _____ Still Used (Yes/No) _____ Stop Date _____

Degree of Success - Poor _____ Fair _____ Good _____ Excellent _____

Have alternative treatments and/or therapies been used, past or present? Check One and/or List All

Therapy/Intervention	Name of Prescribing Physician/Professional	Date Initiated	Date Discontinued (if applicable)
GFCF Diet			
Hyperbaric Chamber Treatment			
Chelation			
Sensory Integration			
Music Therapy			
Dance Therapy			
Other			
Other			

PART VI - PRESENT ABILITY

Estimated Level of Functioning (circle one)

Normal Intelligence Mild ID Moderate ID Severe ID Profound ID

Please score the items listed below using the number that most closely describes your child's ability. If the item is not applicable, please indicate with NA.

- 1 - Cannot Perform Skills Independently or Correctly
- 2 - Requires Much Assistance to Perform Skill Correctly
- 3 - Requires Some Assistance to Perform Skill Correctly
- 4 - Performs Skill Independently and Correctly

	Toileting		Mobility		Bathing		Dressing
Has Bowel Movement in Toilet		Walks		Gets in Bathtub		Put on Undergarments	
Urinate in Toilet		Wheelchair		Takes a Shower		Put on Shirts, Blouses	
Pull Ups/Diapers During Day		Braces		Can Wash Self		Put on Pants or Dress	
Pull Ups/Diapers During Night		Walker		Can Brush Teeth			

Put an "X" Next to the Best Description of the Individual's Food Consumption Skills, Sleep Habits, and Communication Skills

Food Consumption Skills	Consistently	Sometimes	Never
Needs to be Fed			
Throws/Plays with Food			
Properly Uses a Spoon			
Properly Uses a Fork			
Drinks From a Cup			

Sleeping Habits	Consistently	Sometimes	Never
Trouble Falling Asleep			
Sleeps/Wakes Throughout Night			
Urinate Overnight			
Early Waking			
Sleep Apnea			
Snoring			

Time to Bed (PM) _____
 Time to Wake (AM) _____

Communication Skills	Consistently	Sometimes	Never
Speaks Freely and Easily			
Talks Mainly in Phrases			
Uses Single Words			
Communicates with Gestures			
Uses Sign Language			
Communicates with Pictures			
Writes/Prints			
Understands Simple Questions			
Follows Simple Commands/Instructions			
Can Imitate a Model			

If Using a Communication Device, Which One _____

What Frequency/Type of Supervision is Required (circle one)?

1:1 Supervision 2:1 Supervision 3:1 Supervision

Can be Left Alone for Brief Periods - Yes _____ No _____

Needs Continuous Monitoring But Can Work in a Group - Yes _____ No _____

Does the Individual Appear to Enjoy Social Interaction - Yes _____ No _____

Specify _____

Please List Motivating Foods/Activities

Favorite Foods _____
 Favorite Recreational Materials _____
 Favorite Activities _____

Please Add Any Other Details You Feel Would Help Us to Care for Your Child
