LONDONDERRY EARLY EDUCATION PROGRAM
INCLUSION PROGRAM APPLICATION

DATE ________________

CHILD'S INFORMATION

NAME ____
(First) (Nickname) (Middle) (Last)

ADDRESS ____ TELEPHONE # ________________

DATE OF BIRTH ________________________________ SEX: _________ MALE _________ FEMALE

FAMILY INFORMATION

FATHER'S NAME ___________________________________ BIRTHDATE ____________________

ADDRESS (if different) ______________________________ TELEPHONE ____________________

OCCUPATION____________________________________ EDUCATION ____________________

EMPLOYER ______________________________________ TELEPHONE ____________________

MOTHER'S NAME __________________________________ BIRTHDATE ____________________

ADDRESS (if different) ______________________________ TELEPHONE ____________________

OCCUPATION____________________________________ EDUCATION ____________________

EMPLOYER ______________________________________ TELEPHONE ____________________

LEGAL GUARDIAN: (check one) _____ MOTHER _____ FATHER ______ BOTH _______ OTHER

BROTHERS AND SISTERS:

NAME	AGE	EDUCATION AND SPECIAL SERVICE

E-mail address____

OTHER PERSONS LIVING IN THE HOME ______________________________________

LANGUAGE(S) SPOKEN IN THE HOME ______________________________________

DOES ANY MEMBER OF YOUR FAMILY HAVE A DISABILITY? __________________________

PLEASE EXPLAIN ____

HAVE THERE BEEN ANY RECENT BIRTHS, DEATHS, DIVORCE, SEPARATION, OR OTHER MAJOR CHANGES IN THE FAMILY?

PLEASE EXPLAIN ____

IN CASE OF EMERGENCY, CONTACT: (other than the parent of the child)

NAME ______________________ ADDRESS ______________________ PHONE ______________

NAME ______________________ ADDRESS ______________________ PHONE ______________

PRENATAL, BIRTH AND HEALTH HISTORY

BIRTHPLACE ____

Were there any unusual events during your pregnancy or delivery with this child (for example: toxemia, x-ray treatments, rubella, other maternal illness or injury, drugs, bleeding, or other problems)?

____

____

Was your child premature? ____________________________ How many weeks? __________________

Did your child have any birth defects or require special care after birth (for example: needed oxygen, had cleft palate, webbed feet or fingers, heart or lung condition, malformation of spine, etc.)?

____

List of diagnosis your child has been given: ____

____

Describe any serious accidents, illnesses, hospitalizations or surgeries:

TYPE	DATE	CHILD'S AGE	DOCTOR/SURGEON

Has your child had seizures or convulsions? _________________________ When? ____________________

If your child has allergies, please list: ____

If your child is on medication, please list type of dosage: ______________________________________

____

If you child is on a special diet, please describe: ____

____

List your child's pediatrician and other specialists who have seen your child:

NAME	ADDRESS	DATE SEEN

List other agencies that have been involved with your child (clinics, hospitals, physical or occupational therapists, speech therapists, preschools, public health nurses, etc.).

____

____

GROWTH HISTORY

Indicate the age at which your child accomplished the following:

Held head erect ______ Rode tricycle ______ Fed self with spoon ______

Sat unsupported ______ Climbed stairs ______ Gave up bottle ______

Crawled ______ Ate solid foods ______ Drank from cup ______

Walked ______ Finger fed self ______ ***Toilet Trained** ______

Dressed Self ______

***Children in the inclusion program need to be toilet trained prior to starting the program. We understand you may be applying prior to your child being toilet trained in order to participate in the spring lottery.**

MOTOR DEVELOPMENT

If you have concerns about your child's motor development, please explain:

____

____

Please check any of the following that apply to your child:

______ Seems clumsy ______ Falls frequently ______ Moves slowly or jerkily

______ Feels tight ______ Uses one side of the body differently from the other side

______ Feels floppy

How does your child get from room to room? (i.e., crawls, is carried, scoots, walks, etc.) ____________________

What hand does your child use most often? ______ Right ______ Left

Does your child switch hands from: ______ Eating ______ Pencil use ______ Ball throwing ______ Batting

