Foundations Upper Valley

An SD Associates special education school, 147 Main Street, Windsor, VT 05089
Program Phone: 802-674-4428 **Fax:** 802-674-4439 **Website:** www.sdplus.org/where

Date of Application: Date Received (office use only):

Student Application for Enrollment at FUV

(Parent Form)

Student Name: _____

Preferred Pronoun/s: _____ DOB: _____

Address: _____

Parent/Guardian Contact Information (attach guardianship papers if court appointed)

_____
Parent/Guardian 1 Name

_____
Home Phone 1 Mobile Phone 1

_____
Parent/Guardian 1 Address

_____
City/State/Zip

_____
Parent/Guardian 2 Name

_____
Home Phone 2 Mobile Phone 2

_____
Parent/Guardian 2 Address

_____
City/State/Zip

By initialing this box, I confirm that I am the parent or guardian of the above-named student (applicant) and I am submitting this application of my own free will.

What is the primary language spoken at home?

Are any other languages spoken in the home?

Race: ☐ African Origin (black) ☐ Indigenous (Origins in North, South or Central America) ☐ Asian (Origins in Far East, Southeast Asia, or the Indian Subcontinent) ☐ Pacific Islands (Origins in Hawaii, Guam, Samoa, other) ☐ White (Origins in European/Mid East/North African origin) **Ethnicity:** ☐ Hispanic decent (regardless of race)
**This information is reported to the Agency of Education annually if the student is enrolled, per statute.*

Vaccinations
My child has ☐ all required vaccinations ☐ a medical exemption ☐ a religious exemption

Medical History and Demographic Information

Does the student have a primary care physician? ☐ YES ☐ NO
Physician Name:
Practice Name:

Does the student have a psychiatrist? ☐ YES ☐ NO
Psychiatrist Name:
Practice Name:

Developmental/Mental Health Diagnoses (please list or write "none")

Other Medical Conditions (please list or write "none")

Food/Medication/Other Allergies (please list or write "none")

What Medications does the student take? (please list or write "none"). If more space is needed, list additional medications in the notes section at end of this form with the same detail.

Medication	Dose	Prescribing Physician	Purpose of Medication
Will the student need to take medication during the school day? ☐ Yes ☐ No **if yes, we will need a medication order from the prescribing doctor if the student is enrolled*			

Additional information about medication:

Is the student currently receiving any "alternative therapies" (e.g. sensory integration therapy, auditory integration therapy, special diets, vitamin therapy, facilitated communication, chelation, etc.). ☐ NO ☐ YES

If yes, please list/describe.

Social and Communication Skills

Please select the answers that best reflect the way your child typically communicates and responds.

☐ Makes typical eye contact	☐ Reaches for preferred items	☐ Uses a picture system (e.g. PECS)
☐ Leads by the hand	☐ Points finger to get items	☐ Uses AAC device
☐ Responds to name by looking	☐ Requests w/ single words	☐ Addresses people by name
☐ Echoes what is said	☐ Requests w/ phrase/sentence	☐ Looks at items on request
☐ Uses a few simple signs	☐ Asks for information	☐ Sustains joint attention
☐ Signs phrases/sentences	☐ Engages in conversation	☐ Shows items to someone else

☐ Follows 1 step directions in context (e.g. sit down)	☐ Selects item when asked (e.g. "point to cup")
☐ Follows 1 step directions at table (e.g. clap hands)	☐ Follows multi step instructions
☐ Labels things on request (answers "what is it")	☐ Follows instructions in a group
☐ Labels things spontaneously	☐ Fills in the blank (e.g. "The itsy bitsy _____")
☐ Answers questions with various possible responses (e.g. "what did you have for lunch?")	☐ Answers questions with fixed possible responses (e.g. "what's your name"?)
Additional Information:	

Self Help Skills

Please select the answers that best represent how your child gets basic needs met.

☐ Allows others to dress/undress/assist	☐ Allows others to diaper/clean bottom
☐ Allows others to brush teeth/assist	☐ Attempts to wipe/clean bottom
☐ Allows others to bathe/shower/assist	☐ Independently wipes/cleans bottom
☐ Allows others to assist with menstrual care	☐ Sits on toilet
☐ Independently dresses/undresses	☐ Urinates on toilet
☐ Independently brushes teeth	☐ Moves bowels on toilet
☐ Independently bathes/showers	☐ Wears underwear
☐ Independently completes menstrual care	☐ Stays dry most of the time
☐ Accepts food on utensils	☐ Stays clean most of the time
☐ Independently eats with utensils	☐ Stays clean and dry (mostly) overnight
☐ Sits at table to eat meals	☐ Uses toilet on a schedule/when prompted
☐ Eats a healthy variety of foods	☐ Independently initiates bathroom trip
Additional Information:	

Play and Imitation Skills

Please select the answers that best represent how your child imitates & plays with others.
S=spontaneous D=on demand

