Kidspiration
Pediatric Therapy Services

Thank you for your interest in our Early Intervention Day Treatment (EIDT/Preschool) Program! Please fill out and return the right side of this packet as soon as possible in the folder. The left side is for you to read over and keep at home. The initial testing process can take 4-6 weeks from the time you return the packet filled out. We will keep you updated on your child's progress along the way!

**Please note, your child must have full Medicaid, AR Kids A, SSI, Waiver, or TEFRA to participate in the preschool program.** If your child has private insurance or AR Kids B (you pay a small co-pay at the doctor) then they are ineligible for EIDT services but may be evaluated for our Outpatient therapy program. If you have any questions about your child's insurance, please call our office at 870-424-4021.

# Kidspiration Pediatric Therapy Services, Inc.

# EIDT Clinic and

# Developmental Preschool

Right Side of Packet

(parent copies to return)

- Daycare consents initialed and signed for enrollment
- Transportation Standing Order for emergency care
- Developmental Questionnaire for testing
- Food Program Sheet

**Parent**

**to provide social security card, birth certificate, and Medicaid card**

Dear Parents/Guardians,

Welcome to Kidspiration Pediatric Therapy Services! We are very excited to have your child in our facility for evaluation! The attached preschool enrollment packet contains

important information about our program as well as required forms that will need to be filled out and returned to us. Please take the time to review the information included. The sooner you get this packet completed and returned to us the sooner we can get your child in for testing!

After we get this packet and a signed referral from your child's doctor, we will schedule your child to come in for a screening with Optum to get approval for our Early Intervention Day Treatment program (daycare). If Optum says your child "may need services" we will schedule your child for Occupational, Physical, and Speech evaluations with our therapists. If he or she qualifies in at least one area of therapy (OT, PT, ST) we will have your child come back for a developmental evaluation. If your child also qualifies on the developmental evaluation, then they are eligible to participate in our preschool program Monday-Friday and receive therapy throughout the week.

Please contact us if you have any questions or concerns regarding the information and forms provided. We look forward to meeting your child and watching them grow and learn in our program!

Leah Coleman, Owner/Director

Here at Kidspiration, we believe that all children are special! Here are some helpful hints and guidelines that will assist us in providing your child with the best care possible.

- The following items are required before your child can be enrolled in the current

    1. Copy of your child's current shot record. State law requires current immunizations and must be kept up to date.
    2. Copy of Birth Certificate
    3. Copy of Social Security Card

4. Copy of Medicaid Card (if applicable)

- All children are required to bring a change of clothing to be kept at the center in case of an accident or emergency.

- All infants and toddlers should have a supply of diapers/pull-ups, bottles, milk or formula. The caregivers will inform you when more is needed. All items brought in for your child must be clearly labeled with your child's name.

- Breakfast is served at 8:00 am and lunch is served at 11:30 am, after snack will be served at 2:00 pm.

- Please make sure your child is here between 7:30-8:00 am for breakfast and so that they do not miss any therapy or important classroom learning. If your child has an appointment and will arrive later than 8:00 am please call the office and let us know approximately what time they will arrive.

- Every child must be signed in by a parent/guardian upon arrival and signed out when they are leaving for the day.

- Upon arrival please wait in the lobby area for a Kidspiration staff member to greet you and walk your child to class. We do not allow parents or visitors past the front lobby without a staff member. This is for the children's and the safety of the children's medical records.

- There are medication sheets in the nurse's office that must be filled out and signed before medication can be administered to your child. The nurse will ONLY administer medications that are necessary and properly labeled. If the medication is only needed once or twice a day, please give your child the required doses at home.

Please fill out the attached information as it will help us provide appropriate care during the day while your child is with us. Once again, Welcome to KIDSPIRATION!

