The Joseph Sams School Application Checklist
Please enclose all requested items with the application form

_____ Application form with application fee of $300 (Checks can be made payable to The Joseph Sams School)

_____ Recent photograph of child

_____ Copy of current Psychological, Neurological, Speech and Language Reports

_____ Immunization Records (We will need this form at time of enrollment)

If applicable:

_____ Most recent Progress Report

_____ Most recent Behavioral Assessment

_____ Current IEP

_____ Current Eligibility from Public School System

After receipt of required documents, The Joseph Sams School Staff will contact you to verify receipt and schedule an assessment.

280 Brandywine Blvd, Fayetteville, Georgia 30214

Phone: 770-461-5894 Fax: 770-461-5223 Email: info@josephsamsschool.org

www.josephsamsschool.org

The Joseph Sams School
Application for Admission

Applicant Information

Name of Applicant _____
Last *First* *Middle*

Preferred Name_____ Birthdate_____ Age_____ Sex_____

Address_____

City_____ State_____ Zip_____

Telephone_____ Ethnicity _____

Primary Language_____ Current School District_____

Current School_____ Present Grade_____

Primary Diagnosis_____

Requested enrollment date (month) _____ (year)_____

Family Information

Mother's Name_____

Address_____

City_____ State_____ Zip _____

Home phone _____ Cell phone_____ Work Phone _____

Email _____

Employer_____

Occupation_____

The Joseph Sams School
Application for Admission
Family Information Continued

Employer Address_____

City_____ State_____ Zip_____

Marital Status (Please circle)
Married Separated Divorced Remarried Widowed Single

What talents, resources, interests or professional skills would you as a parent/guardian be willing to share with The Joseph Sams School? Please describe _____
_____
_____

Father's Name_____

Address_____

City_____ State_____ Zip _____

Home phone _____ Cell phone_____ Work Phone _____

Email _____

Employer_____

Occupation_____

Employer Address_____

City_____ State_____ Zip_____

Marital Status (Please circle)
Married Separated Divorced Remarried Widowed Single

What talents, resources, interests or professional skills would you as a parent/guardian be willing to share with The Joseph Sams School? Please describe _____
_____
_____

Family Information Continued

Emergency Contact_____

Address_____

City_____ State_____ Zip _____

Home phone _____ Cell phone_____ Work Phone _____

Email _____

If the child does not live with the parents in one household, please complete the following:

The student also lives with:

Stepfather_____ Stepmother _____ Other (please explain)_____
Name_____
Home Phone_____
Cell Phone_____

I give The Joseph Sams School permission to share Applicant's information with the above mentioned person (please initial) _____ Yes _____ No

Step father_____ Step Mother _____ Other (please explain)_____
Name_____
Home Phone_____
Cell Phone_____

I give The Joseph Sams School Permission to share Applicant's information with the above mentioned person (please initial) _____ Yes _____ No

Siblings/Others in the household:

Name	Birthday	Relationship to Applicant

Medical History and Information

Birth and Developmental History

Place of Birth_____ Hospital_____
City *State*

Birth Weight_____

Duration of Pregnancy _____ Duration of Labor_____
Full term/Premature *Number of Hours*

Nature of Delivery_____ If applicant was adopted, at what age?_____
Natural, Breech, Cesarean, Forceps

Age when Applicant:

Sat_____ Crawled_____ Walked _____ Talked_____ Used full words_____ Used full phrases_____

Medical Information

Diagnosis:
Please list all of the applicant's diagnoses, and the dates they were made. Please include health related as well as developmental diagnoses. Please attach supporting documentation to the diagnosis if available.

Diagnosis_____ Date_____

Diagnosis_____ Date_____

Diagnosis_____ Date_____

Diagnosis_____ Date_____

Diagnosis_____ Date_____

Injuries/Illnesses:
Please list any significant past injuries, surgeries or extended illnesses, and the dates they occurred (Including tubes and removal of tonsils and adenoids).

