



Siblings: Please list any brothers and sisters of child.

	Name	Date of Birth	Name of School
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Name of child's primary physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address of physician: \_\_\_\_\_

In case of emergency, please contact: \_\_\_\_\_

Address of emergency contact: \_\_\_\_\_ Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone: \_\_\_\_\_

Names of individuals to whom child may be released:

Name \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child: \_\_\_\_\_

### MATERNAL AND NEONATAL HISTORY

During pregnancy of this child, did mother experience any unusual illnesses, conditions or accidents? If so, please explain. \_\_\_\_\_

List medications that were taken during pregnancy. \_\_\_\_\_

Length of pregnancy (weeks) \_\_\_\_\_ Duration of labor \_\_\_\_\_

Please describe any complications during labor or delivery \_\_\_\_\_

Delivery was  Vaginal  C-section

Birth weight of child \_\_\_\_\_ Birth length of child \_\_\_\_\_

Did the baby have trouble breathing?  Yes  No If yes, please describe. \_\_\_\_\_

Did the baby have a feeding/nursing problems? \_\_\_\_\_

Was the baby on a ventilator?  Yes  No If yes, for how long? \_\_\_\_\_

Did the baby have any seizures? \_\_\_\_\_

Please list any other problems or special conditions present at birth. \_\_\_\_\_

Where was the child born? \_\_\_\_\_

Hospital Address City State

**GENERAL MEDICAL INFORMATION**

What illnesses has your child had? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had any significant injuries?  Yes  No If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Does your child have vision problems?  Yes  No If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Does your child wear glasses?  Yes  No

Does your child have hearing problems?  Yes  No If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Does your child have a hearing aid?  Yes  No

Has your child had any seizures or convulsions?  Yes  No

If yes, at what age did they start? \_\_\_\_\_

Is your child taking medicine at this time?  Yes  No

Type of Medication

Amount and Time Given

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized?  Yes  No If yes, please list hospital, date and reason.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child use any special equipment? Check all that apply:

- Leg Braces       Scoliosis Jacket       Splints       Walker       Crutches  
 Canes       Parapodium       Wheelchair       Travel Chair

Other: \_\_\_\_\_

Does your child have allergies?  Yes  No Is your child allergic to latex?  Yes  No

If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any services your child is receiving (including day care; preschool; physical, speech, nutritional or occupational therapy; infant programs, etc.)

	Type of Service	Program Name/Address	How Long
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Has your child been evaluated, tested, treated or seen by any of the following?

	Name	Where	When
	Allergist	_____	_____
	Audiologist	_____	_____
	Cardiologist	_____	_____
	Cerebral Palsy specialty clinic	_____	_____
	Children's Rehab Services	_____	_____
	Dentist	_____	_____
	Dept. of Pension & Securities	_____	_____
	Down syndrome specialty clinic	_____	_____
	Endocrinologist	_____	_____
	Gastroenterologist	_____	_____
	General Surgeon	_____	_____
	Geneticist	_____	_____
	Low Birth Weight clinic	_____	_____
	Mental Health Center	_____	_____
	Neurologist	_____	_____
	Neurosurgeon	_____	_____
	Nutritionist/Dietician	_____	_____
	Nurse	_____	_____
	Ophthalmologist	_____	_____
	Orthopedist	_____	_____
	Otolaryngologist (ENT)	_____	_____
	Physiatrist	_____	_____
	Physical/Occupational Therapist	_____	_____
	Psychiatrist	_____	_____
	Psychologist	_____	_____
	Public Health Dept.	_____	_____
	Social Worker	_____	_____
	Speech/Language Therapist	_____	_____
	Spina Bifida Clinic	_____	_____
	Other Early Intervention Programs	_____	_____

If the child is accepted, evaluations may be required on separate days. Would you have transportation problems or other difficulties in keeping appointments?  Yes  No If yes, please explain \_\_\_\_\_

What school district do you live in? (Please answer regardless of child's current age or current school placement.) \_\_\_\_\_



