Lochland

"Celebrating Ability"

1065 Lochland Road – Geneva, New York 14456
Phone (315) 789-5208 --- Fax (315) 789-4597

Please enter the requested information in the boxes below. Your answers to these questions will facilitate the application process.

1. BACKGROUND INFORMATION

Applicant's Full Name				Date of Application	
Present Address				Social Security #:	
Phone		Date of Birth		Place of Birth	
Present Height			Present Weight		
Present Diagnosis			Secondary Diagnosis		
Primary language spoken in the home					
Other language spoken in the home					

Biological Mother's Name				Maiden	
Address					
Date of Birth		Home Phone		Business Phone	
Fax		Email		SS #	
Education					
Occupation					
Employer					
Marital Status	Married	Separated	Divorced	Single	Remarried

Biological Father's Name					
Address					
Date of Birth		Home Phone		Business Phone	
Fax		Email		SS #	
Education					
Occupation					
Employer					
Marital Status	Married	Separated	Divorced	Single	Remarried

Legal Guardian (if yes, you will be asked to provide court documents upon admission)					
Name					
Date of Birth		Home Phone		Business Phone	
Address				Fax	
Employer				Email	

2. SIBLING INFORMATION

Name	Date of Birth	Name	Date of Birth

3. FAMILY MEDICAL HISTORY			
Biological Mother's Lineage		**Biological Father's Lineage**	
Ancestry:		Ancestry:	
Mother:		Father:	
Living?	Age:	Living?	Age:
Current Medical Conditions:		Current Medical Conditions:	
Age deceased?		Age deceased?	
Cause of Death:		Cause of Death:	
Maternal Grandmother:		Paternal Grandmother:	
Living?	Age:	Living?	Age:
Current Medical Conditions:		Current Medical Conditions:	
Age deceased?		Age deceased?	
Cause of Death:		Cause of Death:	
Maternal Great Grandmother:		Paternal Great Grandmother:	
Living?	Age:	Living?	Age:
Current Medical Conditions:		Current Medical Conditions:	
Age deceased?		Age deceased?	
Cause of Death:		Cause of Death:	
Maternal Grandfather:		Paternal Grandfather:	
Living?	Age:	Living?	Age:
Current Medical Conditions:		Current Medical Conditions:	
Age deceased?		Age deceased?	
Cause of Death:		Cause of Death:	
Maternal Great Grandfather:		Paternal Great Grandfather:	
Living?	Age:	Living?	Age:
Current Medical Conditions:		Current Medical Conditions:	
Age deceased?		Age deceased?	
Cause of Death:		Cause of Death:	

4. BIOLOGICAL MOTHER'S HISTORY OF PREGNANCY WITH APPLICANT		
Did mother suffer from any of the following, please check:		
Anemia	High Blood Pressure	Toxemia
Swollen Ankles	Kidney Disease	Heart Disease
Bleeding	German Measles	Vomiting
Chronic illness (diabetes, kidney failure, thyroid, etc.)		
Other Illness(es)		
Rh or other blood incompatibility		
Hospitalization	When	Why
Operation		
Injury		
Threatened miscarriage or early contractions		

5. BIRTH HISTORY		
Did the mother have natural childbirth?	Yes	No
Was labor induced?	Yes	No
Was this a breech (feet first) delivery?	Yes	No
Were forceps used? If yes, why?		
Did mother have a cesarean? If yes, why?		
Did mother have twins? If yes, which child was born first?		
Did this baby have breathing problems?		
Cord around neck?		
Did this baby cry quickly?		
Was the baby's color normal?		
Did the baby require transfusions?		
Did the baby require phototherapy?		
Was the baby premature? If yes, how early?		
Was the baby put on respirator?		
What was the baby's birth weight?		
Did mother take the baby home with her from the hospital? If not, how long after?		
Did baby have problems with feeding? If yes, describe.		
Was the cry weak?		
Was the baby normally active?		
Was the baby limp?		
Did the baby have seizures?		
Did any of these problems occur with other pregnancies?		

6. CHILDHOOD GROWTH AND DEVELOPMENT

Is the development of this child different from that of brothers and sisters? Please describe.

Childhood Motor:

Age sat alone	Age walked without holding on
Age fed self	Age dressed self
Age rode bicycle	Drooling past 2 ½ years
Difficulty sucking as an infant	Difficulty chewing

Childhood Language:

Age spoke first word	Age 2-3 words together
Speech problems	

Childhood Behavior:

Toileting problems	
Bed wetting problems	
Did child get along well with children	
Did child get along well with adults	
Was child shy	Of average intelligence
Immature	Well behaved
More active than other children	Clumsy in using hands
Clumsy in walking	Stubborn
Impulsive	Poor handwriting
Temper tantrums	Head banging
Sleep problems	Nightmares
Thumb sucking	Nail biting
Blank spells	Falling spells
Tics & twitching	
Difficulty staying at one activity for reasonable length of time	
Does (did) child eat paint, paper, etc.?	