Event_____ Date_____

Event_____ Date_____

Event_____ Date_____

Event_____ Date_____

The Joseph Sams School
Application for Admission
Medical History and Information Continued

Is the applicant currently medically stable? _____ Yes _____ No
If no, please explain_____

Is the applicant's vision within normal limits? _____ Yes _____ No
If no, please explain_____

Is the applicant's hearing within normal limits? _____ Yes _____ No
If no, please explain_____

Is the applicant's weight within normal limits? _____ Yes _____ No
If no, please explain_____

Allergies:
Please list any allergies from which the Applicant suffers. Please include all allergies (environmental, food and medication). Please attach an additional sheet if necessary.

Allergy	Symptoms	Treatment

Dietary Concerns:
Please list any dietary needs (diets, chewing/swallowing issues, refusing foods, etc.) of which our staff needs to be aware.

_____

_____

_____

_____

_____

_____

Medical History and Information Continued

Seizure Information:
If your child has a history of seizures, please describe what a "typical" seizure looks like, how long it may last, etc. Please know that it is a JSS policy to call 911 for seizures lasting 5 or more minutes.

_____

_____

_____

_____

_____

_____

Current Medications:

Please list all medications that the applicant is **currently** taking.

Drug_____ Dosage_____ Start Date_____
Purpose_____ Reactions_____

Drug_____ Dosage_____ Start Date_____
Purpose_____ Reactions_____

Drug_____ Dosage_____ Start Date_____
Purpose_____ Reactions_____

Drug_____ Dosage_____ Start Date_____
Purpose_____ Reactions_____

Drug_____ Dosage_____ Start Date_____
Purpose_____ Reactions_____

Past Medications:

Please list all medications the applicant has taken in the **past**. Please attach an additional sheet if necessary.

Drug_____ Dosage_____ Start Date_____
Purpose_____ Discontinue Date_____
Reasons for Discontinuing_____

Drug_____ Dosage_____ Start Date_____
Purpose_____ Discontinue Date_____
Reasons for Discontinuing_____

Medical History and Information Continued

Drug_____ Dosage_____ Start Date_____
Purpose_____ Discontinue Date_____
Reasons for Discontinuing_____

Drug_____ Dosage_____ Start Date_____
Purpose_____ Discontinue Date_____
Reasons for Discontinuing_____

Drug_____ Dosage_____ Start Date_____
Purpose_____ Discontinue Date_____
Reasons for Discontinuing_____

Doctor Information:

Primary Physician's Name_____ Date of last physical exam_____

Specialty_____ Office Phone_____

Address_____

City_____ State_____ Zip Code_____

Hospital Affilination_____

Other Specialist's Name_____ Date of last appointment _____

Specialty_____ Office Phone_____

Address_____

City_____ State_____ Zip Code_____

Hospital Affilination_____

Reason for Evaluation_____

Medical History and Information Continued

Other Specialist's Name_____ Date of last appointment _____

Specialty_____ Office Phone_____

Address_____

City_____ State_____ Zip Code_____

Hospital Affilination_____

Reason for Evaluation_____

Educational History

Current School & Services

Name of School_____

Grade/ Class type_____

Name of Principal/Administrator_____

Name of Teacher_____

Current IEP Available_____

Type of school (Public, private, home school, preschool/daycare, early intervention program, etc)
_____

Current Services provided by school (Occupational Therapy, Speech Therapy, Physical Therapy, etc)
_____

School History

Please list, beginning with the most recent, all the schools the Applicant has attended.

Name of School_____

Address_____ City_____ State_____ Zip Code_____

Dates attended: From_____ Until _____ Grade(s) during enrollment_____

Educational History Continued

Please describe reasons for leaving_____

_____

_____

Name of School_____

Address_____ City_____ State_____ Zip Code_____

Dates attended: From_____ Until _____ Grade(s) during enrollment_____

Please describe reasons for leaving_____

_____

_____

Name of School_____

Address_____ City_____ State_____ Zip Code_____

Dates attended: From_____ Until _____ Grade(s) during enrollment_____

Please describe reasons for leaving_____

_____

_____

Has there been any difficulty with the Applicant's behavior in a school situation? If so, please describe in detail:

_____

_____

_____

_____

Educational History Continued

Current Therapies:
Please list all therapies the applicant is currently enrolled in (speech, physical, occupational, etc).

