# APPLICATION FOR ADMISSION

THIS APPLICATION IS FOR: ☐ residential placement ☐ day placement

This form is being completed by _____ (relationship to child) Date_____

CHILD'S FULL NAME _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

Other children in the family (please include any pregnancies ending in miscarriage, abortion or still birth):

Names _____ Date of Birth _____
_____ _____
_____ _____

BIOLOGICAL MOTHER'S NAME _____Birth date: _____
Age at the time of child's birth _____
ADDRESS, City, State, Zip code _____
_____
PHONE _____ (H) _____ (W)
FAX _____ E-Mail_____
CELL PHONE_____
OCCUPATION _____
BUSINESS NAME/ADDRESS_____
_____

Married ☐
Separated ☐
Single ☐
Divorced ☐
Widowed ☐
Remarried ☐

BIOLOGICAL FATHER'S NAME _____Birth date: _____
Age at the time of child's birth _____
ADDRESS, City, State, Zip code _____
_____
PHONE _____ (H) _____ (W) FAX _____
CELL PHONE_____E-Mail_____
OCCUPATION_____
BUSINESS NAME/ADDRESS_____
_____

**IMPORTANT**

**PLEASE PASTE**

**RECENT**

**PHOTOGRAPH**

**HERE!**

CUSTODIAL MOTHER'S NAME_____
☐ Check here if same as biological mother
ADDRESS _____
PHONE_____ (Home)_____(Work)
FAX_____ E-Mail_____
OCCUPATION _____
BUSINESS NAME/ADDRESS_____
_____

CUSTODIAL FATHER'S NAME _____
☐ CHECK HERE IF SAME AS BIOLOGICAL FATHER
ADDRESS_____
PHONE_____ (H) _____(W)
FAX_____ E-MAIL_____
OCCUPATION _____
BUSINESS NAME/ADDRESS_____
_____

# INDIVIDUAL INFORMATION SHEET

Name: _____
Last First Middle

Sex: _____ Birth date: _____ Race: _____ Ethnicity: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Religious Affiliation: _____ Primary language spoken at home: _____

Scars or Identifying Marks: _____

Person (s) to contact in case of emergency:

_____
Name Relationship

_____
Address Phone #

Person to give consent for medical treatment: _____

Contact information/ Phone #: _____

Personal physician / source of health care:

_____
Name Address Phone#

Personal dentist / source of dental care:

_____
Name Address Phone#

Any Specialist Physicians:

_____

_____

Preferred Hospital:

_____

Insurance Information (Name and Telephone Number of Healthcare Provider):

_____

**Thank you for answering the following questions to the best of your knowledge. This information, which will be kept strictly confidential, will help us to understand your child.**

## I. PREGNANCY

**(a)** Do you know of any hereditary or congenital diseases in the family on either side? Note any of the following conditions: genetic syndromes, autism, epilepsy, mental or nervous diseases, malformations, deafness or other serious diseases?

_____

_____

_____

**(b)** Describe any bleeding (during pregnancy), premature labor, infections, accidents or medical complications.

_____

_____

_____

_____

_____

**(c)** Were there any X-rays, ultrasounds tests, or amniocentesis during pregnancy? If so, state.

_____

_____

_____

**(d)** Was mother taking any prescription or illicit drugs, or other medicines during pregnancy? Please give details.

_____

_____

_____

**(e)** Was your child planned? _____Was your child wanted? _____

Comments _____

**(f)** During pregnancy, were there any mental or emotional strains? When and cause?

_____

_____

**(g)** Any additional comments on the pregnancy? _____

_____

**II. BIRTH**

**(a)** Length of Pregnancy _____ (**b**) Duration of Labor _____

**(c)** Describe Birth, easy or difficult, instruments used, anesthesia, c-section, etc.

_____

_____

**(d)** Describe the neonatal course (e.g. neonatal ICU, care, treatment for jaundice, antibiotics, spinal tap, oxygen, etc.)