Kidspiration
Pediatric Therapy Services
Phone: (870) 424-4021 Fax: (870) 424-4112

Parents:

Kidspiration partners with Southeastrans to provide Medicaid funded transportation for our students enrolled in the preschool. In order to get transportation set up for your child, please contact Southeastrans directly.

**Call toll free: 1-888-833-4136**

When you call:

- Have your Medicaid ID ready.
- Provide your name, date of birth, address, and phone number.
- Provide the name, address, and phone number of your doctor.
- Any special transporting needs you might have.
- Your child's hours at Kidspiration are 7:30-3:30 (this is the time the van will drop your child off at Kidspiration in the morning and pick them up from our center. The actual pick-up and drop-off times from your home may vary.)

If you have any questions, feel free to call us and we will do our best to help!

**Please remember that Medicaid requires that the child have no other form of transportation to qualify for van transportation. Make sure you tell the operator that you do not have a vehicle or working vehicle when you call!*

# Kidspiration Pediatric Therapy Services, Inc.

Child's Name: _____ Date of birth: _____

Parents/guardians: _____ Phone number: _____

Persons authorized to pick child up and their phone numbers:

_____

_____

_____

_____

Food allergies: _____ Drug allergies: _____

**Emergency Authorization**

In the case of an emergency we will contact the parent to notify you on need to transport your child to the hospital. In the case of a true emergency we will call 911 and a member of the staff will go with your child to seek medical attention and stay with them until a parent/guardian can get there.

I, _____, parent/ guardian of _____, authorize an acting representative of the school to give consent for any and all necessary emergency medical care for my child. I hereby give my consent to Kidspiration to call Dr. _____ at the following number _____ or to take my child to a hospital emergency room should any emergency arise where such medical service is indicated.

**Medical Authorization**

I hereby authorize the following over the counter medications to be given to my child as needed. Please initial by any medications that can be given at school.

___ Tylenol ___ Ibuprophen ___hydrocortisone (anti itch cream) ___Benadryl (antihistamine) ___antibiotic ointment ___sunscreen ___ diaper ointment __Lice Treatment

I understand that any prescription medications will require a separate form to be filled out before the nurse can give it at school. I understand that no medications can be left in my child's bag in the classroom regardless if it is given while at school. If medication is sent in their bag, then it will be kept in the nurse's office until the end of the day. _____ (Initials)

# Kidspiration Pediatric Therapy Services, Inc.

**Publicity Release Consent**

I hereby give consent for my child's participation in the following forms of publicity releases. Please initial by the forms of publicity your child may participate in. Staff are trained and informed on the rules regarding posting of videos or pictures on the Kidspiration website. All pictures are screened to be sure the child's parent has given consent prior to being posted on any website associated with Kidspiration.

_____ **My child <u>CAN</u> have Publicity** (Kidspiration Facebook Page and/or Website)
_____ **<u>NO PUBLICITY ALLOWED</u>**

**HIPAA Release**

I hereby give permission for my child's allergies/medical needs to be posted in their classroom, the kitchen and other areas as needed. I understand that this information will be posted to ensure all staff members are aware of my child's allergies/medical needs, and that this information will be behind a cover page to protect the confidentiality of my child's medical needs. _____ (Initials)

**Interviewing Children**

This is a statement of verification that I have been informed that my child may be interviewed by Child Care Licensing, DCFS Special Investigators or law enforcement officers for investigative purposes or for determining compliance with licensing requirements. _____ (Initials)

**Kindergarten Readiness Skills**

This is to acknowledge that I have received the Kindergarten Readiness Skills Calendar for my child in accordance with licensing requirements. _____ (Initials)

**Shaken Baby Syndrome Handout**

This is to acknowledge that I have received information on the prevention of Shaken Baby Syndrome in accordance with licensing requirements. _____ (Initials)