Type of Therapy_____ Frequency_____ Start date_____

Therapist's Name_____ Phone Number_____

Type of Therapy_____ Frequency_____ Start date_____

Therapist's Name_____ Phone Number_____

Type of Therapy_____ Frequency_____ Start date_____

Therapist's Name_____ Phone Number_____

Type of Therapy_____ Frequency_____ Start date_____

Therapist's Name_____ Phone Number_____

Academic Information

The following questions are related to pre/academic information. Please **check** the following activities that the applicant is able to complete *independently*. Write an "**A**" in front of tasks that can be done with *some assistance* and a "**P**" if *verbal* prompts are needed.

___ Completes non-interlocking puzzles ___ Completes interlocking puzzles ___ Completes patterning

___ Matches photos ___ Identifies colors ___ Identifies shapes ___ Indentifies letters

___ Spells name ___ Rote counts 1-10 ___ Rote counts 1-20 ___ Rotes counts higher than 20

___ Identifies numbers 1-10 ___ Identifies numbers 11-20 ___ Identifies numbers higher than 20

Academic Information Continued

___Reads sight words ___Reads phonetically ___Comprehends what is read

___Adds single digits ___Adds double digits ___Adds with re-grouping ___Subtracts single digits

___Subtracts double digits ___Subtracts with re-grouping ___Multiples 1 digit x 1

___Multiplies 2 digits x 1 ___ Multiples 2 digits x 2 ___Short division ____Long division

___Composes & writes complete sentences ___Composes & writes complete paragraphs

If math/language art skills exceed those listed above please explain _____
_____

Functional Skills

Please **check** the following activities that the applicant is able to complete *independently*. Write an "**A**" in front of tasks that can be done with *some assistance* and a "**P**" if *verbal* prompts are needed.

Does the applicant have full use of his her/hands and fingers and is able to make all fine motor movements that are typical of children the same age? ___ Yes ___ No
If no, please describe_____
_____
_____

___ Pick up small items with fingers ___ Manipulate objects with both hands ___ Throw a ball

___ Use stairs ___ Run ___ Jump ___ Swim ___ Use slide ___ Use swing ___ Use monkey bars

___ Put on clothing (list items & level of assistance needed)_____
_____

___ Take off clothing (list items & level of assistance needed)_____
_____

___ Use buttons ___ Use zippers ___ Tie laces ___Wash hands ___ Dry hands _____Brush teeth

Functional Skills Continued

___ Comb or brush hair ___ Bathe or shower _____Eat with a fork ___ Scoop with a spoon

___ Drink from a regular cup ___ Cut with a fork ___Drink from a straw ___Uses napkin at meals

___ Operate television ___ Operate remote control ___ Uses computer ___ Uses computer mouse

___ Use computer touch screen ___ Turn pages in a book ___ Play appropriately with toys

___ Get along with siblings ___ Show interest in action of peers ___ Show interest in actions of adults

___ Hold a crayon/pencil ___ Make marks on paper ___ Draw shapes ___ Write name

Toileting:

Is the Applicant toilet trained? ____ Yes ____ No

If no, have you begun toilet training? ____ Yes ____ No If yes, when did you begin?_____

Does the Applicant currently wear diapers? ____ Yes ____ No

If yes, indicate when diapers are worn ____ At all times _____ At night only

Does the Applicant indicate when he/she needs to use the bathroom ____ Yes ____ No

If previous attempts to toilet train have been unsuccessful, please describe the methods used. _____
_____
_____
_____

Sleeping:

Does the Applicant have any difficulty sleeping through the night? ____ Yes ____ No
If yes, please explain. _____
_____
_____

Speech Therapy Information

Oral Motor Information

Tongue Movement: side to side, stick out, elevate	___Yes	___No
Able to open/close mouth	___Yes	___No
Drooling	___Yes	___No
Chew a variety of foods (apples, pretzels, etc.)	___Yes	___No
Lip closure	___Yes	___No

Feeding Information

Did your child have difficulty eating as a newborn/infant? ___Yes ___No

What are his/her favorite foods?