☐ Imitates sounds ☐ S ☐ D	☐ Copies block structures (on request)
☐ Imitates words ☐ S ☐ D	☐ Copies from 2d-3-d (e.g. copies lego design from photo)
☐ Imitates phrases ☐ S ☐ D	☐ Plays with adults ☐ S ☐ D
☐ Repeats scripts ☐ S ☐ D	☐ Plays near other children ☐ S ☐ D
☐ Imitates 5+ fine motor actions (on request)	☐ Plays with other children ☐ S ☐ D
☐ Imitates 5+ gross motor actions (on request)	☐ Asks other children to play ☐ S ☐ D
☐ Imitates 5+ actions w/ object (on request)	☐ Responds when other children initiate play
☐ Imitates something brand-new (on request)	☐ Uses toys as intended
☐ Imitates a series of actions (on request)	☐ Shares toys with others ☐ S ☐ D
☐ Imitates others spontaneously	☐ Engages in imaginary play
☐ Copies shapes, letters or numbers	☐ Sustains independent play for 5+ minutes
Additional Information:	

Problem Behavior

Check the box if your child engages in the behavior (with or without "intent").

☐ Screams/cries	☐ Knocks over or throws items
☐ Hits or kicks others	☐ Destroys property
☐ Headbutts or shoves others	☐ Disrobes
☐ Bites or spits at others	☐ Public masturbation/touches privates
☐ Grabs/pulls others' hair and/or clothing	☐ Sexually inappropriate with others
☐ Hits or bites self	☐ Makes false allegations
☐ Bangs head or body on surfaces	☐ Takes items from others
☐ Picks skin/scabs/pulls own hair	☐ Does not follow directions
☐ Struggles with being told "no"	☐ Engages in high rates of "stim"
☐ Uses objects of convenience to hurt others	☐ Engages in disruptive/harmful "stim"
☐ Makes weapons to hurt others	☐ Mouths or eats non-food items
☐ Makes plans to hurt others	☐ Forces self to vomit
☐ Teases or bullies peers	☐ Plays with/smears feces
☐ Talks about suicide or homicide	☐ Eats own feces, vomit, blood, etc.
☐ Has attempted suicide or homicide	☐ Is unsafe in a car / bus
☐ Verbally aggressive to others/foul language	☐ (Re)arranges objects and/or people
☐ Runs from caregivers	☐ Drops to floor
☐ Sleep problems (difficulty falling asleep, staying asleep, waking up early, sleeping in own bed, sleeping during the day, etc.)	☐ Feeding problems (e.g. limited diet, highly food driven, chew/swallow problems)

Other/additional information (please describe):

Scope of Problem Behaviors

Please respond to the following questions/statements about your child's behavior to the best of your ability. T=True/yes F=False/no

Dysregulation= a behavioral response that does not fall within the traditionally accepted range of reaction to environmental events regardless of "intent", and/or tantrum behaviors that include aggression, self-injury, elopement, property destruction, or any behavior or combination of behaviors listed in the text box above.

When my child is dysregulated, it is difficult for one person to handle.	☐ T ☐ F
When my child is dysregulated, s/he and others may be at a safety risk.	☐ T ☐ F
My child is not often dysregulated, but when s/he is, the intensity is high.	☐ T ☐ F
My child is typically dysregulated more than three times per day.	☐ T ☐ F
When my child is dysregulated, it often lasts longer than 30 minutes	☐ T ☐ F
I can safely take my child to most indoor public places, but s/he is disruptive.	☐ T ☐ F
I do not feel safe taking my child to most indoor public places alone (store, restaurant, etc.)	☐ T ☐ F
I spend a lot of time every day doing things to prevent my child from getting upset.	☐ T ☐ F
Child or caregiver has needed first aid due to (minor) injury following dysregulation.	☐ T ☐ F
Child or caregiver has had moderate injury (large bruising, deep scratches, strains or sprains, etc.) following dysregulation.	☐ T ☐ F
Child or caregiver has had injury requiring medical intervention (broken bones, broken teeth, concussion, open skin injuries, etc.).	☐ T ☐ F
My child is sometimes sent home from school due to his/her behavior.	☐ T ☐ F
My child's behavior at school is very different than his/her behavior at home.	☐ T ☐ F
Other/additional information:	

Ecological and Social Variables

Are there any cultural or spiritual values (e.g., religious beliefs) that might affect a behavioral treatment plan? If yes, please explain.	☐ Yes ☐ No
Are there any family variables that might affect a behavioral treatment plan (e.g., siblings with disabilities, parental work schedules, extended family caregivers, etc.)? If yes, please explain.	☐ Yes ☐ No
Are there any other community resources that are currently being utilized? If yes, please explain.	☐ Yes ☐ No
To the best of your knowledge, has your child experienced trauma/s that may affect his/her behavior? If yes, please explain.	☐ Yes ☐ No
Are there any legal issues that we should be aware of (e.g., custody, protective order, etc.)? If yes, please explain.	☐ Yes ☐ No

Attestation:
I ☐ Have ☐ Have not

Received a copy of the Foundations Handbook.
I ☐ Do ☐ Do not

Need a translated copy, or need someone to read it to me.
I ☐ Do ☐ Do not

Understand the content of the Foundations Handbook.

Please tell us anything else you think it is important for us to know about your child or elaborate on any of your answers above.