LEAGUESCHOOL
OF GREATER BOSTON
SOCIAL AND ACADEMIC ACHIEVEMENT FOR THE CHILD WITH AUTISM

Application for Admission

Child's Name: _____ Sex: _____

Child's Birth date: _____ Child's Age: _____

Child lives with/Child's guardian(s): _____

If the child is 16 years of age or older, what is the current status of guardianship process:

_____

If the child is 18 years of age or older, who is the legal guardian:

_____

**If someone other than the child is guardian, we will require documentation of guardianship before enrollment.

Child's Address: _____

Child's Home Phone: _____

Educational Background

How did you hear about League School? _____

Is the child currently attending school? ___ yes ____ no Grade Level: _____

Name of School (if not in school, last school attended): _____

Address: _____

Date of Last Attendance: _____

If in school, reason for looking at new school/If not in school, reason for leaving/termination:

_____

_____

_____

Other services your child has received or is receiving (i.e. after school care, summer camp, speech therapy, physical therapy, home tutoring, home training):

Service: _____ Date: _____ How Often: _____

Service: _____ Date: _____ How Often: _____

Service: _____ Date: _____ How Often: _____

Service: _____ Date: _____ How Often: _____

Service: _____ Date: _____ How Often: _____

Medical Information

PROFESSIONAL CONTACTS (mental health centers, private doctors, psychologists):

Name: _____ Date Began: _____ Date Ended: _____

Address: _____ Phone: _____

Seen for: _____ Date Last Seen: _____

Name: _____ Date Began: _____ Date Ended: _____

Address: _____ Phone: _____

Seen for: _____ Date Last Seen: _____

Name: _____ Date Began: _____ Date Ended: _____

Address: _____ Phone: _____

Seen for: _____ Date Last Seen: _____

Name: _____ Date Began: _____ Date Ended: _____

Address: _____ Phone: _____

Seen for: _____ Date Last Seen: _____

Family Information

Primary language spoken at home: _____

Mother's Name: _____ Birth date: _____

Custody of child: ___Yes_____No___ Education: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

Mother's Occupation: _____Work Phone: _____

Business Name & Address: _____

Father's Name: _____ Birth date: _____

Custody of child: ___Yes_____No___ Education: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

Father's Occupation: _____Work Phone: _____

Business Name & Address: _____

Siblings (oldest to youngest)	Birth date	Grade Level

Parents Marital Status: _____

Mother Remarried: ____ yes ____ no Father Remarried: ____ yes ____ no

Mother Deceased: ____ yes ____ no If so, date: _____

Father Deceased: ____ yes ____ no If so, date: _____

Sibling Deceased: ____ yes ____ no If so, date: _____

Name of Sibling: _____ Birth date: _____

Is there a family history of autism or mental illness? ____ Yes ____ No

If yes, please explain: _____

_____

_____

Diagnosis

What is your child's diagnosis: _____

When was the diagnosis given: _____

Who diagnosed your child: _____

History of Child

Pregnancy and Birth: Normal: _____ Difficult: _____

Special Problems: _____

Place of Birth: Hospital: _____ City/State: _____

First Indications of Disability: _____

_____

Problem Areas in Infancy (Describe Briefly)

Eating: _____

Sleeping: _____

Crawling/Walking: _____

Understanding Speech: _____

Speaking: _____

Toilet Training: _____

Withdrawal Problems: _____

Unusual Problems: _____

Unusual Behaviors: _____

Hospitalizations

Has the child ever been hospitalized: _Yes_ _No_ If yes, please complete the following:

Hospital: _____ Dates: _____ to _____

Reason for hospitalization: _____

_____

_____

Special Discharge Recommendations: _____

_____

_____

Hospital: _____ Dates: _____ to _____

Reason for hospitalization: _____

_____

_____

Special Discharge Recommendations: _____

_____

_____

Behavior

CHILD'S CURRENT STATUS

Does this child engage in **aggressive** behavior? Yes_____ No_____

If yes, which behaviors:

_____ Biting _____ Kicking

_____ Hair pulling _____ Head butting

_____ Slapping/Hitting _____ Scratching

_____ Property Destruction

_____ Other_____

Frequency:_____ Duration:_____

Does the child engage in **self injurious** behavior? Yes_____ No_____

If yes, which behaviors:

