824 N. Tyler - Little Rock, AR 72205
(501) 664-2961 - FAX (501) 664-6208
www.theallenschool.org

Welcome to The Allen School!

Thank you for choosing The Allen School to provide services for you 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 service for your child. As always, you may contact us with any further questions that you could 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, kindergarten waiver, and a school age summer program. We have been providing services to the central Arkansas community for over 60 years. Our classrooms have between 12-14 student 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 and you need to apply for either one of these, please contact our Service Coordinator for help. 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, on the second and fourth Thursdays of the 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.

FRANCIS A. ALLEN SCHOOL FOR EXCEPTIONAL CHILDREN
824 NORTH TYLER STREET
LITTLE ROCK, AR 72205
(501) 664-2961

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/office 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 _____

Parent 1/Guardian Name: _____ Home phone: _____
Address: _____ Work phone: _____
Social Security Number: _____ Cell Phone: _____
Place of Employment: _____
Email address: _____

Parent 2/Guardian Name: _____ Home phone: _____
Address: _____ Work phone: _____
Social Security Number: _____ Cell phone: _____
Place of Employment: _____
Email address: _____

Child lives with: Parent 1 _____ Parent 2 _____ Both _____ Guardian _____

Siblings:

Name	Age	Grade	Sex	Lives with child	
_____	_____	_____	_____	_____YES	_____NO
_____	_____	_____	_____	_____YES	_____NO
_____	_____	_____	_____	_____YES	_____NO
_____	_____	_____	_____	_____YES	_____NO
_____	_____	_____	_____	_____YES	_____NO

Emergency Contact—NOT living in same household:
Name: _____ Relationship to child: _____
Primary phone: _____ Alternate phone: _____
Address: _____ City, State, Zip: _____

How did you find out about The Allen School?
_____

Date of Enrollment Requested: _____

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 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: _____

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: _____

_____

_____

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 (receiving st/ot/pt)? _____

_____

* 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? YES NO 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 to: _____ Type of reaction: _____ Type of treatment: _____
Allergy to: _____ Type of reaction: _____ Type of treatment: _____
Allergy to: _____ Type of reaction: _____ Type of treatment: _____
Allergy to: _____ Type of reaction: _____ Type of treatment: _____

Please list any medications your child is on, 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 surgery): _____

_____

_____

_____

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

	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 with whom you have had contact concerning your child:

	NAME	ADDRESS	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			

Has your child had vision screening/testing: YES NO If yes, when? _____
Clinic? _____ What were you told? _____

Has your child had hearing screening/testing: YES NO If yes, when? _____
Clinic? _____ What were you told? _____

Are your child's immunizations up to date? YES NO
If no, does your child have an immunization waiver? YES NO
If yes, is the waiver for all, some, or one particular vaccine: ALL SOME ONE
If some or one, please list which vaccines the waiver is for: _____

* Development *

As compared with typical development, describe your child's development. Next to each write: **Normal, Slow or Fast**
Sat alone _____ Crawled _____
Walked alone _____ Made noises, coo/babbled _____

Feeding skills (please check the skills which apply to your child):
Age weaned from the bottle: _____
Finger feeds self _____ Drinks from a cup independently _____
Feeds self with spoon _____ Feeds self with fork _____

Does your child have issues with (please check any that apply):
Sucking bottle _____ Biting _____ Chewing _____
Swallowing _____ Aspirating _____

Does your child have issues with (please check all that apply):
Daytime naps _____ falling asleep at night _____ staying asleep at night _____

TOILETING SKILLS (Please check any that apply):
Cannot take care of toileting needs: _____
Carries out toileting needs: Independently _____ With assistance _____
Toilet trained for: Bowel movements _____ Bladder _____
Child stays dry at night: _____

Does your child respond to any of the following (circle all that apply):
Doorbell footsteps speech phone ringing hand claps soft/loud vibrations none listed

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

Primary language spoken in the home: _____

ANSWER APPROPRIATELY:
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 use gestures (give examples): _____

_____

Please list words that your child says consistently: _____

_____

_____

How does your child indicate wants and needs? _____

_____

* 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.)? _____

_____

_____

How does your child get along with other children? _____

_____

How does your child get along with adults? _____

_____

* Family Profile *

Please list everyone that lives in the home with the child:

NAME	RELATIONSHIP	AGE	EDUCATION	OCCUPATION	BIRTHDAY

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

Please list any family history of physical disorders (To include: diabetes, heart trouble, 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 (To include: marital relationships, relation between parents and children, relationships among children, family solidarity, etc.): _____

Please describe the socio-economic functions of the family (To include: 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? _____

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