**Attendance Policy**

I understand that my child's hours at Kidspiration are Monday through Friday from 7:30-3:30pm. I understand that I can meet with the director to arrange different days or times and provide a work/school schedule at the meeting. I understand that my child can be dropped from the program if they miss 10 days of school without any communication from me as to why they are absent. I understand that it is my responsibility to inform the school of any changes in the person's authorized to pick my child up from school., any changes in the way they are getting to or from school (buses) and to report any changes in my address or phone numbers. I understand that this is for the safety of my child and so that the school can reach me in the case of any illness or emergency that may arise. _____ (Initials)

# Kidspiration Pediatric Therapy Services, Inc.

Discipline Policy

I have read the discipline policy and understand that NO corporal punishment is used at Kidspiration. I understand that discipline is directed more towards behavior modification. I understand that all measures will be sued to communicate with me in regard to my child's behavior at school and may consist of meeting with the director in order to address the individual needs of my child. _____ (Initials)

Immunization Policy

I am aware that per the minimum licensing requirements for childcare centers that my child's immunizations must be kept up to date for them to be enrolled in daycare. I understand that if I choose to waive immunization that it is my responsibility to obtain an Immunization Waiver from the state every year and to provide the school with a copy of this waiver. I am aware that if my child has received immunizations in another stat then it is my responsibility to provide the school with proof of their immunizations. _____ (Initials)

I give consent for the nurse at Kidspiration to obtain my child's immunization record from the Arkansas WebIZ program to be used to track my child's immunizations during their enrollment at Kidspiration. I am aware that I can request a copy of my child's immunization record at any time while they are enrolled at Kidspiration. _____ (Initials)

Consent for Enrollment

I have been provided with a copy of the Kidspiration Pediatric Therapy Services, Inc. Parent Information and Policy Guide. I am aware that any concerns with these policies can be addressed in a meeting with the director. By signing below, I am agreeing to the enrollment of my child at Kidspriration Pediatric Therapy Services, Inc.

_____ _____

Parent/Guardian Signature Date

_____ _____

Kidspiration Staff Signature Date

# Allergies:

____ My Child has no known allergies

Please list any known allergies and reactions:

_____

_____

_____

_____

Please provide information on how to treat your child's allergic reaction:

_____

_____

Medications prescribed for allergy and date prescribed:

_____

_____

_____

_____ _____

Parent/Guardian Signature Date

# Kidspiration Pediatric Therapy Services, Inc.

## Bathing Policy

At times it may be necessary to bathe a child at the center. Children frequently have accidents, soil themselves, or become quite dirty while playing. Kidspiration is equipped with adequate bathing facilities. Bathing is scheduled on an individual, as needed basis, and is not a part of the regular routine. At NO TIME shall a child be left unsupervised during this procedure. It will be at the discretion of the Director, RN, or other professional that a bath is appropriate and will provide adequate supervision of the bathing procedure. All classrooms will remain within ratio during the time a child is out being bathed.

Signature of Parent/Guardian: _____

Date: _____

# Pick-up List

Date:_____

Child's Name: _____

Mom/Guardian Name: _____ Mom/Guardian Cell#: _____

Mom/Guardian Workplace: _____ Mom/Guardian Work#: _____

Dad/Guardian Name: _____ Dad/Guardian Cell#: _____

Dad/Guardian Workplace: _____Dad/Guardian Work #: _____

Home phone # _____

## Person's Authorized to Pick Up Child

Name: _____

Phone: _____

Relationship: _____

Can we give them information? Yes/No

Name: _____

Phone: _____

Relationship: _____

Can we give them information? Yes/No

Name: _____

Phone: _____

Relationship: _____

Can we give them information? Yes/No

Name: _____

Phone: _____

Relationship: _____

Can we give them information? Yes/No

Name: _____

Phone: _____

Relationship: _____

Can we give them information? Yes/No

Name: _____

Phone: _____

Relationship: _____

Can we give them information? Yes/No

# Classroom Information Form

**Child's Name: _____ DOB: _____**

**Allergies: _____**

_____

**Is your child potty trained? _____**

_____

**Is your child a picky eater? Explain: _____**

_____

_____

**What kind of milk does your child drink? _____**

**Do you have a naptime routine, or do you do anything special to help your child go sleep (sing, rub back, etc.)?**

_____

_____

**Who lives in the home with your child?**

| Name: | Relationship: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Is there anything else you think your child's teacher may need/like to know about your child (sensory concerns, behaviors, ?**

