



APPLICATION FOR ADMISSION

THIS APPLICATION IS FOR: residential placement day placement

This form is being completed by _____ (relationship to child) Date _____

CHILD'S FULL NAME _____ S.S. # _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

Other children in the family (please include any pregnancies ending in miscarriage, abortion or still birth):

Names _____	Date of Birth _____
_____	_____
_____	_____

BIOLOGICAL MOTHER'S NAME _____ Birth date: _____
 Age at the time of child's birth _____ SS# _____ Married
 ADDRESS _____ Separated
 PHONE _____ (H) _____ (W) Divorced
 FAX _____ E-Mail _____ Widowed
 CELL PHONE _____
 OCCUPATION _____
 BUSINESS NAME/ADDRESS _____

BIOLOGICAL FATHER'S NAME _____ Birth date: _____
 Age at the time of child's birth _____ SS# _____
 ADDRESS _____
 PHONE _____ (H) _____ (W) FAX _____
 CELL PHONE _____ E-Mail _____
 OCCUPATION _____
 BUSINESS NAME/ADDRESS _____

IMPORTANT

PLEASE PASTE

RECENT

PHOTOGRAPH

HERE!

CUSTODIAL MOTHER'S NAME _____
 Check here if same as biological mother
 ADDRESS _____
 PHONE _____ (Home) _____ (Work)
 FAX _____ E-Mail _____
 OCCUPATION _____
 BUSINESS NAME/ADDRESS _____

CUSTODIAL FATHER'S NAME _____
 CHECK HERE IF SAME AS BIOLOGICAL FATHER
 ADDRESS _____
 PHONE _____ (H) _____ (W)
 FAX _____ E-MAIL _____
 OCCUPATION _____
 BUSINESS NAME/ADDRESS _____



Camphill Special School
1784 Fairview Road
Glenmoore, PA 19343

Phone: 610-469-9236
Fax: 610-469-9758

INDIVIDUAL INFORMATION SHEET

Name: _____
Last First Middle

Sex: _____ Birth date: _____ Race: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Religious Affiliation: _____ Primary language spoken at home: _____

Scars or Identifying Marks: _____

Person (s) to be contacted in case of emergency:

Name	Relationship

Address	Phone #

Person to give consent for medical treatment: _____

Contact information/ Phone #: _____

Personal physician / source of health care:

Name	Address	Phone#

Personal dentist / source of dental care:

Name	Address	Phone#

Any Specialist Physicians:

Preferred Hospital:

Insurance Information (Name and Telephone Number of Healthcare Provider):



Thank you for answering the following questions to the best of your knowledge. This information, which will be kept strictly confidential, will help us to understand your child.

I. PREGNANCY

(a) Do you know of any hereditary or congenital diseases in the family on either side? Note any of the following conditions: genetic syndromes, autism, epilepsy, mental or nervous diseases, malformations, deafness or other serious diseases?

(b) Describe any bleeding (during pregnancy), premature labor, infections, accidents or medical complications.

(c) Were there any X-rays, ultrasounds tests, or amniocentesis during pregnancy? If so, state.

(d) Was mother taking any prescription or illicit drugs, or other medicines during pregnancy? Please give details.

(e) Was your child planned? _____ Was your child wanted? _____

Comments _____

(f) During pregnancy, were there any mental or emotional strains? When and cause?

(g) Any additional comments on the pregnancy? _____



II. BIRTH

(a) Length of Pregnancy _____ (b) Duration of Labor _____

(c) Describe Birth, easy or difficult, instruments used, anesthesia, c-section, etc.

(d) Describe the neonatal course (e.g. neonatal ICU, care, treatment for jaundice, antibiotics, spinal tap, oxygen, etc.)

(e) Did the baby require special treatment to assist breathing? (injections, oxygen, etc.)?

(f) Birth weight: _____ lbs. _____ oz.

(g) Apgar Scores _____ (1 minute) _____ (5 minutes)

(h) Any other comments on the birth. _____

III. INFANCY

(a) How was your baby fed during the first year of life? _____

(b) Did the infant show affection in the usual way? Was he/she quiet or restless? Was he/she a "happy" baby?

(c) Were there any disturbances of digestion, recurrent vomiting, or colic?

(d) Was there any unusual sleep pattern? _____



IV. DEVELOPMENTAL MILESTONES:

(a) At what age was:

- First smile _____
- Reaching out for things _____
- Teething _____
- Sitting unaided _____
- Walking unaided _____
- First word said _____ What was it? _____
- Speaking in sentences _____
- Toilet trained by day _____ by night? _____
- Any other comments relating to infancy _____

(b) Were there any periods of regression, loss of speech, etc.? _____

(c) Did your child have tics, repetitive movement patterns, fixations or self-stimulatory behavior?

