

824 Tyler St. Little Rock, AR 72205 ~501-664-2961 Fax 501-664-6208

[www.theallenschool.org](http://www.theallenschool.org)

**Welcome to The Allen School!**

Thank you for choosing The Allen School to provide services for your child. Below is some information about our school, the services we provide and what you can do as a parent/guardian to help us provide services for your child. As always, you may contact us with any further questions that you may have before, during, and after enrollment. We look forward to working with your family!

**The Allen School**

The Allen School is an EIDT (Early Intervention Day Treatment) facility. We provide such services as a developmental preschool, day habilitation, speech, occupational and physical therapy, outpatient therapy, and kindergarten waiver. We have been providing services to the central Arkansas community for over 60 years. Our classrooms have up to 12 students with a Special Education Supervisor, a lead teacher, and 1-2 assistants.

**How to pay for services for my child**

If your child is enrolled in our day habilitation program, he/she will have to have an active Medicaid account. That can either be AR Kids A, SSI, or TEFRA or a Passe. Medicaid will cover all cost for programming hours for your child. If your child has not previously received services, you need to apply for either one of these. If your child is receiving outpatient services, he/she will have to have either active Medicaid (AR Kids A or B, TEFRA, SSI, or Passe), private insurance (co-pay may be required), or privately pay (call for rates).

**How to get services started if my child currently receives services**

To qualify for our developmental program, your child must qualify on a developmental evaluation and for one individual therapy such as speech, occupational, or physical therapy. If your child currently receives services from a similar provider, we would simply have to get a referral from their pediatrician, copies of their current evaluations, and for parents/guardians to fill an application and schedule an appointment to fill out enrollment paperwork. Once we have all evaluations a request for a therapy prescription will be sent to your child’s pediatrician for those services to be started. You may contact our Service Coordinator to schedule a tour or to see if your child has everything needed to enroll.

**How to get services started if my child has never received services**

If you have concerns for your child’s development, you could call our Service Coordinator and schedule an appointment for a developmental screening. Optum comes to our facility twice a month to provide the screenings to those that have scheduled appointments. Once the screening results are mailed back (both parents/guardians and The Allen School will receive a copy) a referral request for an evaluation prescription will be sent to the child’s pediatrician. Once that is returned to The Allen School, the Service Coordinator will contact your family to schedule a time to come in for a full developmental evaluation and an additional individual therapy evaluation determined by the need indicated on the screening. If more than one individual therapy evaluation is warranted, we will complete the others upon enrollment. Once it is determined that your child qualifies for services, we would complete enrollment paperwork and set a start date. Once your child is enrolled and all evaluations are completed a therapy prescription request will be sent to their pediatrician’s office and upon return of that, their therapy sessions will begin.



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**APPLICATION/SOCIAL HISTORY**

Child’s Full Name: Sex: \_\_ DOB:

Address: \_\_\_ Race: Age: \_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_ County:

Child’s Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis:

Doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Name: \_\_

Address: Phone: \_\_

Date of child’s last Well Child Check-up:

Child’s Insurance Coverage: \_ \_ Medicaid \_\_\_ TEFRA \_\_\_ SSI \_\_\_ Passe Pending Application

Medicaid Number/Passe information:

Child has private insurance coverage: (If yes, please name the company and provide a copy of insurance card):

NO YES

**1.)** Parent/Guardian Name: Home Phone:

Address: Work Phone:

Social Security Number: Cell Phone:

Place of Employment: Relationship to Child: \_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2.)** Parent/Guardian Name: Home Phone:

Address: Work Phone:

Social Security Number: Cell Phone:

Place of Employment: \_\_\_ Relationship to Child:

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1.)** Emergency Contact—NOT living in same household:

Name: Relationship to child:

Primary phone: Alternate phone:

Address: City, State, Zip:

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2.)** Emergency Contact—NOT living in same household:

Name: Relationship to child:

Primary phone: Alternate phone:

Address: City, State, Zip:

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Allen School**

**Application/Social History**

**FAMILY PROFILE**

Please list adults that live in the home with the child:

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | **RELATIONSHIP** | **OCCUPATION** | **LIVES WITH CHILD** |
| 1. |  |  | € YES € NO |
| 2. |  |  | € YES € NO |
| 3. |  |  | € YES € NO |
| 4. |  |  | € YES € NO |
| 5. |  |  | € YES € NO |

Please list siblings:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME** | **AGE** | **GRADE** | **SEX** | **LIVES WITH CHILD** |
| 1. |  |  |  | € YES € NO |
| 2. |  |  |  | € YES € NO |
| 3. |  |  |  | € YES € NO |
| 4. |  |  |  | € YES € NO |