_____
_____
_____
_____

# Good to Know!

- Toys are not allowed to be brought from home. This includes cars, dolls, balls, tiaras, sunglasses, tablets, etc. When items are brought from home, they cause disruptions in the classroom and tend to come up missing or broken. Please check your child's pockets and backpack before coming to school to ensure they do not have anything on them they are not supposed to have.

- Please make sure you bring adequate diapers for your child. Licensing requires that we change any wet or soiled diapers immediately and that we at least check diapers every hour. If your child is potty training, they must be accident free *at Kidspiration* for two weeks before they can wear underwear instead of diapers/pull ups.

- Your child is always required to have at least one change of clothes in their cubby. If they have an accident, please make sure to send another set of clothes the next day. If your child is newly potty trained please send 2-3 sets of clothes to keep at school (shirt, pants, underwear, socks). Please make sure extra clothes and jackets are labeled with your child's name.

- Please make sure your child is here by 8:00 every day. Breakfast is served at 8:00am and if there are any leftovers, they are thrown out at 8:30am to make room for lunch preparations. Also, therapists check attendance shortly after breakfast and may mark your child absent for the day if they are late.

- All children are to be picked up by 4:00pm every day. Exceptions are only made when a therapist requests to see a child past 4:00pm or if a parent has met with administration and turned in a work or school schedule that prohibits them from picking their child up prior to 4:00pm. Staff is very limited in the afternoons so please work with us to make sure your child is picked up on time. **ALL children must be picked up by 4:30pm. No exceptions.**

## Pick-up and Drop Off Times

Morning Drop-Off: 7:30-8:00am
Afternoon Pick-Up: 3:00-4:00pm

# CONSENT for Tylenol

I hereby give _____ do not give _____ the Director of the Child Care Facility or their appointed representative permission to give _____ (Child's name) Tylenol. I understand I will be notified that Tylenol has been administered.

Signature _____ Date_____)

# CONSENT for Emergency Treatment

Child's Physician or emergency facility_____

Address_____ City_____ Phone_____

## Consent for medical care:

I, _____, Father, Mother, Guardian ( circle the one that applies) of _____ (Child's Name) do hereby give my consent to the Director of the Child Care Facility, or their duly appointed representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director or their duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached.

Signature _____ Date _____

Witness_____ Date _____

# Provider Choice Explanation Letter

Name of Child: _____

Dear Parent/Guardian

Attached you will find a provider choice form. Federal law requires that you be made aware of other services possibly available to you and your child. A referral to First Connections, Arkansas Infant and Toddler program, or to your local school districts Education Services Cooperative will be made by us upon your child's enrollment in our program. Services available through these programs are listed on the attached provider choice form. You may be contacted by a member of one of the above facilities for further explanation of services.

Early Intervention Day Treatment Programs are covered by Medicaid and/or private insurance. There are other state programs which issue Medicaid Waiver Services should your child become Medicaid ineligible. Your caseworker can refer you to these programs should you so desire.

Thank you.

I have read and understand the above.