B. Motor Activity

1. No head control
2. Can hold head up without support
3. Can sit with support
4. Can sit alone without support
5. Rolls over (a) front to back (b) back to front
6. Crawls (a) pulls with arms (b) on hands and knees
7. Can walk around furniture
8. Can walk alone
9. Frequently stumbles or falls when walking
10. Can run and jump
11. Participates willingly in activities such as rolling a ball and singing songs

Describe special problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Toilet Training

1. In diapers
2. In training pants
3. Will go to toilet when taken by adult
4. Goes by himself/herself when reminded
5. Goes by himself/herself with occasional accidents
6. Completely trained except for accidents at night
7. Bowel but not bladder trained
8. Bladder but not bowel trained
9. Completely bowel and bladder trained
10. Uses (a) potty chair (b) small seat on big toilet (c) regular toilet seat
11. Is catheterized?     Yes     No    If yes, how often? \_\_\_\_\_

Describe special problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. Communication

1. Grunts
2. Gestures and/or points
3. Crying
4. Babbling
5. Single words
6. Phrases
7. Sentences

Describe special problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. Dressing

1. Does not dress or undress self or help with dressing
2. Can remove some clothing (socks, pants, shirt)
3. Assists with dressing (holds arm out for shirt, lifts leg for pants)
4. Puts on some clothing
5. Dresses self but needs help in buttoning and tying

Describe special problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Social Behavior

1. Does not respond to people or things around him/her
2. Shows some awareness of people and objects (smiles, laughs)
3. Will respond to simple games (peek-a-boo, pat-a-cake)
4. Plays by himself/herself with simple toys
5. Parallel play (will play alongside other children but does not play with them)
6. Plays simple games with other children (ring around rosies)
7. Enjoys pretend play (feed the doll, comb hair, talk on phone)

Describe special problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

G. Behavior Problems

1. Does not obey commands
2. Frequent tantrums and/or crying
3. Withdrawal (avoids social contact, shy, timid)
4. Frequent hitting, kicking, biting, spitting
5. Self –injurious behavior (head-banging, scratching)
6. Unusual behavior (rocking, spinning, finger-movements, other activity). Please describe

\_\_\_\_\_  
\_\_\_\_\_

Please describe the major concerns you have in seeking help for your child and how long they have been present.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you like The Bell Center for Early Intervention Programs to help with these concerns? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A detailed medical assessment of your child follows. Please have this completed by your child’s personal physician or medical caregiver. Return as soon as possible. Thank you.

Please enclose a picture of your child.

**MEDICAL ASSESSMENT**

Name of child \_\_\_\_\_

Date of Examination \_\_\_\_\_

Birth Term \_\_\_\_\_ Date of Birth \_\_\_\_\_ Birth Height \_\_\_\_\_ Birth Weight \_\_\_\_\_

General Appearance \_\_\_\_\_ Abnormalities \_\_\_\_\_

Skin \_\_\_\_\_ Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Head \_\_\_\_\_

Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Throat \_\_\_\_\_ Nose \_\_\_\_\_

Glands \_\_\_\_\_ Abdomen \_\_\_\_\_ Extremities \_\_\_\_\_

Muscle Tone \_\_\_\_\_

Sight \_\_\_\_\_ Hearing \_\_\_\_\_ Allergies \_\_\_\_\_

**VACCINATIONS**

Type of Vaccine	Date	Date	Date	Date	Date	Date
DPT or DT						
Polio						
Rubella						
Measles (Red)						
Mumps						
Hepatitis B						
H. Influenzae type B (Hib)						
Chickenpox						

Neurological Exam (if indicated) \_\_\_\_\_ Stool Exam (if indicated) \_\_\_\_\_

Test	Date	Results
Urinalysis		
Hemoglobin or Hematocrit		
TB Skin Test		
Sickle Cell		

**Previous Illness (with age)**

- Asthma \_\_\_\_\_
- Menigitis \_\_\_\_\_  
(type) \_\_\_\_\_
- Pneumonia \_\_\_\_\_
- Tonsilitis \_\_\_\_\_
- HIV \_\_\_\_\_
- CMV \_\_\_\_\_
- Hepatitis B \_\_\_\_\_
- Ear Infections \_\_\_\_\_
- RSV \_\_\_\_\_
- Other \_\_\_\_\_

