



## The Special Children's School

4505 Shattalon Drive  
Winston-Salem, NC 27106

Phone 924-9309  
Fax 924-0388

### Student Application

Child's name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
Birth date \_\_\_\_\_ Social Security number \_\_\_\_\_  
Address \_\_\_\_\_  
City and zip code \_\_\_\_\_ Phone number \_\_\_\_\_

#### Family History

Father's name: \_\_\_\_\_  
Address and Phone (if different) \_\_\_\_\_  
Birth date \_\_\_\_\_ Social security number \_\_\_\_\_  
Place of Employment and Occupation \_\_\_\_\_  
Work Phone \_\_\_\_\_ Estimate annual income \_\_\_\_\_

Mother's name: \_\_\_\_\_  
Address and Phone (if different) \_\_\_\_\_  
Birth date \_\_\_\_\_ Social security number \_\_\_\_\_  
Place of Employment and Occupation \_\_\_\_\_  
Work Phone \_\_\_\_\_ Estimate annual income \_\_\_\_\_

Child lives with: \_\_\_\_\_ Both Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other  
If Other, Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Address and Phone (if different) \_\_\_\_\_  
Place of Employment and Occupation \_\_\_\_\_  
Work Phone \_\_\_\_\_

Others living in home with child

Name: _____	Relation: _____	Age: _____
Name: _____	Relation: _____	Age: _____
Name: _____	Relation: _____	Age: _____
Name: _____	Relation: _____	Age: _____

Do you receive support payments on behalf of your child from outside sources?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, from whom? \_\_\_\_\_

Does your child receive any of the following?

Medicaid \_\_\_\_\_ if so, Medicaid Number \_\_\_\_\_

Private Insurance \_\_\_\_\_ if so, Name \_\_\_\_\_

---

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

CAP \_\_\_\_\_ if so, Case Manager \_\_\_\_\_

Early Intervention \_\_\_\_\_ if so, Child Service Coordinator \_\_\_\_\_

Educational History

Has your child attended a day care or school? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, Where? \_\_\_\_\_ For how long? \_\_\_\_\_

Who referred you to this school? \_\_\_\_\_

Is your child receiving any of the following services?

Physical Therapy \_\_\_\_\_ Provider \_\_\_\_\_ Sessions per Week \_\_\_\_\_

Occupational Therapy \_\_\_\_\_ Provider \_\_\_\_\_ Sessions per Week \_\_\_\_\_

Speech Therapy \_\_\_\_\_ Provider \_\_\_\_\_ Sessions per Week \_\_\_\_\_

Nursing Services \_\_\_\_\_ Provider \_\_\_\_\_ Visits per Week \_\_\_\_\_

Medical History

Were there any problems during pregnancy, birth or delivery? \_\_\_\_\_

Were there any problems during the newborn period? \_\_\_\_\_

Is your child undergoing any current medical treatment? \_\_\_\_\_

Does your child take any medication? If so, please list: \_\_\_\_\_

Does your child have any known allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, please list: \_\_\_\_\_

Has your child had any surgeries, illnesses, seizures or hospitalizations? \_\_\_\_\_

If so, please list: \_\_\_\_\_

Child's Primary Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child see any specialist? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, Who? \_\_\_\_\_

Where are they located? \_\_\_\_\_

Developmental History

Please check all that apply

Does your child have difficulty in: \_\_\_\_\_ sucking \_\_\_\_\_ swallowing \_\_\_\_\_ seeing  
\_\_\_\_\_ attending \_\_\_\_\_ talking \_\_\_\_\_ chewing \_\_\_\_\_ hearing \_\_\_\_\_ walking \_\_\_\_\_ sitting

At what age did your child accomplish the following skills?

Rolling \_\_\_\_\_ Crawling on belly \_\_\_\_\_ on hands and knees \_\_\_\_\_

Sitting \_\_\_\_\_ pulling to stand \_\_\_\_\_ walking \_\_\_\_\_

Does your child use a bottle \_\_\_\_\_ cup \_\_\_\_\_ finger feed \_\_\_\_\_

use a spoon \_\_\_\_\_  
Does your child vocalize different sounds \_\_\_\_\_ use words \_\_\_\_\_  
Speak in sentences \_\_\_\_\_

---

Does your child have any adaptive equipment? Please check all that apply  
Wheelchair \_\_\_\_\_ adaptive stroller \_\_\_\_\_ braces \_\_\_\_\_ hearing aid \_\_\_\_\_  
Communication devices \_\_\_\_\_ switches \_\_\_\_\_ switch activated toys \_\_\_\_\_  
Wear glasses \_\_\_\_\_

Please list your child's strengths and needs

Strengths \_\_\_\_\_

Needs \_\_\_\_\_

### Child's Behavior

Please check all that apply

attentive _____	takes a nap _____
clings to caretaker _____	cries easily _____
easily distracted _____	short attention span _____
overactive, restless _____	friendly _____
withdrawn _____	easily frustrated _____
disruptive _____	aggressive towards other children _____
language difficulties _____	avoids eye contact _____
speech problems _____	spits _____
natural curiosity _____	toilet trained _____
temper tantrums _____	in diapers _____
repetitive behaviors _____	demands excessive attention _____
cooperative _____	does not follow direction _____
shy _____	takes turns, shares _____
bites _____	eats well _____

---

Has your child been evaluated by a psychologist or evaluation clinic? \_\_\_\_\_

If so, where? \_\_\_\_\_ When? \_\_\_\_\_

If your child is younger than 3 years, has your child been referred to Consortium?  
(consisting of members from Forsyth/Stokes Mental Health, Forsyth Health Dept  
and the Developmental evaluation clinic) \_\_\_\_\_

If yes, when? \_\_\_\_\_

If not, please sign the following permission statement:

I hereby give permission for my child's name to be referred to Placement Consortium. A member of the Consortium will contact the parents about their child's placement within 45 days after receiving the referral.

---

Parent/Guardian Signature

date

Signature of person completing the application:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
date

Relationship to child \_\_\_\_\_

\*Please note incomplete applications will not be accepted.

Please return the completed application to:

The Special Children's School  
4505 Shattalon Drive  
Winston-Salem, NC 27106  
Attention: Social Work Dept.

Or you may fax the completed application to:

Attn: Social Work Dept.  
Fax: 924-0388