---

Signature of Parent/Guardian
Date:_____

---

CHMS Program Staff Member
Date:_____

Informed Consent

Child: _____ Age: _____ DOB: _____

Address: _____

Authorization is hereby granted to Kidspiration to (check those that apply):

A. _X_ To conduct a comprehensive screening or evaluation and provide necessary treatment as indicated in the following areas:

| | |
|---|---|
| ___ Medical | ___ Substance Abuse |
| ___ Psychological | ___ Counseling |
| _X_ Speech and Language | ___ Nutrition |
| _X_ Occupational Therapy | ___ Neuropsychological |
| _X_ Physical Therapy | ___ Speech Therapy |
| ___ Behavior | ___ Psychiatric |
| ___ Audiology | ___ Social Services |
| ___ Early Intervention (<2 years) | _X_ Developmental Preschool |
| ___ Other _____ | ___ Financial Screening for Services |

B. ___ Conduct a specialized evaluation of my child.

Type of Evaluation: _____

Name of evaluator or agency: _____

C. ___ Release the following information to a third party:

Information to be released: _____
Name of third party: _____
Address: _____
City, State, Zip Code: _____
Purpose of release: _____

D. ___ Use the following information for other purposes:

Information: _____
Purpose: _____

I have read and I understand the information regarding parent's consent. I understand the purpose(s) for which my consent is requested. I understand that giving consent for the above-stated purpose(s) is voluntary on my part and may be revoked at any time.

Signature of Parent: _____ Date: _____

# Kidspiration Pediatric Therapy Services

## Consent to Release

Name of Patient: _____

Dear Parent:

As part of your child's evaluation, he/she will be seen by one or more of the Kidspiration Pediatric Therapy Services, Inc. clinic professionals:

If you have any questions concerning the services that you and your child receive, you should ask any of the professionals who are providing care to your child.

---

Consent to Treat

I hereby give consent for the examination/evaluation of my child at Kidspiration Pediatric Therapy Services, Inc, including the diagnostic test ordered by my child's physician.

Signature: _____Date: _____

Relationship to Child: _____

ARKANSAS INFANT & TODDLER PROGRAM

Provider Choice Form

Name of Child: _____

I have been informed of all services available and would like to access the following choices.

SERVICES

__ Certified Case Management

_X Occupational Therapy/Eval

_X_ Physical Therapy/Eval

_X_Speech Therapy/Eval

_X_ Preschool-Center Based

__ Preschool-Comm. Based

__ Family Support

__ E.I- Center Based

__ E.I-Home Based

__Transportation

__Home Based Parent Training

__Evaluation

__Consultation

__Adaptive Equipment

__Other_____

I have been informed of all authorized providers for the services I have requested. I am choosing the following providers:

| | |
|---|---|
| Sharon Dibble | Developmental |
| (Provider) | (Service) |
| Molly Lischeron & Kelly Carter | Physical Therapy |
| (Provider) | (Service) |
| Derek Hinson & Melissa Bassham | Occupational Therapy |
| (Provider) | (Service) |
| Sarah Dewey, Allyson Woods, Ruth Wilson | Speech Therapy |
| (Provider) | (Service) |

I understand that I have the option to change this choice at any time. I also understand that if the chosen provider is unable to provide services, I may then choose another provider.

_____

Parent/Guardian Date

Child Health Management Clinic

# CONSENT TO RELEASE TO MEDICAID

AUTORIZATION TO PAY BENEFITS TO PHYSICIAN:

*I hereby authorize payment directly to the signed Physician to the Medicaid Benefits, if any, otherwise payable to me for his/her services as described but not to exceed the reasonable and customary charge for those services.*

ALL PATIENTS:

*This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all diagnostic, assessment, and/or such medical treatment, which in the judgement of the clinical physician or his authorized agent may consider necessary or advisable. No guarantee has been made as a result of assessment or treatment.*

*Signature:*_____ *Date:*_____

*Relationship to child:*_____

Kidspiration Pediatric Therapy Services

1310 Bradley Dr.

Mountain Home, AR. 72653

Phone: 870-424-4021

Fax: 870-424-4112

Kidspiration Pediatric Therapy Services, Inc.

I have been provided a copy of the Patient's Rights and Responsibilities of Kidspiration Pediatric Therapy Services, Inc.