**Current**

- Head Circumference \_\_\_\_\_
- Height \_\_\_\_\_
- Weight \_\_\_\_\_ lbs.
- Temp \_\_\_\_\_ Resp \_\_\_\_\_
- Pulse \_\_\_\_\_

Problem	Check if Present	Minimal	Moderate	Severe
Cerebral Palsy				
Athetoid				
Spastic				
Mixed				
Hemiplegia				
Diaplegia				
Paraplegia				
Quadriplegia				
Hypotonia				
Mental Retardation				
Genetic Conditions				
Down Syndrome				
Other				
Visual Deficit				
Specify type				
Hearing Impairment				
Seizure Disorder				
Hydrocephalus				
Spina Bifida				
Myelomeningocele				
Meningocele				
Occulta				
Other Problems				
Specify type				

**Diagnosis:** \_\_\_\_\_

**Recommendation:** \_\_\_\_\_

Apgar (if known): One minute \_\_\_\_\_ Five Minutes \_\_\_\_\_

Is the etiology of this disability known? \_\_\_\_\_ If so, what? \_\_\_\_\_

**REGULAR MEDICATIONS**

Medicine	Dosage	When Taken

I have examined this client and found him/her to be free from communicable and/or infectious disease and capable of participating in activities at The Bell Center for Early Intervention Programs, except as noted below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Recommendations:**

- Speech Therapy
- Physical Therapy
- Occupational Therapy
- Nutrition

Any Additional Comments? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Permission for Physical Management Program:

\_\_\_\_\_ has been examined and is  
(Name of Child)

Physically able to be evaluated and treated by a physical therapist and to have a physical management program designed by a physical therapist.

\_\_\_\_\_  
Print Physician Name

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician's Complete Mailing Address

\_\_\_\_\_  
Date

**Please return to:**

The Bell Center for Early Intervention Programs  
1700 29<sup>th</sup> Court South  
Birmingham, AL 35209  
Phone: 205-870-0081



## EMERGENCY MEDICAL AUTHORIZATION FORM

As parent or legal guardian of the undersigned child, a minor, I hereby give my consent, authorization and permission to The Bell Center for Early Intervention Programs and its agents, servants, volunteers and employees for: The administration of any emergency medical treatment deemed necessary by \_\_\_\_\_ (preferred physician) or \_\_\_\_\_ (preferred dentist), or, in the event the designated preferred practitioner is not available, by any other licensed physician, dentist, or medical personnel; and also for the transfer of the undersigned child to any hospital or medical treatment facility reasonably accessible. I will be responsible for any medical or hospital fees or costs associated with the illness or treatment of this minor in accordance with the terms of this authorization, and the terms of the "Full Release and Waiver of Liability" executed by me with respect to the undersigned child are incorporated fully herein by reference to the same.

Done this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Parent/Legal Guardian



**FULL RELEASE AND WAIVER OF LIABILITY**

In consideration for accepting the undersigned child into The Bell Center for Early Intervention Programs, and the providing of professional services to the undersigned child by the same, I, as the parent and legal guardian of the undersigned child, do hereby fully release and discharge, for myself, my heirs, legal representatives, and assigns, the following: The Bell Center for Early Intervention Programs, The Service Guild of Birmingham, Inc., and their agents, servants, volunteers, and employees from any and all legal liability or claims for money damages, compensation or indemnification, arising from, and by reason of, any and all known and unknown illness, injuries or damages, that may be suffered by the undersigned child due to or resulting from his/her participation or attendance in any activities or professional services provided by The Bell Center Early Intervention Programs. This release incorporates as it fully set forth herein the Alabama “Volunteer Service Act.” I understand that The Bell Center is not responsible for determining when medical procedures are needed for my child nor for the administration of any procedure nor the upkeep of any medical equipment.

Done this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Parent/Legal Guardian



**PICTURE THERAPY RELEASE**

I hereby give my permission to The Bell Center for Early Intervention Programs to use a picture or pictures of \_\_\_\_\_ (name of child) for therapy purposes as a part of services offered by The Bell Center for Early Intervention Programs.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Parent/Legal Guardian