(d) When and why did you become concerned that your child was not developing normally? What did you do about it?

(e) What is your child's diagnosis? When was it first made? Has it changed over the years?

(f) What do you, as parents, think was the cause of your child's difficulties?



V. CHILDHOOD TO PRESENT

(a) COMMUNICATION

1. Describe your child's ability to speak, and/or other means of communication. _____

2. What other means are used (sign, gesture, assistive device)? _____

(b) BEHAVIOR

1. Has your child received special behavioral treatment or therapy, such as wrap-around services, or ABA (Applied Behavioral Analysis)? yes no

If so, did you find ABA helpful? Give details _____

Where were the services received: (name/address) _____

Dates (approximate) _____

2. Describe any self-stimulatory behaviors and/or aggressive behaviors, such as rocking, head-banging, and/or verbal or physical aggression, etc. _____

3. Describe any behavior issues, e.g. running away, stealing, bad habits, obsessions and/or compulsions, destructiveness, self-abusive, aggression (verbally/physically, etc.)?

4. When does the inappropriate behavior(s) usually occur (what conditions/situations)?



5. What do you do to discipline the child?

6. How does she/he react to discipline? _____

7. Does your child have a "behavior plan?" If so, are you willing to work with the school staff to review and modify if necessary?

8. Describe any issues or history of difficulties around sexuality. Are you open to working with the school staff in this realm? _____

9. Describe your child's self care and toileting habits (teeth brushing, washing, toilet trained, etc.)

10. How many hours per day does your child watch TV, movies, or play computer/video games? Please specify.

Are you willing to work with staff to make adjustments to media exposure, if necessary?

(C) EATING HABITS

1. Describe eating habits (use of utensils, how your child relates to food/meal times) _____

2. What does your child usually eat for:

Breakfast _____

Lunch _____



Supper _____

Snacks _____

How many snacks a day? _____

3. Is your child on a special diet? What is the reason for the special diet? _____

Give details. _____

(D) SLEEPING HABITS

1. Describe sleeping habits (bedtime, how long, how deeply). _____

2. What does your child do if he/she awakens in the night (cry, make noise(s), wander, etc.)?

(E) MEDICAL-DIAGNOSIS/TREATMENT

1. What illnesses or childhood diseases has your child had, and at what age?

2. Describe any falls or accidents and at what age. _____

3. Has your child had any seizures? If so, describe type, duration, and frequency. Did they recur at particular times? _____



4. ALL **CURRENT** MEDICATIONS AND PURPOSES (SEIZURES, ANXIETY, BEHAVIOR, ETC.), DOSAGES AND WHEN STARTED (APPROXIMATELY).

Drug	Dosage	Purpose	Date Started

LIST ALL **PREVIOUS** MEDICATIONS AND PURPOSES (SEIZURES, ANXIETY, BEHAVIOR, ETC.), DOSAGES AND WHEN STARTED AND STOPPED (APPROXIMATELY).

Drug	Dosage	Why was it discontinued?	Date Started/Stopped

5. Has your child been prescribed or given any unconventional treatments—special diets, supplements, vitamins, homeopathy, etc.? _____

Have they been effective? _____

6. Admission or out-patient attendance at hospital:

(a) Date(s) of Admission _____

(b) Name and address of hospital(s) _____

(c) Name of doctor(s) or surgeon(s) _____



(d) Reason(s) for admission or attendance _____

(F) SOCIAL

1. How would you describe the child as a person?

Strengths and Needs _____

2. What does your child like to do? (hobbies/interests)

3. What kinds of things scare or worry your child?

4. What are some of the things your child does which please you or make you proud?

5. Put a circle around any of the following things which concern you about the child.

- | | |
|--|--------------------------------------|
| 1. Bedwetting | 14. Nightmares |
| 2. Wetting during the day | 15. Temper Tantrums |
| 3. Thumb sucking | 16. Contrary or stubborn |
| 4. Stammering or stuttering | 17. Disobedient |
| 5. High strung or easily upset | 18. Lying |
| 6. Too restless | 19. Selfish in sharing |
| 7. Shy | 20. Jealous of brothers & sisters |
| 8. Sad or sulky | 21. Fighting with other children |
| 9. Feelings easily hurt | 22. Purposely destroys things |
| 10. Wanting too much attention | 23. Feeding |
| 11. Wanting too much comfort/
support from parent | 24. Toilet issues |
| 12. Day dreaming | 25. Any other problems? Or comments: |
| 13. Sleep issues | |



Elaborate further if needed:

6. How does your child get along with mother, father, and other children/family members? Does your child show normal affection? How does child relate to peers?

7. How many other members of the family live in the same house as the child and what is each member's relationships to the child?