Signature Date

Kidspiration

Pediatric Therapy Services

Kidspiration has created a parent networking group on Facebook for all current parents of our facility to communicate and stay in touch. This is a private group set up just for parents/guardians and will NOT take the place of our regular Facebook page where we post events, newsletters, and fun pictures of the children. You may post birthday invites, ask for advice, set up play groups, etc. This group is strictly monitored by our Admin and will not tolerate any negative comments or bashing of ANYONE. You will immediately be removed if this becomes a problem. Thank you guys, for all you do!

____ Yes, I would like to be added to the Parent Networking Group.

____ No, I do not want to be added to the Parent Networking Group.

My Child's Name:

_____

My Social Media Name:

_____

Signature:

_____

# Developmental Questionnaire

1. ALL THE INFORMATION ON THIS FORM WILL BE CONFIDENTIAL AND USED ONLY FOR THE EVALUATION AND TREATMENT OF YOUR CHILD.

Child's Name _____ Birth Date_____ Sex_____

Address _____
STREET CITY STATE ZIP CODE

County _____ Main Telephone #_____

Child's Physician _____ Location_____

Who referred the child to this clinic? _____

Medicaid Number_____ Social Security Number_____

## 2. FAMILY DATA

School District _____ _____

Father/Guardian Name _____ Age_____Phone_____

Occupation_____ Phone_____

Mother/Guardian Name_____ Age_____Phone_____

Occupation_____Phone_____

Child Lives with: Father_____ Mother_____ Both_____ Guardian_____

BROTHERS AND SISTERS

| NAME | AGE | GRADE | SEX | FULL, 1/2, STEP |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

## 3. BEHAVIOR

Do you think your child has a behavioral problem? YES_____ NO_____

Describe behavioral problem: _____

_____

_____

Do parents agree on methods of discipline? YES _____ NO _____

Describe each of your methods:

_____

_____

Is anyone else (ex. School, sitter) having problems with your child's behavior?

YES _____ NO _____

If so, please describe:

_____

_____

What do you like best about your child? _____

_____

_____

## 4. PRENATAL INFORMATION

Nutrition during pregnancy: GOOD _____ POOR _____

Were any prescriptions, drugs, alcohol, or tobacco products used? _____

If yes, explain: _____

When did you begin prenatal care?_____

Complications during pregnancy? _If yes, explain: _____

_____

_____

***Gestation Age at birth: ____weeks (We must know this for testing purposes.)***

Type of birth: C-Section_____ Vaginally_____

Labor induced? _____ Birth Weight_____ Birth Length_____

Complications at delivery/after birth? Explain if yes:

_____

## 5. CHILD'S GROWTH AND DEVELOPMENT

Has your child ever had developmental evaluations (Occupational, Physical, Speech)?_____
If so, when and where were the test completed? _____

Has your child been tested for vision? Yes_____ No _____ If yes, when? _____

Where?_____ What were you told? _____

Has child been tested for hearing? Yes _____ No_____ If yes, when?_____

As compared with other children, describe your child's development._____
_____

At what age did your child…..

Sat alone_____ Toilet Trained: Yes_____ No_____

Crawled_____ Bowel: Yes_____ No_____

Walked Alone_____ Bladder: Yes_____ No_____

Made sound, coo/babble_____ Dry at night: Yes_____ No_____

**ANSWER APPROPRIATELY**:

Single Words Yes____ No_____ Age weaned from bottle_____

Phrases/Sentences Yes____ No_____ Temper Tantrums Yes____ No_____

Says words clearly Yes____ No_____ Describe Tantrums _____

Understood by Mother Yes____ No_____ _____

Understood by Others Yes____ No_____ _____

How does your child get along with other children?
_____
_____
_____

Adults?_____

## 6. LANGUAGE AND HEARING

Do you feel your child hears?
Well _____ Poorly or not at all _____ Inconsistently _____ Uncertain _____