_____
_____
_____
_____

What does he/she like to drink?

_____
_____

Please check which of the following your child uses to drink:
___cup ___straw ___bottle

Does he/she use eating utensils appropriately?	___Yes	___No
Does he/she have any food/texture aversions?	___Yes	___No

Please give a brief feeding history:

_____
_____
_____
_____

Speech/Language/Verbal

How does your child primarily communicate?
___ Verbal ___Behaviors ___Gestures ___Eye gaze ___Devices
___PECS ___Sign language

What sounds have you heard your child say?

_____
_____
_____

Speech Therapy Information Continued

Did/does your child babble? ___Yes ___No
How many words does your child say? _____
Please list:
_____
_____
_____

Does your child use yes and no appropriately? ___Yes ___No
Voice screening ___Hoarse ___Nasal ___Breathy
___Monotone ___Too Loud ___ Too Soft
Fluency Screening Repetitions: ___Hesitations ___Additions ___Too fast ___Too slow

Social Skills

Areas of
Strengths:_____
_____
_____

Areas of
Weaknesses:_____
_____
_____

Does your child respond to greetings? ___Yes ___No
Does your child make requests? ___Yes ___No
Does your child follow commands? ___Yes ___No
Does your child make eye contact? ___Yes ___No
Does your child attend to tasks? ___Yes ___No

Eating

Does the Applicant currently have a feeding/eating disorder? ___ Yes ___ No
If yes, please describe_____
_____
_____

Speech Therapy Information Continued

Does the Applicant have any of the following feeding problems? Please indicate all that apply.

____ Food Refusal (refuses all or most foods)
____ Food Selectivity by Type (eats only a narrow variety of foods)
____ Food Selectivity by Texture (eats only specific textures)
____ Oral Motor Delays (problems with chewing, lip closure or tongue lateralization)
____ Dysphagia (problems with swallowing)
____ Abnormal Preferences (ex. refuses food if not a certain temperature, eats only certain brands, must have a certain utensil or certain dinnerware to eat)
____ Other feeding problems (please describe)_____
_____
_____

Motor Skills Information

The following questions are related to motor skill development for the Applicant. If the applicant does not have issues in this area please move to the next section. The questions are going to relate to sitting, standing, walking and transitions to sit and stand. Please indicate what the applicant is able to do or where he/she may need improvement.

Does the applicant have full range of motion in his/her arms legs and is able to make all gross motor movements that are typical of children the same age? ___Yes ___ No
If no, please describe_____
_____
_____

Please check:

Sitting

___Sit independently in a regular chair ___Sit with some assistance to sit in a regular chair; Describe:
_____
_____
___Needs full support to sit

Motor Skills Information Continued

Standing

___Stands independently ___Stands with some assistance; describe:
_____
_____
___Needs full support to stand ___Not yet able to stand

Walking

____Walks independently ___Walks with some assistance; describe:
_____
_____
____Needs full support to walk ___Not yet able to walk

Transition from sitting to standing and standing to sitting (this section is to determine how much help the applicant needs to go from different positions or equipment)

___Able to transition independently to/from a chair ___Able to transition independently to/from the floor
___Needs some assistance to transition to/from a chair; describe:
_____
_____
___Need some assistance to transition to/from the floor; describe:
_____
_____
___Not yet able to help with transitions

What type of furniture or equipment does the applicant sit in at school?
_____

What type of furniture or equipment does the applicant sit in at home?
_____

What is the applicant favorite position to be in?
_____

What activity is the most difficult for you when physically helping the applicant?
_____
_____

Why is this activity difficult?
_____
_____

Behavioral Information

The following questions are related to problematic behaviors that the Applicant may demonstrate as well as current and previous interventions used. Please indicate all behaviors that have occurred over the last six months and describe to the best of your abilities.

