Clarke Schools
for Hearing and Speech

Application and Enrollment
STUDENT INFORMATION

Date ______________________

Student ______________________ ______________________
Last First Middle

Date of Birth ______________ Preferred Name ______________________

Sex ____________ Height __________ Color of Eyes ______________________

Race ____________ Weight __________ Color of Hair ______________________

Identifying marks ____

FAMILY INFORMATION / FAMILY HISTORY (If different from initial application)

Parent/Guardian 1 ______________________ Date of Birth ______________________
Last First Middle

Address ______________________ Preferred
Home Phone ______________________ ☐

Primary Language ______________________ Cell Phone ______________________ ☐

Work Phone ______________________ ☐

Occupation ______________________

Employer ______________________

E-mail address ______________________

Parent/Guardian 2 ______________________ Date of Birth ______________________
Last First Middle

Address ______________________ Preferred
Home Phone ______________________ ☐

Primary Language ______________________ Cell Phone ______________________ ☐

Work Phone ______________________ ☐

Occupation ______________________

Employer ______________________

E-mail address ______________________

Parents Marital Status: ___ married ___ single ___ separated ___ divorced ___ widowed
If separated or divorced, parent with custody: ___ both ___ father ___ mother ___ legal guardian(s)
If separated or divorced what type of custody: ___joint legal ___joint physical ___ sole physical

Note: Please attach a copy of the legal document that supports custody. This information is necessary and required for the protection of children's records, as well as to ensure that legal guardians receive appropriate correspondence and reports. Thank you.

HISTORY OF HEARING LOSS

Birth Hospital: ____________________ Results of newborn hearing screening: ___ passed ___ failed ___ unknown

Please explain if unknown:

What is the degree of hearing loss: ____________________

Have there been any changes in the degree of hearing loss since first diagnosed? ___ Yes ___ No

Age your child began using hearing aids: __________

Current Amplification (H.A., Cochlear Implant, BaHa, FM): Right ear: __________ Left ear: __________

Describe how and when your child uses amplification (ex, when is it first put on, when does s/he not use it during the day):

Describe how your child reacts when wearing it or not wearing it:

Does your child have an FM system for his/her hearing aid or CI? ___ Yes ___ No

Describe your child's communication/speech/language skills:

Related to your child's hearing loss, has your child had genetic testing? ______ CT-scan/MRI? ______ ABR? ______

What clinics, audiologists, ENT or other specialists have examined your child? (Please list name(s) and address (es) on page 5)

Name	Date	Specialty	Results/Findings

DEVELOPMENTAL

What time is your child's bedtime? ________ Does s/he sleep through the night? ______ How many hours sleep does your child typically get? ________ Does your child nap? How often/how long? ____________

Is your child toilet trained? ____________________

Has your child been examined by an eye doctor? ___ Yes ___ No

If yes, please list doctor's name and address on page 5.

Does your child wear glasses/contact lenses? ___ Yes ___ No

Do you have concerns about your child's behavior? ___ Yes ___ No

If yes, please explain.

____

____

____

Has your child ever been seen or evaluated by a Psychologist, Psychiatrist or Counselor?

___ Yes ___ No

If yes, please complete the following: ___ Psychologist ___ Psychiatrist ___ Counselor

school/family to follow. If seen by a Psychiatrist also indicate medication/dosage your child is receiving. Please list doctor's full name and address on page 5.

Name	Date	Specialty	Results/Findings/Medications

If he/she has had a serious illness, please list additional information below:

____

____

____

____

HEALTH INFORMATION/ MEDICAL HISTORY

General Health ____

Special needs in addition to hearing loss: (circle) None

Visual problem   Epilepsy   Heart Disorder   Mentally Impaired   Brain damage   Perceptual-motor disorder

Cerebral Palsy   Emotional-Behavioral Disorder   Learning Disability   Attention Deficit Disorder

Orthopedic   Other (specify) ____

Diagnosed Conditions ____

Is your child taking medication? (specify) ____

Does your child have allergies (specify) ____

Is your child allergic to any foods such as peanuts, eggs or milk? ______________________________

Date of Last Physical Exam ____________________

Appetite: ___ Good   ___ Fair   ___ Poor

Does your child: ___ drink milk?   ___ eat eggs?   ___ vegetables?

Special Dietary Considerations ____

____

Does your child have a history of ear infections: ___ Yes   ___ No

If yes, at what age did your child start having ear infections? ______________________________

How many a year? _____ Has your child ever had tubes in the eardrums? ___ Yes   ___ No

If yes, give dates: ____

Other than tubes, has there been other ear surgery? ___ Yes   ___ No

If yes, give date(s) and reason: ____

____

Describe below any illnesses, operations, emergency treatment or conditions requiring medication for your child:

Name of condition | Age at which it occurred | Medication or other treatment

____
____
____
____
____
____
____

Specific details for handling medical emergencies ____
____

EDUCATION / INTERVENTION (from birth to present – use extra sheets if necessary)

Early Intervention Program
Service Coordinator's Name/number: ____

Check the services your child has/did receive:

Service	How often	Length of session	Location: Home, Daycare or Center based
___Speech	___x/week		
___ OT	___x/week		
___ PT	___x/week		
___ Feeding	___x/week		
___Special Instruction	___x/week		
___ Other:	___x/week		

Preschool Services:

Name of School:	
Services:	
Additional Needs:	
In what areas does your child do well?	
What social activities does your child enjoy?	