_____

_____

_____

**(e)** Did the baby require special treatment to assist breathing? ( injections, oxygen, etc.)?

_____

_____

**(f)** Birth weight:_____ lbs. _____ oz.

**(g)** Apgar Scores _____ (1 minute) _____ (5 minutes)

**(h)** Any other comments on the birth. _____

_____

_____

_____

**III. INFANCY**

**(a**) How was your baby fed during the first year of life? _____

_____

_____

**(b**) Did the infant show affection in the usual way? Was he/she quiet or restless? Was he/she a "happy" baby?

_____

_____

**(c)** Were there any disturbances of digestion, recurrent vomiting, or colic?

_____

**(d)** Was there any unusual sleep pattern? _____

**IV. DEVELOPMENTAL MILESTONES**:

**(a)** At what age was:

- First smile _____
- Reaching out for things _____
- Teething _____
- Sitting unaided _____
- Walking unaided _____
- First word said _____ What was it? _____
- Speaking in sentences_____
- Toilet trained by day _____ by night? _____
- Any other comments relating to infancy _____

_____

_____

**(b)** Were there any periods of regression, loss of speech, etc.?_____

_____

**(c)** Did your child have tics, repetitive movement patterns, fixations or self-stimulatory behavior?

_____

_____

_____

_____

**(d**) When and why did you become concerned that your child was not developing normally? What did you do about it?

_____

_____

**(e)** What is your child's diagnosis? When was it first made? Has it changed over the years?

_____

_____

_____

**(f)** What do you, as parents, think was the cause of your child's difficulties?

_____

_____

_____

_____

## V. CHILDHOOD TO PRESENT

### (a) COMMUNICATION

1. Describe your child's ability to speak, and/or other means of communication._____

_____

_____

2. What other means are used (sign, gesture, assistive device)? _____

_____

### (b) BEHAVIOR

1. Has your child received special behavioral treatment or therapy, such as wrap-around services, or ABA (Applied Behavioral Analysis)? ☐ yes ☐ no

If so, did you find ABA helpful? Give details_____

_____

Where were the services received: (name/address)_____

_____

_____

Dates (approximate) _____

_____

2. Describe any self-stimulatory behaviors and/or aggressive behaviors, such as rocking, head-banging, and/or verbal or physical aggression, etc._____

_____

_____

3. Describe any behavior issues, e.g. running away, stealing, bad habits, obsessions and/or compulsions, destructiveness, self-abusive, aggression (verbally/physically, etc.)?

_____

_____

_____

4. When does the inappropriate behavior(s) usually occur (what conditions/situations)?

_____

_____

_____

5. What do you do to discipline the child?

_____

_____

6. How does she/he react to discipline? _____

_____

7. Does your child have a "behavior plan?" If so, are you willing to work with the school staff to review and modify if necessary?

_____

_____

8. Describe any issues or history of difficulties around sexuality. Are you open to working with the school staff in this realm? _____

_____

_____

9. Describe your child's self-care and toileting habits (teeth brushing, washing, toilet trained, etc.)

_____

_____

10. How many hours per day does your child watch TV, movies, or play computer/video games? Please specify.

_____

_____

Are you willing to work with staff to make adjustments to media exposure, if necessary?

_____

_____

**(C) EATING HABITS**

1. Describe eating habits (use of utensils, how your child relates to food/meal times)_____

_____

_____

2. What does your child usually eat for:

Breakfast _____

Lunch _____

Supper _____

Snacks _____

How many snacks a day? _____

3. Is your child on a special diet? What is the reason for the special diet?_____

Give details._____

_____

**(D) SLEEPING HABITS**

1. Describe sleeping habits (bedtime, how long, how deeply)._____

_____

_____

2. What does your child do if he/she awakens in the night (cry, make noise(s), wander, etc.)?

_____

_____

**(E) MEDICAL-DIAGNOSIS/TREATMENT**

1. What illnesses or childhood diseases has your child had, and at what age?
_____

_____

_____

_____

2. Describe any falls or accidents and at what age._____

_____

_____

3. Has your child had any seizures? If so, describe type, duration, and frequency. Did they recur at particular times? _____