Does the Applicant engage in Physical Aggression (Any attempt to come in contact with another person with force using either his/her own body or an object. Examples are hitting, kicking, biting, scratching, throwing objects)? _____ Yes _____ No

If yes, has the physical aggression resulted in injury? _____ Yes _____ No
Describe this behavior_____
_____
_____
How often does this behavior occur? _____ Hourly _____ Daily _____ Monthly _____ Rarely
Are there any situations in which the behavior is most likely to occur?_____
_____
_____
Are there any situations in which the behavior is least likely to occur?_____
_____
_____
Please describe all previous and current interventions used_____
_____
_____
Are any of these interventions successful in reducing the behavior? _____ Yes _____ No

Does the Applicant engage in self-injurious behaviors (Any attempt to harm themselves. Examples head banging, biting, poking eyes etc.)_____ Yes _____ No
If yes, has the self injurious behavior resulted in injury? _____ Yes _____ No
Describe this behavior_____
_____
_____
How often does this behavior occur? _____ Hourly _____ Daily _____ Monthly _____ Rarely
Are there any situations in which the behavior is most likely to occur?_____
_____
_____
Are there any situations in which the behavior is least likely to occur?_____
_____
_____
Please describe all previous and current interventions used_____
_____
_____
Are any of these interventions successful in reducing the behavior? _____ Yes _____ No

Behavioral Information Continued

Does the Applicant engage in self-stimulatory behaviors (rocking, hand flapping, repeating vocalizations etc.)_____ Yes _____ No
If yes, has the self-stimulatory behavior resulted in injury? _____ Yes _____ No
Describe this behavior_____
_____
_____

How often does this behavior occur? _____ Hourly _____ Daily _____ Monthly _____ Rarely
Are there any situations in which the behavior is most likely to occur?_____
_____
_____
Are there any situations in which the behavior is least likely to occur?_____
_____
_____
Please describe all previous and current interventions used_____
_____
_____
Are any of these interventions successful in reducing the behavior? _____ Yes _____ No

Please indicate any other behaviors that have occurred in the past 6 months.

_____ Attention Seeking Behaviors _____ Noncompliance _____ Yelling/Screaming

_____Throwing/Dumping Objects _____Running/Elopement _____ Whining/Crying

_____ Spitting _____Putting non edible items in mouth

_____ Other, please explain:_____
_____
_____

Please list any item/activities that the applicant dislikes or may make them uncomfortable (ex. loud noises, animals, swinging, tickles, etc.)_____
_____
_____

Behavioral Information Continued

Does the Applicant accept "No" when he/she cannot have a desired item or activity? If not, please describe the reaction._____
_____

Are you able to remove reinforcing items/activities at home or in public? If not, please describe._____
_____
_____

Does the Applicant wait appropriately? Please describe._____
_____
_____

Does the Applicant demonstrate compliance when asked to follow directions? Please describe_____
_____
_____

Please briefly describe behaviors that the Applicant currently demonstrates that you would like to see continue or increase._____
_____
_____
_____

Please briefly describe behaviors that the Applicant currently demonstrates that you would like to see decrease and or stop._____
_____
_____
_____

Motivators:

What items/ activities are most motivating to the Applicant?

Visual Motivators (ex. TV/movies, computer, video games, wind up toys, light up toys, books, balloons, glittery/shiny items etc.)_____
_____

Auditory Motivators (ex. music, books with sound, whistles, musical instruments, singing etc.)_____
_____

Tactile (touch) Motivators (ex. squishy/stress balls, lotion, sands, beans, shaving cream, play doh, finger painting etc.)_____
_____

Kinetic (movement) Motivators (ex. trampolines, bounce toys, rolling, spinning, jumping, swinging, rocking etc)_____

Parent Expectations

Please state your Vision Statement for your child.

_____
_____
_____
_____

Please describe your Short Term Goals for your child.

_____
_____
_____
_____

Please describe your Long Term Goals for your child.

_____
_____
_____
_____

Please describe how you would like The Joseph Sams School to help you achieve these goals.

_____
_____
_____
_____

Please describe your concerns with your child's current placement.

_____
_____
_____
_____

How did you learn about The Joseph Sams School?

_____
_____
_____