COMMUNICATION

HEARING:

If you have concerns about your child's hearing, please explain: ____

Has your child had frequent ear infections? ______Yes ______No

If yes, explain: ____

Has your child had a recent hearing exam? ______Yes ______No

If yes, explain: ____

Please check any of the following that your child responds to:

______ Doorbell or telephone ______ Speech when facing speaker ______ Speech from another room

______ Children playing outside ______ Speech with back to speaker ______ Whispered speech

______ Truck or motorcycle outside ______ Speech on TV

SPEECH AND LANGUAGE:

If you have concerns about your child's speech and language, please explain: ______________________________

____

____

My child: (please check those that apply to your child)

_______ drools

_______ babbled or cooed during the first 6 months of age

_______ spoke the first words with meaning by approximately one year of age

_______ spoke in short sentences by approximately 2 ½ years of age

_______ spoke in complete sentences by 4 years of age

_______ began to babble or talk and then stopped

My child uses speech: ______ Frequently ______ Occasionally ______ Never

Comment: ____

____

Give an example of your child's typical speech: ____

____

If your child uses other forms of communication, such as a communication board or sign language, please explain:

____

Which of the following is most typical of your child's ability to understand speech? **(check only <u>one</u>)**

______ Does not understand what is said
______ Understands very little of what is said
______ Understands what is said when speaker gestures
______ Understands familiar statements or questions
______ Clearly understands everything said

What of the following is most typical of your child's ability to communicate? **(check only <u>one</u>)**
______ Does not use speech or gestures to communicate
______ Uses gestures or motions but no speech
______ Uses babbling sounds but doesn't try to talk
______ Uses sounds when trying to talk
______ Uses speech, primarily single words
______ Uses sentences that are understood by the family but not by others
______ Uses sentences that can be understood by others
______ Speech is clearly understandable

SOCIAL AND COGNITIVE DEVELOPMENT

SOCIAL BEHAVIOR:

If you have concerns about your child's social interaction with others, please explain: ________________________

____

____

Please check any of the following that apply to your child. My child:

______ Smiles

______ Laughs spontaneously

______ Cries

______ Reaches to be picked up

______ Likes to be held and cuddled

______ Recognizes familiar people

______ Makes eye contact

______ Separates easily from me

Describe your child's favorite toys and activities: ____

____

Describe how your child plays with toys (i.e., length of play, supervised or unattended, pretends with objects):

____

____

Describe how your child interacts with other children:

____

____

Describe how you discipline your child:

____

____

How does your child respond to discipline?

____

____

COGNITIVE BEHAVIOR

If you have concerns for your child's learning ability, please explain:

____

____

____

My child (please check all that apply to your child):

______ Plays peek-a-boo

_______ Plays pat-a-cake

______ Waves bye-bye

_______ Responds to "No"

______ Uses scissors

______ Identifies colors

______ Looks at books

______ Stacks blocks

______ Puts puzzles together

______ Uses pencil or crayon

______ Identifies letters

______ Identifies number

Please explain why you and your child would like to participate in the Preschool Inclusion Program:

____

____

____

____

____

____

Families of inclusion preschool children may select either one slot for two days or purchase two slots for four days. Our inclusion prek students attend three days per week, however, families have the option to purchase an additional day.

Please let us know your preference:

Preschool: _____ 1- two day slot (equaling 2 days per week) or ____ 2- two day slots (equaling 4 days per week)

Prekindergarten: _____ 3 days per week _____ 3 days per week plus 1 additional day (equaling 4 days per week)

****

I understand that my child is being considered for admittance into the LEEP Inclusion Program. Requirements include that your child turn three (3) by September. 1st of the school year he or she is applying for. Your child will need to be toilet trained and have age appropriate speech and language development.

PARENT/GUARDIAN SIGNATURE ____

DATE ______________________

PLEASE RETURN THIS FORM TO:

KIM SPEERS
LONDONDERRY EARLY EDUCATION PROGRAM
MOOSE HILL SCHOOL
150 PILLSBURY ROAD
LONDONDERRY, NH 03053