_____

_____

4. ALL **CURRENT** MEDICATIONS AND PURPOSES (SEIZURES, ANXIETY, BEHAVIOR, ETC.), DOSAGES AND WHEN STARTED (APPROXIMATELY).

| Drug | Dosage | Purpose | Date Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

LIST ALL **PREVIOUS** MEDICATIONS AND PURPOSES (SEIZURES, ANXIETY, BEHAVIOR, ETC.), DOSAGES AND WHEN STARTED AND STOPPED (APPROXIMATELY).

| Drug | Dosage | Why was it discontinued? | Date Started/Stopped |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

5. Has your child been prescribed or given any unconventional treatments—special diets, supplements, vitamins, homeopathy, etc.?_____

_____

Have they been effective? _____

_____

6. Admission or out-patient attendance at hospital:

(a) Date(s) of Admission_____

_____

_____

(b) Name and address of hospital(s) _____

_____

(c) Name of doctor(s) or surgeon(s)

_____

_____

(d) Reason(s) for admission or attendance _____

_____

_____

**(F) SOCIAL**

1. How would you describe the child as a person?

_____

_____

Strengths and Needs_____

_____

2. What does your child like to do? (hobbies/interests)

_____

_____

3. What kinds of things scare or worry your child?

_____

_____

4, What are some of the things your child does which please you or make you proud?

_____

_____

5. Put a circle around any of the following things which concern you about the child.

1. Bedwetting
2. Wetting during the day
3. Thumb sucking
4. Stammering or stuttering
5. High strung or easily upset
6. Too restless
7. Shy
8. Sad or sulky
9. Feelings easily hurt
10. Wanting too much attention
11. Wanting too much comfort/ support from parent
12. Day dreaming
13. Sleep issues
14. Nightmares
15. Temper Tantrums
16. Contrary or stubborn
17. Disobedient
18. Lying
19. Selfish in sharing
20. Jealous of brothers & sisters
21. Fighting with other children
22. Purposely destroys things
23. Feeding
24. Toilet issues
25. Any other problems? 0r comments:

Elaborate further if needed:

_____

_____

_____

6. How does your child get along with mother, father, and other children/family members? Does your child show normal affection? How does child relate to peers?

_____

_____

_____

7. How many other members of the family live in the same house as the child and what is each member's relationships to the child?_____

_____

_____

8. Are there any family social/economic issues, such as problems with housing, employment, food, etc. (describe)?

_____

_____

9. Who looks after the child most of the time?_____

Day? _____

Night?_____

10. Please describe any other incidents or facts which might help understand your child's difficulties and what may cause/have caused them?

_____

_____

_____

_____

**(G) EDUCATION**

a. Why are you considering a change of school for your child at this time?

_____

_____

_____

b. Are you presently considering any other school(s)?

_____

_____

c. What is the current ratio of staff/child at your child's current/previous school?

_____

d. Has your child needed or does need a classroom aide?

_____

Why?

_____

e. Has your child needed or does one-to-one-nursing or a TSS?

_____

f. Does your child presently receive related services? List types and frequency (e.g. Speech – 1x/week 30 min.)_____

_____

_____

_____

g. Are you open to reassessing/adjusting the need for/frequency related services in order to achieve the right balance for your child should he/she begin at The Camphill School?

_____

_____

h. How does your child relate to going to school/education?

_____

_____

i. Describe your child's academic abilities.

_____

_____

_____

j. What does you child like best/least about school?

_____

_____

11. Has your child seen a psychologist, psychiatrist, counselor, or other mental health professional? If so, please state reason_____

Name and address _____

_____

Approximate period of attendance _____

_____

Advice given to you, and your comments _____

_____

_____

12. Has your child undergone any psychological or intelligence tests? ☐ yes ☐ no

(1) If yes, where was he/she tested? _____

When? _____Result of Test (IQ) _____

(2) Where was he/she tested? _____

When? _____ Result of Test (IQ) _____

13. Has your child had any private tutoring? ☐ yes ☐ no
When? For what_____

_____

14. Where? And when was most recent evaluation? _____

_____

_____

_____

15. If any unusual progress or regression took place during school attendance and/or transitions, please describe. _____

_____

_____

16. Is your child registered with the local human services, social services, or MH/IDD agency to receive services? _____ If YES, please provide the following information:

- **Name of Supports Coordinator/Case Manager/Social Worker -** _____
- **Name of Agency**_____
- **Contact Info: Address**_____
- **Phone** _____ **Email**_____

17. Are you comfortable with the fact that The Camphill School does not generally encourage computer use through the elementary school (below grade 9)?