_____ Bites _____ Face Slaps

_____ Head bangs _____ Scratches/Picks

_____ Other_____

Frequency:_____ Duration:_____

Does the child have tantrums? Yes _____ No _____

If yes, please describe: _____

Frequency: _____ Duration: _____

Does the child engage in PICA (ingesting non-edible items)? Yes_____ No_____

If yes, specify: _____

Frequency: _____

Does the child have self preservation skills? Yes _____ No _____

(i.e. do they know to leave a building if an alarm is going off or to look both ways before crossing street?)

Does the child engage in bolting behavior:? Yes_____ No_____

If yes, please specify:_____

Frequency: _____

Does the child have difficulty riding in a vehicle? Yes_____ No_____

If yes, please specify: _____

Frequency: _____

Does the child present with suicidal ideations and/or suicidal attempts? Yes_____ No_____

If yes, please specify: _____

Frequency: _____

Does the child present with homicidal ideations and/or homicidal attempts? Yes___ No____

If yes, please specify: _____

Frequency: _____

Does the child have a history of and current issue with possession of weapons? Yes___ No____

If yes, please specify: _____

Frequency: _____

Does the child have a history of and/or current issue with being teased/bullied by others?

Yes_____ No_____

If yes, please specify: _____

Frequency: _____

Does the child have identified reinforcers/preferred items or activities? Yes_____ No_____

If yes, please specify: _____

Does the child have access to the internet and/or email?

If yes, is the time on-line supervised? _____

Frequency: _____

Any additional behavior information: _____

_____

_____

Communication

Oral Motor Functioning (eating): Good_____ Fair_____ Poor_____

Verbal: _____ Non-verbal:_____

If verbal, how does the child communicate:

_____	Good conversational skills	How many turns: _____	
_____	Two to three words utterances	_____	Single word responses
_____	Preservative speech	_____	Echolalic
_____	Good articulation	_____	Difficult to understand
_____	Expresses needs and wants	_____	Makes choices
_____	Uses computer for writing		

If non-verbal, how does the child communicate:

Pictures

_____	Uses black and white line drawings	_____Independent	_____Assisted
_____	Uses color enhanced line drawings	_____Independent	_____Assisted
_____	Uses color photographs	_____Independent	_____Assisted
_____	Uses representational objects	_____Independent	_____Assisted
_____	Uses actual objects	_____Independent	_____Assisted

Sign Language

_____	Uses multiple signs in combination		
_____	Uses single signs in		
_____	Answers yes and no questions		
_____	Uses sign approximations		
_____	Communicates primarily through pointing and gestures		
_____	Expresses needs and wants	_____Independent	_____Assisted
_____	Makes Choices	_____Independent	_____Assisted
_____	Currently has an augmentative/alternative system in place		

_____

OTHER INFORMATION

Does the child have **food allergies:** Yes_____ No_____

Does the child have medication allergies: Yes_____ No_____

If yes, please specify: _____

If yes, how do the symptoms manifest:_____

Does the child have **environmental allergies**: Yes_____ No_____

If yes, please specify: _____

If yes, how do the symptoms manifest:_____

Does the child have Asthma: Yes_____ No_____

Inhalers: _____

Does the child have a history of anaphylaxis? Yes_____ No_____

If yes, do they require an Epipen? Yes_____ No_____

Does the child have a history of seizures? Yes_____ No_____

If yes, please specify: _____

Does the child have a history of choking? Yes_____ No_____

If yes, please specify: _____

The child is: Ambulatory_____ Non-ambulatory_____

If non –ambulatory, how does child ambulate (walker, wheelchair):_____

The child is: Toilet Trained _____ Not Toilet Trained _____

If the child is not toilet trained: Wear diapers_____ Is on a schedule: _____

Does the child sleep through the night? Yes_____ No_____

If no, please describe: _____

Other medical conditions (asthma, diabetes, etc):_____

_____

_____

Identifying Information

Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Skin: _____

Other Identifying Marks: _____

Photo of Child:

SIGNATURES:

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____