For Administrative Use Only

Class Name: ________________________
Team: ____________________________
Class Time: ________________________
Number of Days: ____________________
EI Provider: ________________________
Pediatrician: ________________________

Scholarship: Yes No
Amount of Scholarship: ______________
Program Start Date: _________________
Entry Date: _________________________
Marketing Release: Yes No

E ____ DS ____ TS ____ SP ____ CEF _____ CF ____ DL ____ GW ____

GENERAL INFORMATION

Child's Name ____
Last First Middle

What name do you prefer to call your child? ___________________________________

Address ____
Street City State Zip Code County

Home Telephone ________________ Child's Social Security Number _______________

Present Age ______ Gender ______ Date of Birth _________ Hospital Where Born_____________

Present Height _______ Present Weight ______ Color Eyes _________ Color Hair ___________

Diagnosis ____

Insurance ☐ Yes ☐ No If yes, what company? ______________________________

Medicaid ☐ Yes ☐ No If yes, what member number? __________________________

FAMILY BACKGROUND

The information below refers to: ☐ Parents ☐ Foster Parents ☐ Legal Guardians

Do both parents live in the home? ☐ Yes ☐ No

If child does not live with both parents, with whom does child live? _____________________

Father's Name: ________________________________ Date of Birth: _______________

Address: ____
Street City State Zip Code Home Telephone

Employer: ____
Name Address

Work Phone: ____________________ Cell Phone: ____________________

Mother's Full Name: ____________________________ Date of Birth: _______________

Address: ____
Street City State Zip Code Home Telephone

Employer: ____
Name Address

Work Phone: ____________________ Cell Phone: ____________________

Email Address: ___________________ Is this address checked regularly? ☐ Yes ☐ No

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: ____
Name Relationship to child

Address of emergency contact: ________________________________ 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 you 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.) ____________________

DEVELOPMENTAL PROFILE

AT WHAT AGE DID YOUR CHILD:

Turn over (front/back or back/front) ____________

Get head control ______________________________

Sit alone ____________________________________

Give up breast/bottle __________________________

Finger feed ___________________________________

Use spoon independently _______________________

Say single words______________________

Hold cup or glass ____________________

Crawl ______________________________

Pull to stand _________________________

Walk around furniture ________________

Walk alone __________________________

What does your child like to do? (what toys does he/she like, what food does he/she like, what makes him/her happy) ____

____

____

____

What do you do when your child misbehaves? Check one:

☐ Spank ☐ Scold ☐ Time out ☐ Take away privileges Other ____________________

Does anyone help you with the care of your child? ☐ Yes ☐ No

If yes, who helps you the most frequently? (Relative, friend, babysitter) _________________________

____

PLEASE CIRCLE APPROPRIATE ANSWERS

A. Feeding

1. Has difficulty sucking and swallowing
2. Is breast fed
3. Drinks from bottle
4. Holds own bottle
5. Weaned
6. Drinks from cup with help
7. Drinks from cup by himself/herself
8. Is fed by an adult
9. Is able to feed himself/herself finger foods
10. Can feed self except for filling the spoon
11. Feeds self completely
12. Is tube fed (a) naso-gastric (b) gastrostomy
13. Diet consists of: (a) baby food: stage one stage two stage three
    (b) table foods
    (c) special formula
14. Able to chew foods ☐ Yes ☐ No

Describe special problems ____

____

____

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 catherized? ☐ 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.

The BELL CENTER for Early Intervention Programs

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) **Current**

□ Asthma __________ □ CMV ________________ Head Circumference _______
□ Menigitis _________ □ Hepatitis B ____________ Height ___________________
(type) ___________ □ Ear Infections __________ Weight ________________ lbs.
□ Pneumonia ________ ______________________ Temp ______ Resp ________
□ Tonsilitis __________ □ RSV _________________ Pulse ____________________
□ HIV ______________ □ Other ________________

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 29th Court South
Birmingham, AL 35209
Phone: 205-870-0081
Fax: 205-879-3416

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

Program Fee Responsibilities

The Bell Center requires several fees each year. Following is a list of these fees and when they are due.

Registration Fee - $50.00

Each year my child registers for a Bell Center program a registration fee applies which typically occurs in February.

Evaluation Fee - $100.00

This fee is due at the time of the evaluation. I understand that the professional staff will evaluate my child using the Revised Hawaii Early Learning Profile before he/she begins therapy at TBC.

I also understand that my child will be re-evaluated each year that he/she participates in a Bell Center Program, and on his/her entry date anniversary the existing evaluation fee applies.

Supply Fee - $75.00

I understand that a $75 supply fee is due each year that my child participates in TBC programs. This supply fee is due September 1st.

If my child enters the program between February 1st and June 1st, this fee is $37.50.

Tuition Fees

Tuition is due on the 15th of each month. The tuition schedule is provided on our website (www.thebellcenter.org).

____

Name of Child

____

Signature of Parent/Legal Guardian

*The Bell Center recognizes that each family comes to us with unique financial circumstances. Financial assistance is available for tuition and applications are available by contacting Jeannie Colquett, Executive Director, at JColquett@thebellcenter.org or 205-879-3417.

A monthly payment plan for evaluation fees and supply fees can be arranged with Janet Wilson, bookkeeper, at djwilson1640@bellsouth.net.