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 _____ Class: _____ Section: _____

Referred by: _____

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

Speech - Language
Articulation
Fluency
Voice
Social Skills
Other:_____

Occupational Therapy
Fine Motor
Organizational Skills
Other:_____

Feeding

Swallowing

Physical Therapy
Gross Motor
Other:_____

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

Parent Information:

Mother's Full Name:_____ DOB:_____

Home PH:_____ Cell PH: _____ Email (Personal):_____

Home Address:_____

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

Work Address:_____

City:_____ State:_____ Zip Code:_____

Email (Work):_____ Work PH:_____

Father's Full Name:_____ DOB:_____

Home PH:_____ Cell PH: _____ Email (Personal):_____

Home Address (If Different):_____

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

Work Address:_____

City:_____ State:_____ Zip Code:_____

Email (Work):_____ Work PH:_____

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 ☐ Foster Parents ☐ Other (Specify)

_____

Sibling Information:

Brothers' Names:	Brothers' Age	Sisters' Names:	Sisters' Age

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

_____

Who lives in household with the child?_____

Section II- Birth History

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

_____

Child's Birth Weight: _____ Length: _____ Was labor (*Check all that apply*): ☐ Normal? ☐ Induced? ☐ Caesarian Delivery?

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

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

_____

Duration of care _____ Length of hospital stay: Child_____ Mother_____

Section III -Health History

Pediatrician's Name: _____

Address: _____Phone: _____

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

Current vision problems? ☐ Yes ☐ No If so, explain _____

Has your child had frequent ear infections? ☐ Yes ☐ No Date of last hearing screening: _____

Where was hearing screening conducted?_____

What were the results of the hearing screening? _____

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

When were tubes removed? _____

Who inserted and removed the tubes? _____

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.")

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 feeding/swallowing difficulties?_____

_____

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?
Fail to take turns during conversation?
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 Passive Shy Quiet Uncooperative Temper Tantrums Easily Frustrated Selfish Stubborn Exhibits Aggressive Behavior (e.g., biting, scratching, kicking, spitting, pinching) 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?YesNo If so, please explain:_____

_____

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 in the home? _____

What is the primary language spoken in the home?_____

What language(s) does your child speak? _____

What is the child's primary language? _____

Who is child's primary care giver and what language does he/she speak?_____ _____

Do family members, neighbors, peers, school staff, and others understand your child? Yes No

If not, then please explain:_____

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

Describe how the child's problem impacts his/her interactions with adults and other children at home and school?_____

_____

Does your child seem aware of the problem?YesNo If so, how do you think he/she feels about it? _____

_____

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: _____

City:_____State:_____ Phone:_____ 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.")

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

_____

How old was your child when he/she: Reached for objects? _____Held small objects?___ Transferred objects between hands? ____ Held crayon with index finger and thumb? ____ Put on/take off shoes/socks____ Held spoon____ Drew straight line____ ___ Copied straight line or circle____ Fed self_____ Held cup with no spillage____ Cut with scissors____ Managed buttons, zippers, & snaps____

Has an Occupational Therapist (OT) provided services to your child before? Yes No If so, when? _____
Why? _____ Please state: OT's Name: _____
Address:_____
City:_____State:_____Phone:_____
What were the OT's findings and suggestions? _____
_____ Do you have a copy of the evaluation report? Yes No

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

How old was your child when he/she: Propped up with arms_____Rolled over_____Sat independently_____
Supported weight on legs_____Crawled_____Pulled self to standing_____ Walked_____ Climbed furniture_____
Walked up/down stairs independently____Stood on one foot____Jumped____ Started running?____ Kicked a ball forward_____
Walked on tip-toes_____ Other_____

Has a Physical Therapist (PT) provided services to your child before? Yes No If so, when? _____
Why?_____Please state: PT's Name: Address:_____
City:_____State:_____ Phone:_____
What were PT's findings and suggestions?_____
_____ Do you have a copy of the evaluation report? Yes No

Section VIII - Psychological and Neurological Development

Has your child had a psychological evaluation? Yes No If so, when? _____ Why? _____
_____ _____Please state: Psychologist's Name:_____
Address: _____
City: _____State:_____ Phone:_____
Do you have a copy of the evaluation report? Yes No Has your child had a neurological exam? Yes No If so, when? _____
Why? _____ Please state: Neurologist's Name: _____
Address:_____
City: _____State:_____ Phone:_____
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?_____
_____
Describe your child's academic performance (e.g., grades or progress by subject area) _____
_____
Grades repeated: _____ _____ How does your child feel about school?_____
Has your child ever been tested for special education services? Yes No If so, when? Why? _____
_____
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) ?_____Does/did your child have an IEP? Yes No
What do you see as your child's strengths?_____
Other:_____

Section X - Family History

Has anyone in the family ever had speech and language development disorders or delays? Yes No
(If so, please describe) _____

Has anyone in the family ever had significant fine or gross motor development problems or delays? Yes No
If so, please describe: _____

Has anyone in the family ever had a psychological or medical diagnosis? Yes No
If so, please describe: _____

Is there a family history of academic or learning problems? Yes No
If so, please describe:_____

What is your desired outcome of our services? _____
_____

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:_____
_____
_____
_____