7. CHILDHOOD IMMUNIZATIONS

Immunization Dates:

D.P.T.	Rubella	Measles
Mumps	Tetanus	Polio
Tuberculosis Skin Test	Hepatitis B	Other

8. APPLICANT'S MEDICAL HISTORY					
Place a check next to any illness or condition that the applicant has had. When you check an item, also note the approximate date (or age) of the illness.					
Check	**Illness or Condition**	**Date(s) or Age(s)**	**Check**	**Illness or Condition**	**Date(s) or Age(s)**
	Measles			Dizziness	
	German Measles			Frequent or Severe Headaches	
	Mumps			Difficulty Concentrating	
	Chicken Pox			Memory Problems	
	Whooping Cough			Extreme Tiredness or Weakness	
	Diphtheria			Rheumatic Fever	
	Scarlet Fever			Epilepsy	
	Meningitis			Tuberculosis	
	Encephalitis			Bone or Joint Disease	
	High Fever			Gonorrhea or Syphilis	
	Convulsions			Anemia	
	Allergy			Jaundice/Hepatitis	
	Hay Fever			Diabetes	
	Injuries to Head			Cancer	
	Broken Bones			High Blood Pressure	
	Hospitalizations			Heart Disease	
	Operations			Asthma	
	Ear Problems (disease, infection, injury, or impaired hearing)			Bleeding Problems	
	Visual Problems			Eczema or Hives	
	Fainting Spells			Suicide Attempt	
	Loss of Consciousness			Other _____	
	Paralysis				

9. HISTORY OF MEDICAL TESTING AND FINDINGS		
Body System	**Date**	**Type of Testing and Findings**
SKELETAL: • Joint injuries • Disorders • Fractures		
MUSCULAR: • Injuries • Disorders		
CARDIOVASCULAR: • Circulatory • Heart		
NERVOUS SYSTEM: • Vision • Hearing • Touch/Taste/Smell • Infections • Spinal Cord • Other Nerve Injuries		
IMMUNE SYSTEM:		
URINARY SYSTEM: • Kidneys, etc.		
RESPRIATORY: • Lungs		
REPRODUCTIVE:		
GASTROINTESTINAL: • Digestion/Swallowing		
DERMATOLOGIC: • Skin Disorders		

10. SURGICAL HISTORY			
Date	**Type/Reason For Surgery**	**Complications**	**Outcome**

11. SLEEPING HISTORY
What time does the applicant go to bed?
Does the applicant sleep through the night?
How often does the applicant use the bathroom in the night?
Does the applicant wake up during the night?
Does the applicant have difficulty falling back to sleep?
Any further information?

12. SCHOOL HISTORY	
Did applicant attend preschool (any problems)?	
Did applicant attend kindergarten (any problems)?	
Were there any school entry problems?	
Present school and grade if still attending?	
Had the school reported problems with reading?	
Writing?	Spelling?
Arithmetic?	Social adjustment?
Did the applicant like school?	
Results of previous psychological testing?	
Has the applicant had special tutoring?	

13. RESIDENTIAL HISTORY	
Place	Phone
Address	Fax
Contact Person	
Place	Phone
Address	Fax
Contact Person	
Place	Phone
Address	Fax
Contact Person	

14. SOCIAL AND ADAPTIVE BEHAVIOR

Describe a typical day for this applicant:

Can The Applicant <u>Routinely</u> Perform The Following Living Skills

Daily Living Skills	Yes	No	Remarks
Eating Uses a fork to spear			
Uses spoon to scoop			
Uses knife to spread			
Uses knife to cut			
Drinks from cup			
Uses napkin appropriately			
Eats with rapid pace			
Eats slowly			
Drops/spills food often			
Drools			
Bathing Takes bath			
Takes shower			
Adjusts water temperature independently			
Needs assistance for thoroughness			

Daily Living Skills	Yes	No	Remarks
Uses washcloth or brush			
Shampoos own hair			
Rinses hair thoroughly			
Dries self thoroughly			
Cleans bathroom by self			
Personal Hygiene Washes face independently			
Brushes teeth independently			
Combs hair well			
Attends to menstruation			
Keeps mouth and nose clean			
Shaves			
Applies make up			
Trims/cuts nails			
Dressing Puts on socks			
Ties shoes			
Puts on undergarments			
Puts on pants			
Puts on dress			
Puts on shirt			
Buttons shirt or blouse			
Buttons/snaps pants			
Wears belt			
Chooses/matches clothing			
Wears clothing appropriate to weather conditions			
Toileting Indicates need to use toilet			
Defecates in toilet			
Wipes self appropriately			
Incontinent – wets self			
Wears adult briefs			

Daily Living Skills	Yes	No	Remarks
Has nighttime accidents			
Washes hands when finished toileting			
Social States or manually signs name when asked			
Introduces self			
Uses please, thank you, other social amenities			
Engages in conversation			

Instructions: Please answer all questions. Beside each item below, indicate the degree of the problem with a checkmark (✓).

