The Bridge of Georgia

2020-2021 Connections Application

Applicant Information: **Current Client**: ☐ **New Client**: ☐ **Date:** _____

Client Name: _____ Date of Birth: _____ Gender: Female ☐ Male ☐

Age as of August 1st: _____ Class Entering: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

Client Ethnicity: _____ Client Race: _____

Other: _____

How Did You Hear About Us? _____

Primary Language Spoken at Home: _____ Birth City: _____ Birth State: _____ Birth Country: _____

Religious Affiliation: _____

Does client have any educational challenges that they have been diagnosed with? Yes ☐ No ☐

If yes, please list the diagnosis: _____

Previous Schools (Optional)

Most Recent Attended: _____

School Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Grade Completed: _____

From Date: _____ To Date: _____

Previous Schools (Optional)

Second Recent Attended: _____

School Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Grade Completed: _____

From Date: _____ To Date: _____

School where last IEP was created _____ County: _____

Parent/Guardian Information

Home Address if Different Than Client:

Home Address: _____ City: _____ State:_____ Zip: _____

Home Phone: _____

#1 Parent/Guardian:

Last Name: _____ First Name: _____ Gender: Female ☐ Male ☐

Relationship to Applicant: _____ Custodial Rights: Yes ☐ No ☐

Financial Responsibility: Yes ☐ No ☐ Marital Status: _____ Religious Affiliation: _____

Receive Correspondence: Yes ☐ No ☐ E-mail 1: _____ E-mail 2: _____

Cell Phone: _____ Work Phone: _____

Employer: _____ Job Title: _____

Employer Address: _____ City: _____ State:_____ Zip: _____

Highest Level of Education: _____ School Name: _____ Degree: _____

#2 Parent/Guardian:

Last Name: _____ First Name: _____ Gender: Female ☐ Male ☐

Relationship to Applicant: _____ Custodial Rights: Yes ☐ No ☐

Financial Responsibility: Yes ☐ No ☐ Marital Status: _____ Religious Affiliation: _____

Receive Correspondence: Yes ☐ No ☐ E-mail 1: _____ E-mail 2: _____

Cell Phone: _____ Work Phone: _____

Employer: _____ Job Title: _____

Employer Address: _____ City: _____ State:_____ Zip: _____

Highest Level of Education: _____ School Name: _____ Degree: _____

Please list names and ages of all those living in the home:

_____

_____

Does the client have a parent/guardian that lives at another address? Yes ☐ No ☐

Does the client have any siblings? Yes ☐ No ☐
If yes, please list name and ages: _____
_____

Does the client have any other relatives who currently attend, have attended or have graduated from our school?
Yes ☐ No ☐ If yes, please list: _____

Medical Information

Primary Doctor: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Preferred Hospital: _____

Insurance Company: _____
Policy: _____ Group: _____
Name on Insurance: _____

Any Known Allergies to Medications: Yes ☐ No ☐
If Yes, Please list: _____

Any Known Allergies to Food: Yes ☐ No ☐
If Yes, Please list: _____

Any Known Allergies to Bites/Stings from Insects: Yes ☐ No ☐
If Yes, Please list: _____

Any Known Allergies to the Environment: Yes ☐ No ☐
If Yes, Please list: _____

Does the client have any of the following?

☐ Asthma	☐ ADD/ADHD	☐ Epilepsy/Seizures	☐ Headaches/Migraine	☐ Diabetes
☐ Head Injury	☐ Nose Bleed	☐ Heart Condition	☐ Reflux/Indigestion	☐ Hypoglycemia
☐ Bipolar	☐ Bone/Joint Issues	☐ Bladder/Kidney Issue	☐ Down Syndrome	☐ Mitochondrial

Does the client have any medical challenges that they have been diagnosed with? Yes ☐ No ☐
If yes, please list the diagnosis and who gave diagnosis. _____
_____

Does the client have any other special medical considerations we need to be aware of? Yes ☐ No ☐
If yes, please list: _____
_____

Does the client take prescribed medications on a daily basis? Yes ☐ No ☐
If yes, please list: _____
_____

Does the client take over the counter medications: Yes ☐ No ☐
If yes, please list: _____
_____

Behavior Assessment

Please check any behaviors that the client has exhibited in the last three months?

☐ Biting	☐ Hitting	☐ Kicking	☐ Pulling Hair
☐ Licking	☐ Self-Injury	☐ Head banging	☐ Dumping liquids
☐ Running	☐ Screaming	☐ Chewing	☐ Throwing Things
☐ Aggression to animals	☐ Scratching	☐ Pinching	☐ Inappropriate laughter
☐ Inappropriate crying			

Does the client have behavior difficulties that have caused removal from other programs? Yes ☐ No ☐
If yes, what were the behaviors and what type of program*?* _____
_____

What behaviors concern you the most in the home and community? _____
_____

Has the client had a behavior assessment done before? Yes ☐ No ☐
If yes, where was it done*?* _____
(Please submit a copy of the behavior assessment or Behavior Intervention Plan if possible.)

