A Bholaram Education Society Initiative

SAARANSH©

FOUNDATION

PLEASE AFFIX PASSPORT SIZE PHOTO OF STUDENT

# REGISTRATION FORM

Registration No: _____ Issued on: _____ For session: _____

## Section I - Child's Identifying Information

**Please carefully review and thoroughly complete this entire form, which will help us evaluate and determine your child's needs. Note that some sections may not apply to which you may note "N/A."**

Child's Full Name: _____ Date of Birth: _____

Male/Female _____ Diagnosis: _____ Referred by: _____

Please indicate areas of concerns regarding your child: (*Check all that apply*):

**Speech - Language**

Articulation
Fluency
Voice
Social Skills
Other:_____

**Occupational Therapy**

Fine Motor
Organizational Skills
Other:_____

**Blood Group:**

**Physical Therapy**

Gross Motor

Other:_____

**Educational Services**

Educational Evaluation
Special Education Advocacy
Academic or Special Education Language Support Services
Other:_____

## Parent/s' Information:

Mother's Full Name: _____ DOB: _____

Mob No: _____ Email (Personal): _____

Home Address: _____

Mother's Place of Employment: _____ Job Title: _____

Work Address: _____

City: _____ State: _____ Pin Code: _____

Father's Full Name: _____ DOB: _____

Mob No _____ Email (Personal): _____

Home Address (If Different): _____

Father's Place of Employment: _____ Job Title: _____

Work Address: _____

City: _____ State: _____ Pin Code: _____

Are parents: ☐ Married ☐ Separated ☐ Divorced ☐ Other If separated, divorced, or other, who has legal custody of child (Please check all that apply)? Mother Father Both Other (Please explain)_____

Child lives with (Check all that Apply): ☐ Mother ☐ Father ☐ Adoptive Parents ☐ Other (Specify)

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**Sibling's Information:**

| Sibling's Name: | Age | Class |
|---|---|---|
| | | |
| | | |
| | | |

Do any siblings have developmental delays or disabilities? ☐ Yes ☐ No If so, please describe_____

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## Section II- Birth History

Pregnancy Normal: ☐ Yes ☐ No If pregnancy was abnormal, please describe: _____

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Child's Birth Weight: _____Was labor (*Check all that apply*): ☐ Normal? ☐ Induced? ☐ Caesarean Delivery?

Was child premature? ☐ Yes ☐ No ☐ Other Circumstances? _____

Describe any special care or procedures child required following birth: _____

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Duration of care in hospital: Child: _____ Mother: _____

## Section III - Health History

Pediatrician's Name: _____

Has your child ever been given a medical diagnosis? ☐ Yes ☐ No If so, what? _____

Does your child have a history of health problems? ☐ Yes ☐ No If so, describe: _____

Does your child have a history of vision problems? ☐ Yes ☐ No If so, explain _____

Has your child had frequent ear infections? ☐ Yes ☐ No If so, explain _____

Has your child had tubes in ears? ☐ Yes ☐ No If "Yes," when were tubes inserted?_____

List any allergies that your child has: _____

List any medications that your child is currently prescribed: _____

State purpose of current medication(s):_____

## Section IV – Feeding/Swallowing

**(Please complete ONLY if you suspect that your child has feeding/eating or swallowing problems.**

**If "Not Applicable," then note "N/A.")**

**Not applicable for the child above 12 years of age**

How old was your child when he/she started: Drinking from a cup? _____Eating table foods? _____Using a spoon? _____

Does or did your child suck(ed) his/her thumb? Yes / No If so, for how long?_____

Describe the type of foods that your child likes or dislikes? _____

How often does your child eat?_____How long are mealtimes? _____

Does your child have difficulties: sucking, swallowing, chewing, drinking from a cup, drinking from a straw, or eating different textures? Yes / No If so, please explain:_____

_____

Does your child exhibit avoidance behaviors (e.g., refuses to eat, acts out, etc.) during mealtimes? Yes / No If so, please explain:

_____

Does your child drool, cough or gag during mealtimes or have reflux? Yes / No If so, please describe _____

_____

Is there anything else you can tell us that will help us better understand your child's food habits?_____

_____

## Section V – Social Skills Development

**(Please complete ONLY if you have concerns about your child's social skills or ability to interact with others.**
**If "Not Applicable," then note "N/A.")**

Does your child like to play (Check all that apply): Alone? With other children? With older children? With younger children?