8. Are there any family social/economic issues, such as problems with housing, employment, food, etc. (describe)?

9. Who looks after the child most of the time?

Day? _____

Night? _____

10. Please describe any other incidents or facts which might help understand your child's difficulties and what may cause/have caused them?

(G) EDUCATION

a. Why are you considering a change of school for your child at this time?



b. Are you presently considering any other school(s)?

c. What is the current ratio of staff/child at your child's current/previous school?

d. Has your child needed or does need a classroom aide?

Why?

e. Has your child needed or does one-to-one-nursing or a TSS?

f. Does your child presently receive related services? List types and frequency (e.g. Speech – 1x/week 30 min.)

g. Are you open to reassessing/adjusting the need for/frequency related services in order to achieve the right balance for your child should he/she begin at Camphill Special School?

h. How does your child relate to going to school/education?

i. Describe your child's academic abilities.

j. What does your child like best/least about school?



11. Has your child seen a psychologist, psychiatrist, counselor, or other mental health professional? If so, please state reason _____

Name and address _____

Approximate period of attendance _____

Advice given to you, and your comments _____

12. Has your child undergone any psychological or intelligence tests? yes no

(1) If yes, where was he/she tested? _____

When? _____ Result of Test (IQ) _____

(2) Where was he/she tested? _____

When? _____ Result of Test (IQ) _____

13. Has your child had any private tutoring? yes no

When? For what _____

14. Where? And when was most recent evaluation? _____

15. If any unusual progress or regression took place during school attendance and/or transitions, please describe. _____



16. Are you comfortable with the fact that Camphill Special School does not generally encourage computer use through the elementary school (below grade 9)?

17. If your child is accepted, would you continue, or plan any other programs after or during school hours? If so, please explain/describe. Camphill Special School offers a full educational program and services; additional programs may conflicts with our programs/practices.

VI. QUESTIONS FOR HIGH SCHOOL APPLICATIONS:

1. What do you envision for your child beyond 12th grade (the completion of Camphill Special School's program on our Beaver Run campus at age 18 or19)?

2. Are you willing to be actively involved in looking for new/appropriate placements for the 18/19- to 21-year phase of your child's education?

3. Are you aware that there is a separate application for Camphill Special School's Transition Program? (for ages 18/19 to 21)

VII. PARENT INVOLVEMENT

1. How would you like to, or imagine you would, be involved in your child's education (e.g. parent teacher evenings, parent workshops, parent groups, volunteering for events, etc.)

Specify

2. If your child is accepted as a residential student, might you be making on-campus visits? How often?

a. Might you be taking your child for weekend visits? How often?



b. Would you like a current parent to contact you regarding their experience at Camphill?
 Yes No

HOW DID YOU LEARN ABOUT CAMPHILL SPECIAL SCHOOL?

IF YOU ARE APPLYING FOR RESIDENTIAL PLACEMENT PLEASE TELL SOME OF YOUR REASONS OR MOTIVATING FACTORS

Do you have remarks you wish to add? Please feel free to use additional sheets for more information on any of the previous questions, or for any information you feel important that was not asked for.

LIVING GRANDPARENTS

MATERNAL (names/address/phone)

PATERNAL (names/address/phone)

1 _____ 2 _____

3 _____ 4 _____



Do you know of others who might wish to receive information about Camphill Special School?

- Name/Address

Relationship to you _____

- Name/Address _____

Relationship to you _____

- Name/Address _____

Relationship to you _____

Please return application to: Admissions Office: Camphill Special School

1784 Fairview Road
Glenmoore, PA 19343

Camphill Special School does not discriminate on the basis of race, age, color, creed, gender,
sexual orientation, national origin, ethnic origin, or disability.



Dear Parent or Guardian:

This form enables Camphill Special School to obtain medical information about your child. Please send one to the doctor who has been chiefly responsible for your child's care and one to either a specialist, or to a hospital (if your child has been hospitalized).

Please do not send this form to Camphill. Send it directly to the doctor/clinic who has seen your child.

**Richard G. Fried, M.D., School Physician
Camphill Special School – Beaver Run
1784 Fairview Road, Glenmoore, PA 19343**

TO: _____
(name of doctor, hospital or clinic)

(address)

Please send copies of office records and / or any applicable hospital discharge summary concerning my child

(child's name and date of birth)

to Dr. Fried at the above school address, for the purpose of review and evaluation for possible admission and/or treatment. Please list any treatment dates or time frame:

This authorization expires one year after the date below. We have the right to revoke this authorization. We confirm that we have not been required by the doctor, hospital, or clinic to sign this authorization in order to receive treatment or payment or to enroll or be eligible for benefits.

Signed _____
(Parent/guardian)

Address: _____

_____ Phone: _____

Date _____



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_____ Phone: _____

Date _____