Are there certain events that seem to trigger behavior outbursts? Yes ☐ No ☐
If yes, what are they? _____
_____

What methods have you tried to use to manage behaviors? _____
_____

Have they been successful? Yes ☐ No ☐

A strong component of our behavior management plans is a parent support component. When we put together a plan, the greatest success comes when it is implemented across environments. Are you willing to come to training, implement behavior plans at home, and be a part of the team to help your child reduce inappropriate behaviors and gain appropriate behaviors? Yes ☐ No ☐

Please use this space to tell us of any other concerns regarding behaviors*:* _____
_____
_____

Communication Assessment

Does the client presently see a speech therapist? Yes ☐ No ☐ Name of Speech Therapist: _____

What is the client's primary area of need in the area of communication? _____

How does the client communicate? Please check the following that apply:

☐ Has articulation errors.	☐ Understands what I say and often responds
☐ Often does not seem to understand what others say.	☐ Has difficulty initiating conversation.
☐ Uses sign language.	☐ Uses a picture communication system.
☐ Has difficulty responding to conversations.	☐ Speaks but is often babbling or meaningless.
☐ Often seems frustrated because he/she is not understood.	☐ Language mostly of scripts from movies/books.

☐ Tries to communicate wants and needs through verbal communication.
☐ Has an augmentative communication device. Which one? _____

Communication Assessment cont.

Can you estimate the amount of words the client uses regularly?

☐Less than ten ☐Between ten and thirty ☐Between thirty and fifty ☐Between fifty and one hundred ☐Hundreds

What would be your number one goal in language and communication? _____

_____

_____

_____

Self-Help Skills Questionnaire

Toileting:

☐ Fully toilet-trained and goes without reminders and without help.
☐ Fully toilet-trained but goes on a schedule and without help.
☐ Fully toilet-trained but goes on a schedule and does need help.
☐ Trained for urine but not bowel movements.
☐ Currently toilet-training but is not yet consistent.
☐ Is not toilet-trained at all.

Eating:

Is client on special diet? Yes ☐No ☐
If yes, please explain: _____

Client is able to drink from the following:

☐Straw ☐Sippy cup ☐ Small cup with no lid

What does client drink from most often*?*_____

Does the client independently eat with utensils? Yes☐ No ☐

Does the client chew and swallow thoroughly? Yes ☐No ☐

Is the child limited in what he/she chooses to eat? If so, describe: _____

_____

_____

Other Self-help Skill

☐Put on shoes
☐Take off shoes
☐Put on socks
☐Take off socks

☐Pull down underwear
☐Pull up underwear
☐Put on shirt
☐Take off shirt

☐Pull up pants
☐Pull down pants
☐Brush hair
☐Wash hands
☐Brush teeth with limited help

Please use the space below to share any self-help concerns you have or any extra areas in which they may need help.

_____

_____

_____

Sensory Assessment

Please check the following that apply to the client:

- ☐ Becomes upset if he spills something on his clothes.
- ☐ Is sensitive to strong smells.
- ☐ Is alarmed by loud noises and loud spaces.
- ☐ Is distracted or becomes agitated with some types of lights.
- ☐ Is very picky about the fabrics he/she will wear or tags in clothes.
- ☐ Is uncomfortable with certain textures. Please describe*:* _____
- ☐ Often falls off of his seat.
- ☐ Enjoys using a weighted blanket.
- ☐ Likes to hold small objects in his/her hand.
- ☐ Only eats a limited number of foods.
- ☐ Does not like to be touched.
- ☐ Will not walk on the grass barefooted.
- ☐ Does not like to have haircuts or get hair washed.
- ☐ Likes to spin or watch things spin.
- ☐ Likes to swing.
- ☐ Likes to jump on the trampoline.

Please list things that make your child uncomfortable and things that make your child feel calm: _____
_____
_____
_____
_____
_____
_____

Does your child see an occupational therapist? Yes ☐ No ☐ Name of therapist: _____

Signature Page:

The electronic signatures below and their related fields are treated by The Bridge of Georgia School, Inc. like a physical handwritten signature on a paper form. (This form can be printed and filled out if necessary.)

Agreements:

My signature below affirms that all of the information contained in this application is correct, complete, and honestly presented. I understand that withholding or misrepresenting information in this application may jeopardize my child's admission.

☐ Check for electronic signature. Name: _____ Date: _____

Release of Records:

I waive my right to access confidential information contained in my child's admission file.

☐ Check for electronic signature. Name: _____ Date: _____