Please share any details pertaining to your child’s family dynamic. Has there been someone close to the child that passed away? Has there been a recent divorce/separation? Are there particular custody arrangements for your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**~ Please note if there are any custody arrangements, restricted visitation, or orders of protection in place, you must provide paperwork before your child is enrolled.**

**PRESCHOOL EXPERIENCE**

Has your child been enrolled in a typical preschool/daycare program? \_\_\_\_\_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_\_\_\_NO

If yes, what is the name of the program:

Dates enrolled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been enrolled in a developmental preschool program? \_\_\_\_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_\_\_\_NO

If yes, what is the name of the program:

Dates enrolled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BIRTH HISTORY**

Pre-natal care was in the week and was routine/sporadic (circle one)

Name of the hospital and city where your child was born (complete address, if possible).

Child was born at weeks Birth weight: lbs. oz. Was labor induced? YES NO

Was delivery via c-section? YES NO If yes, please list reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Application/Social History**

Please describe any complications during pregnancy and/or birth for the mother:

Please describe any complications during pregnancy and/or birth for the child:

Please describe any complications for the child after birth:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH AND MEDICAL HISTORY**

Does your child have any adaptive equipment (i.e., wheelchair, corner chair, stander, etc.) or medical equipment (i.e., tube feeding, oxygen, catheterizations, etc.)?

Has your child had any feeding or dietary issues? NO YES If yes, please explain: \_\_

Is your child on a special diet? NO YES If yes, please explain: \_\_\_

\_

Does your child have any allergies or restrictions (food, medications, etc.)?

Allergy: Type of Reaction: Type of Treatment:

Allergy: Type of Reaction: Type of Treatment:

Allergy: Type of Reaction: Type of Treatment:

Allergy: Type of Reaction: Type of Treatment:

Please list any prescription medications your child must take, including dosage (if it is to be taken at school, we will need a copy of the current prescription): \_\_

Has your child had any surgeries? Please list type and date of the surgery.: \_

\_

Has your child had vision screening/testing: \_\_\_\_NO \_\_\_\_YES When/Date: \_\_\_

Clinic where the test was given: \_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_ \_

Has your child had hearing screening/testing: \_\_\_\_\_NO \_\_\_\_\_YES When/Date: \_\_\_\_\_\_\_\_ \_

Clinic where the test was given: \_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_ \_

Are your child’s immunizations up to date? YES NO

If no, does your child have an immunization exemption waiver from the state of Arkansas? YES NO

If yes, is the waiver for all, some, or one vaccine? ALL SOME ONE

If some or one, please list which vaccine the waiver is for: \_\_\_\_\_\_\_\_\_

**The Allen School**

**Application/Social History**

Please check any of the following in which your child has been diagnosed with or treated for:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DIAGNOSIS** | **NO** | **YES** | **AGE** | **COMPLICATIONS/COMMENTS** |
| MEASLES |  |  |  |  |
| GERMAN MEASLES |  |  |  |  |
| CHICKEN POX |  |  |  |  |
| WHOOPING COUGH |  |  |  |  |
| MUMPS |  |  |  |  |
| MENINGITIS/ENCEPHALITIS |  |  |  |  |
| ASTHMA |  |  |  |  |
| INFECTIONS |  |  |  |  |
| TUBES IN EARS |  |  |  |  |
| SEIZURES/CONVULSIONS |  |  |  |  |
| ADD/ADHD |  |  |  |  |
| CANCER |  |  |  |  |
| CEREBRAL PALSY |  |  |  |  |
| DIABETES |  |  |  |  |

Indicate any of the following specialists with whom you have had contact with concerning your child:

|  |  |  |  |
| --- | --- | --- | --- |
| **SPECIALIST** | **NAME** | **REASON** | **DATES** |
| AUDIOLOGIST |  |  |  |
| CARDIOLOGIST |  |  |  |
| CASE MANAGER |  |  |  |
| DENTIST |  |  |  |
| DIETITIAN/NUTRITIONIST |  |  |  |
| EAR, NOSE & THROAT SPECIALIST |  |  |  |
| GASTROENTEROLOGIST |  |  |  |
| NEUROLOGIST |  |  |  |
| OCCUPATIONAL THERAPIST |  |  |  |
| OPHTHALMOLOGIST |  |  |  |
| ORTHOPEDIST |  |  |  |
| PHYSICAL THERAPIST |  |  |  |
| PSYCHIATRIST |  |  |  |
| SOCIAL WORKER |  |  |  |
| SPEECH THERAPIST |  |  |  |
| SURGEON |  |  |  |

