THE FAISON SCHOOL at The Faison Center
1701 Byrd Avenue
Richmond, VA 23230
804-612-1947
wwwfaisoncenter.org

ENROLLMENT APPLICATION

Please Complete and Return This Form to:

The Admissions Office
sciszek@faisoncenter.org

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

1) State School Health Entrance Form (including physical exam and immunization record)
2) Most recent/current Individualized Education Program (IEP), IFSP, or 504 Plan
3) Most recent Eligibility (for Special Education services) meeting minutes
4) Most recent/current Behavior Intervention Plan, if applicable
5) Most recent educational and psychological evaluations, from within the last 2 years, if applicable

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** _____

Relation to Applicant _____

Address _____

Telephone _____ **Email** _____

Parents' Names _____

Mother's Address _____

Father's Address _____

PART I - BIOGRAPHICAL INFORMATION

Applicant's Name (i.e., person in need of services) _____

Date of Birth _____ **County of Residence** _____

Gender (circle): Male Female **Does the applicant live with you?** _____

If not, please specify name of group home/residential facility _____

Address of Residential/Group Facility _____

Contact Person at Facility _____ **Telephone** _____

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)?
Applicant (has own rights) Parent/Guardian Other Not Assigned Yet

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

Does the Applicant Have Medical Insurance? _____

Name of Insurance Provider_____

Policy# and Subscriber Name _____

Group# _____

If through the parent, by what means do you/they access this health insurance?_____

If through work, please list company name _____

*****If seeking insurance coverage for services, please provide a copy (front+back) of your insurance card*****

Primary Care Physician _____ **Telephone** _____

Address _____

Other Physician(s) _____ **Telephone** _____

Address _____

PART II - PSYCHOSOCIAL/DEMOGRAPHIC BACKGROUND

	Caregiver's Name	Age	Occupation	Marital Status
Father				
Mother				
Guardian				

Mother - Race/Ethnicity (circle one)
White Black/African American Hispanic/Latino Asian American Indian/Alaskan Native Other

Father - Race/Ethnicity (circle one)
White Black/African American Hispanic/Latino Asian American Indian/Alaskan Native Other

This information helps Faison obtain monetary support from foundations and corporations that, in turn, helps us provide our specialized services:

Total Household Income (please round to nearest thousand): $_____
Number of Depedents in Household:_____

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 Applicant's Residence?
Name Age Gender Relationship
_____
_____
_____
_____
_____

What is the Primary Language Spoken in the Home? _____

Please List Community Agencies/Contacts Who Provide Services to the Applicant
Agency Contact Name Telephone Nature of Service
_____
_____
_____
_____
_____

PART III - MEDICAL

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

List All Previous and Current Medical Diagnoses/Problems
_____

Diagnosing Physician or Other Professionals **Specialty, Area of Expertise, etc.**
_____
_____

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

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

_____

_____

_____

ALLERGIES (Food, Medication, and Environmental)

Allergen	What Symptoms Occur with Allergy	Treatment for Allergic	Formally Tested or Suspected?

Medication

List All Information for Each *Current* Medication

Drug Name	Date Started	Dosage	Purpose	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 What Seizure Activity Looks Like _____

_____

Describe Other Neurological Problems _____
_____

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

Date of Last Neurologist Visit _____

Physician's Name _____ **Telephone** _____

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

Glasses (Y or N)? _____ **How Often Are Glasses Worn?** _____

What issue do the corrective lenses address? _____

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 (Y or N)? _____ **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

Current Weight _____ **Current Height** _____

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

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

Does the applicant take any nutritional supplements? _____
If so, please list _____

PART V - PROBLEM BEHAVIOR

Record each problem behavior the applicant 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)
Minor Moderate Severe Life Threatening

Has the Applicant Ever Been Sent to the Hospital to Treat an Injury Resulting from the Behavior?
Yes _____ No _____
If Yes, Describe _____

Has the Applicant Ever Injured Someone In Such a Way That Required Them to Seek Medical Treatment?
Yes____ No_____
If Yes, Describe _____

Has the Applicant Ever Been Hospitalized to Develop a Treatment for These Behavior Problems?
Yes____ No_____
If Yes, Describe _____

In What Setting Does Problem Behavior Occur (Circle)
Home School Community Other
If Other, Describe _____

How Long Has the Applicant Been Engaging in the Problem Behavior (circle one)?
Within Past 6 Months
More than 6 Months, But Less than 1 Year
More than 1 Year, But Less than 3 Years
More than 3 Years, But Less than 5 Years
More than 5 Years, But Less than 10 Years
More than 10 Years

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

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

Are There Any Situations or Environments, When the Problem Behavior Rarely or Never Occurs?

_____

_____

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

_____

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

If Yes, Please Include With This Application

How Long Has the Program Been in Place? _____

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

Increasing (Behavior Getting Worse) Stable (About the Same) Decreasing (Improving)

Does the Applicant 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 _____

Positive Reinforcement Procedures (describe) _____

Which Problem Behavior was the Treatment Indicated for? _____

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

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

Time Out (describe) _____

Which Problem Behavior was the Treatment Indicated for? _____

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

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

Corporal Punishment, Spanking, etc. (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

Alternative Therapy/Interventions	Name of Prescribing Physician/Professional	Date Initiated	Date Discontinued (if applicable)
Gluten and/or Casein Diet			
Hyperbaric Chamber Treatment			
Chelation			
Sensory Integration			
Music Therapy			
Dance Therapy			
Other			

PART VI - CURRENT PERFORMANCE

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	
Urinates in Toilet		Wheelchair		Takes a Shower		Put on Shirts and Pants	
Pull Ups/Diapers During Day		Braces		Can Wash Self		Uses Zippers and Buttons	
Pull Ups/Diapers During Night		Walker		Can Brush Teeth		Put on shoes	

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			
Urinates 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 an Augmentative Communication Device, Provide Name of Device _____

What Frequency/Type of Supervision is Required (circle one)?
Constant (1-on-1) Individualized (small group) Large Group Completely Independent

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

Needs Continuous Monitoring But Can Work in a Group - Yes _____ No _____
Does the Applicant Appear to Enjoy Social Interaction - Yes _____ No _____
Specify _____

Please List Motivating Foods/Activities
Favorite Foods _____
Favorite Toys _____
Favorite Activities _____
Favorite Types of Social Interaction _____

Are there certain items, activities, places, or environements that your child does not like? If so, please list.
_____

Please Add Any Other Details You Feel Would Help Us Serve the Applicant
_____
_____
_____
_____
_____
_____
_____

----------For office use only----------

Received by _____ **Date** _____

Completed Application Received On _____ Parent or School Contact On _____
Observation Scheduled for _____ with _____ (observer's name)
Application Reviewed On _____ Accepted or Rejected _____
Reason for Rejection _____
Acceptance/Rejection Letter Sent On _____

Notes _____