	Not at all	Just a little	Pretty much	Very much
1. Picks at things (nails; fingers; hair; clothing).				
2. Talks back to others.				
3. Problems with making or keeping friends.				
4. Excitable, impulsive.				
5. Wants to run things.				
6. Sucks or chews (thumb; clothing; blanket).				
7. Cries easily or often.				
8. Carries a chip on his or her shoulder.				
9. Daydreams.				
10. Difficulty in learning.				
11. Restless, paces.				
12. Fearful (of new situations; new people or places; going to school).				
13. Restless, always up and on the go.				
14. Destructive.				
15. Tells lies or stories that aren't true.				
16. Shy.				
17. Gets into more trouble than others.				
18. Speaks differently from others (stuttering; hard to understand).				
19. Denies mistakes or blames others.				
20. Quarrelsome.				
21. Pouts and sulks.				
22. Steals.				
23. Disobedient or obeys, but resentfully.				
24. Worries more than others (about being alone; illness or death).				
25. Fails to finish things				
26. Feelings easily hurt.				
27. Bullies others.				
28. Unable to stop a repetitive activity.				
29. Cruel.				

	Not at all	Just a little	Pretty much	Very much
30. Immature (wants help he or she shouldn't need; clings; needs constant reassurance).				
31. Distractibility or attention span problem.				
32. Headaches.				
33. Mood changes quickly and drastically.				
34. Doesn't like or doesn't follow rules or restrictions.				
35. Fights constantly.				
36. Doesn't get along well with peers.				
37. Easily frustrated in efforts.				
38. Disturbs others.				
39. Basically an unhappy person.				
40. Problems with eating (poor appetite; up between bites).				
41. Stomach aches.				
42. Problems with sleep (can't fall asleep; up too early; up in the night).				
43. Other aches and pains.				
44. Vomiting or nausea.				
45. Feels cheating in family circle.				
46. Boasts and brags.				
47. Lets self be pushed around.				
48. Bowel problems (frequently loose; irregular habits; constipation).				

Presenting Problem(s)
Briefly describe the applicant's current difficulties, if any?
How long has this problem been of concern to you?
When was the problem first noticed?
What seems to help the problem?
What seems to make the problem worse?
Has the applicant receive evaluation or treatment for the current problem or similar problems?
If yes, when and with whom?
Is the applicant on medication for this problem? (note medication)

15. CURRENT MEDICATIONS		
Drug	**Dosage**	**Purpose**

16. PHYSICIANS/CLINICIANS/PROFESSIONALS MOST FAMILIAR WITH THE APPLICANT	
Pediatrician/Primary Care Physician	Phone
Address	
Date of Last Exam	Results
Dentist	Phone
Address	
Date of Last Exam	Results
Neurologist	Phone
Address	
Date of Last Exam	Results
Psychiatrist	Phone
Address	
Date of Last Exam	Results
Ophthalmologist	Phone
Address	
Date of Last Exam	Results
Other	Phone
Address	
Date of Last Exam	Results

Does the applicant receive any type of therapy (physical, occupational, speech, psychological, etc.)? Please list.	
Name	Type
Address	Phone
Name	Type
Address	Phone
Name	Type
Address	Phone
Name	Type
Address	Phone

17. HEALTH INSURANCE	
Does the applicant have health insurance?	
Name of Company	Type of Coverage
Does the applicant have Medicaid?	Number:
Does the applicant have Medicare?	Number:
Does the applicant have SSI?	Number:
Does the applicant have SSD?	Number:

18. ADDITIONAL INFORMATION SECTION
Please provide any additional information that you believe might be helpful to Lochland School.

19. REFERRAL SOURCE
Referred by:
How did you learn about Lochland School?

The applicant will be asked to sign the enclosed "Lochland School, Inc. Consent to Give and Release Information forms for each medical provider, clinician, professional, school, residential placement, or other knowledgeable informant. If applicant is unable to provide consent, legal guardian, parent or closest relative should sign and date as indicated. Written consent allows Lochland School, Inc. to consult with other parties in regard to the applicant, and to access written documents and information. Please read and sign the enclosed forms.

Thank you for completing this Lochland School, Inc. Application for Admission form. This form is a necessary and intregal part of the application process. Please return fully completed to Lochland School, Inc. If you have questions regarding this application, please notify Lochland School, Inc.

Carrie Fiorilla
Chief Operation Officer
Lochland School, Inc.

KDH:cel
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