**The Allen School**

**Application/Social History**

**DEVELOPMENT**

**As compared with typical development, describe your child’s development. Please check one for each task.**

|  |  |  |  |
| --- | --- | --- | --- |
| **TASK** | **NORMAL** | **SLOW** | **FAST** |
| Sat alone without assistance |  |  |  |
| Began walking without assistance |  |  |  |
| Crawled |  |  |  |
| Made noises, coo/babbled |  |  |  |

**Feeding Skills**

|  |  |
| --- | --- |
| **SKILL** | **RESPONSE**  **(please mark yes, no, and at what age)** |
| Child is/was able to finger feed him/herself? | € YES € NO At what age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child is/was able to feed self with a spoon? | € YES € NO At what age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child is/was able to feed self with a fork? | € YES € NO At what age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child is/was able to drink independently from a cup? | € YES € NO At what age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child was weaned off the bottle without issues? | € YES € NO At what age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Does your child have trouble with any of the following?**

|  |  |
| --- | --- |
| **SKILL** | **RESPONSE**  **(please mark yes or no)** |
| Sucking a bottle | € YES € NO |
| Swallowing | € YES € NO |
| Biting | € YES € NO |
| Aspirating | € YES € NO |
| Chewing | € YES € NO |

**Does your child have trouble with any of the following? (Please check all that apply)**

|  |  |  |
| --- | --- | --- |
| Daytime naps \_\_\_\_\_\_\_ | Falling asleep at night \_\_\_\_\_\_\_ | Staying asleep at night \_\_\_\_\_\_ |

**Toileting Skills (Please check any that apply):**

|  |  |
| --- | --- |
| **SKILL** | **RESPONSE**  **(please choose the correct response)** |
| Child takes care of toileting needs: | € Independently € With Assistance € Not at All |
| Child stays dry at night: | € Always € Sometimes € Not at all € With no issues |
| Child is completely toilet trained for which: | € Bladder € Bowel Movements € Both € Not Yet |

Does your child respond to any of the following? (Check all that apply)

€ Doorbell € Footsteps € Speech € Phone ringing € Hand claps € Soft/loud vibrations € None

Do you suspect hearing loss? € YES € NO

Do any family members have a hearing loss? € YES € NO

Does your child have a history of frequent ear infections? € YES € NO

**The Allen School**

**Application/Social History**

Primary language spoken in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING:**

Does your child use single words? € YES € NO

Does your child use phrases/sentences? € YES € NO

Does your child say words clearly? € YES € NO

Is your child understood by you? € YES € NO

Does your child gesture to tell you something? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child indicate wants and needs?

Please list words that your child uses consistently. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your main developmental concerns for your child? \_

\_

When and how was this first noticed? \_

\_

What have you tried to do or what assistance have you tried to obtain for your child when your concerns began? \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BEHAVIOR**

Please describe your child’s personality (activity level, affectionate, shy, noisy, fearful, etc.):

Please describe your child’s behavior (please include what types of discipline you use at home and what behaviors you usually discipline):

Please indicate some of your child’s favorites (activities, toys, characters, treats, etc.):

Does your child have tantrums? If so, please describe: \_

How does your child react to separation from you (i.e., being left with baby-sitter, dropping off at school etc.)?

**The Allen School**

**Application/Social History**

How does your child interact with other children?

How does your child interact with adults?

Please list any psychological disorders that might exist in your family (such as mental illness, juvenile or adult anti-social behavior, mental retardation, anxiety, depression, school problems, etc.):

Please list any family history of physical disorders (such as diabetes, heart problems, cancer, epilepsy, liver or kidney diseases, allergies or any other condition that might be transmitted genetically): \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the family unit and emotional atmosphere of the home (such as marital relationships, relation between parents and children, relationships among children, family solidarity, etc.): \_\_\_\_\_\_\_\_

Please describe the socio-economic functions of your child’s family (such as number of members in the family, recreation and civic activities, income, any financial assistance of benefits child might receive, type of house, rent or own, rural, or urban, whether family owns car, etc.):

What would you like to see come out of your child’s time with us here at The Allen School?

How did you find out about The Allen School? What date are you wanting your child to be enrolled by?

\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

*I, the undersigned, certify that I have provided accurate information and answered all questions on the form truthfully to the best of my knowledge.*

\_\_\_

Parent/Guardian Signature Date

\_\_\_\_

Printed Name Relationship to Child