Clarke Schools
for Hearing and Speech

Clarke NY Preschool Application

Date _____

Program: ☐Start as soon as possible ☐ Summer _____ ☐ School Year _____

Student _____Sex _____
Last First Middle

Date of Birth _____ Preferred Name _____

FAMILY INFORMATION/ FAMILY HISTORY (please complete in full)

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

Address

_____

Home Languages _____ E-mail address _____

Phone Numbers **(please check the number you prefer to use)**

Home Phone _____☐ Cell Phone _____ ☐ Work Phone _____ ☐

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

Address

_____

Home Languages _____ E-mail address _____

Phone Numbers **(please check the number you prefer to use)**

Home Phone _____☐ Cell Phone _____ ☐ Work Phone _____ ☐

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: If your child is enrolled at Clarke, you will need to provide a copy of the legal document that supports custody.

HISTORY: BIRTH, MEDICAL, HEARING LOSS (please complete fully)

Birth Hospital: _____ Child's weight at birth: _____

Pregnancy length: _____ months Birth mother's age at child's birth _____

Pregnancy complications: _____

Was your child a ☐ single birth ☐ one of multiple (twins, triplets, or more)

NICU stay: ☐ Yes ☐ No If yes, describe length and reason: _____

_____

Newborn hearing screening results: ☐ passed ☐ referred (failed) ☐ don't know ☐ not done

If not done or not known, please explain: _____

Has your child had genetic testing and if yes, what were the results? ☐ Yes ☐ No

Has your child had an ABR? ☐ No ☐ Yes At what age? _____

Has your child had audiology behavioral testing? ☐ No ☐ Yes When? _____

What is your child's degree of hearing loss in each ear?

Right: _____ Left: _____

What type of hearing loss does your child have? ☐ Sensorineural ☐ Conductive ☐ Mixed

What amplification is your child currently using (hearing aid, Cis, bahas, etc.)? ☐ None yet

Right: _____ Left: _____

Age first received: _____

What time does your child:

Start using hearing aids/cochlear implants/bahas in the morning _____

Take hearing aids/cochlear implants/bahas off at night _____

Other times/activities when your child doesn't wear hearing aids/cochlear implants/bahas (example: bath time, nap time) _____

Who does your child see for hearing related needs?

	Name	Hospital/Clinic	Phone	Email Address
Audiologist:				
ENT/Otologist				
Other:				

Does your child have other medical needs or diagnosis? ☐ Yes ☐ No If yes, please explain:

Which medical specialists are involved?

Family Priorities and Needs

Why do you want your child to come to Clarke?

What are your concerns about your child and their hearing loss?

What are your goals for your child's language and communication?

What are your goals for your family while at Clarke?

What will you want Clarke's support to do or learn related to your child's hearing loss?

What other family members or caregivers are involved with your child who should learn about your child's hearing loss and language learning needs?

What questions do you have?

Language/Communication

What languages are used in your home/family?

What words does your child use?

What words does your child understand?

How does your child react when you don't understand what he/she is trying to communicate?

Development

Sleep

When does your child go to bed and wake up? _____

Does he/she sleep through the night? ☐ Yes ☐ No

How many hours, total, does your child sleep during the night? _____

Does your child nap? ☐ Yes ☐ No How many times and for how long? _____

Social Skills/Behavior

Do you have concerns about your child's behavior or social skills? ☐ Yes ☐ No

If yes, please explain. _____

How does your child play or interact with other children their age?

What does your child like to do or play with?

Toileting

Is your child toilet trained? ☐ Yes ☐ No

If not, what age do you think a child should be toilet trained? _____

Eating/Food/Nutrition

Do you have concerns about your child's eating habits or diet? _____

_____

What foods does your child eat? _____

_____

What foods can your child eat independently? _____

Therapy and Intervention History

Type	Receiving?	Therapist name	Frequency of Service
Speech	☐Yes ☐ No		
Occupational therapy	☐Yes ☐ No		
Physical therapy	☐Yes ☐ No		
Nutrition	☐Yes ☐ No		
Special education	☐Yes ☐ No		
Psychologist	☐Yes ☐ No		
Other:	☐Yes ☐ No		

Daycare/School Information

Current daycare	
Daycare address	
Daycare phone number	
Current preschool	
School address	
School phone number	

Can we speak to your child's current therapist? ☐ Yes ☐ No

Can we speak to your child's current school? ☐ Yes ☐ No