_____

_____

18. If your child is accepted, would you continue, or plan any other programs after or during school hours? If so, please explain/describe. The Camphill School offers a full educational program and services; additional programs may conflicts with our programs/practices.

_____

_____

_____

**VI. QUESTIONS FOR HIGH SCHOOL APPLICATIONS:**

1. What do you envision for your child beyond 12th grade (the completion of The Camphill School's program on our Beaver Run campus at age 18 or19)?

_____

_____

_____

2. We have a distinct Transition Program at our Beaver Farm campus for the 18/19- to 21-year phase of your child's education. Are you interested in this for your child?

_____

**VII. PARENT INVOLVEMENT**

1. How would you like to, or imagine you would, be involved in your child's education (e.g. parent teacher evenings, parent workshops, parent groups, volunteering for events, etc.) Specify_____

_____

2. If your child is accepted as a residential student, might you be making on-campus visits? How often? _____

_____

a. Might you be taking your child for weekend visits? How often?

_____

_____

b. Would you like a current parent to contact you regarding their experience at Camphill?
Yes ☐ No ☐

**HOW DID YOU LEARN ABOUT THE CAMPHILL SCHOOL?**

_____

_____

**IF YOU ARE APPLYING FOR RESIDENTIAL PLACEMENT PLEASE TELL SOME OF YOUR REASONS OR MOTIVATING FACTORS**

_____

_____

_____

Do you have remarks you wish to add? Please feel free to use additional sheets for more information on any of the previous questions, or for any information you feel important that was not asked for.

_____

_____

_____

_____

## LIVING GRANDPARENTS

**MATERNAL** (names/address/phone)

1_____

_____

_____

_____

3_____

_____

_____

**PATERNAL** (names/address/phone)

2_____

_____

_____

_____

4_____

_____

_____

Do you know of others who might wish to receive information about The Camphill School?

- Name/Address
  _____

  _____

  Relationship to you_____

- Name/Address _____

  _____

  Relationship to you _____

- Name/Address_____

  _____

  Relationship to you_____

**Please return application to:**

Admissions Office
The Camphill School
1784 Fairview Road
Glenmoore, PA 19343

The Camphill School does not discriminate on the basis of race, age, color, creed, gender, sexual orientation, national origin, ethnic origin, or disability.

Dear Parent or Guardian:

This form enables The Camphill School to obtain medical information about your child. Please send one to the doctor who has been chiefly responsible for your child's care and one to either a specialist, or to a hospital (if your child has been hospitalized).

**Please do not send this form to Camphill. Send it directly to the doctor/clinic who has seen your child.**

---

**Bernard Wolf, Director of Admissions**
**The Camphill School**
**1784 Fairview Road, Glenmoore, PA 19343**

TO: _____
(*name of doctor, hospital or clinic)*

_____
*(address)*

**Please send copies of office records and / or any applicable hospital discharge summary concerning my child**

_____
*(child's name and date of birth)*

**to Bernard Wolf, Director of Admissions, at the above school address, for the purpose of review and evaluation for possible admission and/or treatment. Please list any treatment dates or time frame:**

_____

This authorization expires one year after the date below. We have the right to revoke this authorization. We confirm that we have not been required by the doctor, hospital, or clinic to sign this authorization in order to receive treatment or payment or to enroll or be eligible for benefits.

Signed _____
*(Parent/guardian)*

Address: _____

_____ Phone: _____

Date_____

Dear Parent or Guardian:

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TO: _____
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**Please send copies of office records and / or any applicable hospital discharge summary concerning my child**

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Signed _____
*(Parent/guardian)*

Address : _____

_____ Phone: _____

Date_____