Does your child make inappropriate comments or exhibit inappropriate behaviors when interacting with other children or adults? Yes / No If so, please explain: _____

_____

**Does your child (Check all that apply):**

Avoid eye contact? _____

Dislike being touched or cuddled? _____

Appear to be "in his/her own little world"? _____

Perform repetitive movements (e.g., rocking, flicking finger) _____

Exhibit obsessive behaviors or interests in objects or toys? If so, please explain:_____

Rarely or never initiate communication? _____

Inappropriately express wants, desires, or emotions? If so, please explain:_____

**Please describe your child (Check all that apply):**

Poor or Limited Attention, Restless or Hyperactive, Low Energy, Shy / Quiet, Uncooperative, Temper Tantrums, Easily Frustrated, Stubborn, Exhibits Aggressive Behavior (e.g., biting, scratching, kicking, spitting, pinching, hitting) If so, please explain:_____

_____

How do you manage the aggressive behavior? _____

## Section VI - Speech and Language Development

**(Please complete ONLY if you have concerns about your child's communication development. If "Not Applicable," then note "N/A.")**

What are your concerns regarding your child's speech and/or language development? _____

_____

Who first noticed your child's problem?_____When?_____

Since the problem was first noticed, has there been any improvement? Yes or No If so, please explain: _____

_____

**Not applicable for child above 12 years of age**

How old was your child when he/she: Said first word?__Combined two or more words (e.g. "Want cookie," "I want more"):

_____

Named common objects (e.g., ball):_____Asked simple questions (e.g., "Where's Papa?"):____Engaged in conversation:

_____

What languages are spoken at the home? _____

What language(s) does your child speak? _____

What is the child's primary language? _____

How does your child communicate? Please describe whether he/she uses gestures, single words, simple phrases, communication board or device, etc.: _____

Was there ever a time when your child's speech and language skills regressed or your child stopped talking? Yes / No If so, please state age and describe circumstances: _____

_____

Has a Speech-Language Pathologist (SLP) provided services to your child? Yes / No If so, when? _____

Why? _____Please state: SLP's Name: _____

Address: _____What were the SLP's findings and suggestions? _____

Do you have a copy of the evaluation report? Yes / No

## Section VII - Fine and Gross Motor Development

**(Please complete ONLY if you have concerns about your child's fine or gross motor skills. If "Not Applicable," then note "N/A.")**

**Gross Motor:** What are your concerns regarding your child's gross motor skills development?_____

_____

**Fine Motor:** What are your concerns regarding your child's fine motor skills development?_____

_____

Has an Occupational Therapist (OT) provided services to your child before? Yes / No If so, when? _____

Why? _____Please state: OT's Name: _____

Address: _____

What were the OT's findings and suggestions? _____

Do you have a copy of the evaluation report? Yes No

Has a Physical Therapist (PT) provided services to your child before? Yes / No If so, when? _____

Why?_____Please state: PT's Name: _____

Address: _____

What were PT's findings and suggestions?

Do you have a copy of the evaluation report? Yes / No

Interest in Specific Sports: _____

## Section VIII - Psychological and Neurological Development

Has your child had a psychological/ Neurological evaluation? Yes / No If so, when? _____Why? _____

_____Psychologist's/Neurologist's Name:_____

Address: _____

Do you have a copy of the evaluation report? Yes / No

## Section IX - Educational History

Name of the school that your child previously attended: _____

What are your concerns regarding your child's academic progress?_____

_____

Grades repeated: _____How does your child feel about school?_____

Has your child ever been tested for special education services? Yes / No If so, when? _____

_____

Was your child found to be a child with disabilities? Yes / No If so, please state: Disability _____

Does or did your child receive special education services? Yes / No If so, state: Frequency (Times/Week): _____

Duration (Hours/Day):_____What do you see as your child's strengths: _____

## Section X - Family History

Has anyone in the family ever had speech and language development disorders or delays, psychological or medical diagnosis, academic or learning problems, Neurological diagnosis? Yes / No

(If so, please describe) _____

Do you wish to add any additional comments or information that will help us to better understand your child or your concerns?_____

_____

_____

_____

_____

_____

_____

_____

It is hereby declared that the information and particulars furnished above are true and correct to the best of my/our knowledge and belief and nothing has been concealed. I/We also understand that admission in Saaransh Foundation does not guarantee admission in DPS Gandhinagar.

Parent/s' signature:_____ Date: _____

**FOR OFFICE USE ONLY**

Date of Parent Interview: _____
Name of Staff Conducting Interview: _____
Comments/Follow-up: _____
_____