Does your child have a history of ear infections? _____

Has your child had p.e. tubes placed in his/her ears?_____Date_____

Does your child communicate mostly by: Gestures _____ Crying_____

Sentences _____ Words_____ Phrases_____

At what age did your child: (write "not yet" when appropriate)
_____Make single sounds _____ Use words_____ Combine words in short sentences
What concerns do you have about your child's speech, language, or hearing?
_____
_____
_____

Describe the kinds of sounds your child made before one year of age---- cooing, prolonged vowel sounds, babbling, repeated syllables, squealing, etc.
_____
_____
_____

When did your child say his/her first real word? _____

Did your child's speech or language development seem to stop for some time?_____

If you answer "yes" to this question, please respond to a and b below.

a. When and why do you think it stopped?_____
b. How did your child communicate with you during this time? _____

When did your child first put two or three words together? _____

When did your child begin to use more complete sentences? _____

How many different words is your child saying now? _____

Do you consider your child to be talkative or quiet?_____

How does your child usually let you know what he/she wants_____

If you answer with "pointing" or "gesturing" to this question, please respond to a and b below.

a. Does your child try to talk in combination with pointing? _____
b. Does anyone in the family talk for your child or interpret his/her gestures?_____

Do you think your child's speech is normal for his/her age? _____

***IF you answer "no" to this question, please respond to a, b, and c below***.

a. How well do you understand your child's speech? _____

b. How well do people outside the family understand your child's speech? _____

c. How does your child react if he/she is not understood by others? _____

Do you have any concerns about the way your child's tongue or mouth works for speech or for eating?_____

If "yes" to this question, please describe: _____

_____

Does anyone in the family have a history of any speech or language problems?_____

If "yes" to this question, please describe:

_____

_____

## 7. FEEDING

For his/her age is your child: Average weight_____ Underweight_____

Overweight_____

Has the child had frequent or severe problems with: Feeding_____

Chewing_____ Teeth_____ Swallowing_____

What eating problems, diet problems or unusual food habits does the child have?

_____

_____

## 8. MEDICAL HISTORY

List all medical diagnoses that your child has/had (ex. Down Syndrome, Autism, Asthma, etc.):

_____

_____

_____

_____

Has your child ever been seriously ill? YES_____ NO_____

If yes, with what?_____

Has your child ever been hospitalized? _____ When?_____

Why?_____

Has your child had any of the following? (circle all that apply): x-ray, MRI, CT Scan, Other medical tests. Explain: _____

List all medications your child currently takes, amount, and reason for taking:

| MEDICINE | AMOUNT | REASON |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Check any of the following which pertain to your child, indication age and complication:**

| | AGE | COMPLICATIONS |
|---|---|---|
| Meningitis and/or Encephalitis | | |
| Convulsions/Seizures | | |
| Fainting Spells | | |
| Headaches and/or Migraines | | |
| Frequent Falls | | |
| Ear Infections | | |
| Diarrhea or constipation | | |
| Head Injury | | |
| Rheumatic Fever | | |
| Diabetes | | |
| Allergies | | |
| Eyes or Visual Problems | | |

9. **FAMILY HISTORY**

Complete the following table for all of the mother's pregnancies in chronological order including any miscarriages or stillbirths:

| **Name** | **Date of Birth** | **Birth Weight** | **Problems at birth** | **Any physical, emotional, behavioral, or educational problems** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Does anyone in the family (parent or child) have a history of physical or sexual abuse?

_____

Drug use? _____

Alcohol use? _____

**Note below if any of the child's relatives have had any of the following conditions (for example: brother, aunt, etc.)**

Convulsions (seizures) _____ Hyperactivity_____

Hearing Loss _____ Deformations _____

Mental Retardation _____ Severe Visual Impairment_____

Speech Problems _____ Alcoholism_____

School Difficulties_____ Emotional Problems_____

Other _____

Describe any of the above:

_____

_____ _____

Parent/Guardian Signature Date Completed