The Shafer Center
CREATING OPPORTUNITIES FOR SUCCESS

Application for Admission

Person(s) completing the form _____ Date _____

Client's Information: Child

Last Name | First Name | Middle Name

Name by which your child is called

Street Address

City | State | Zip Code

Age | Date of Birth (/ /) | ☐ Female ☐ Male

Parent / Guardian Information: Parent #1

Last Name | First Name

Address *(if different from child)*

Home Phone Number | Cell Phone Number | E-mail

Work Phone Number | Occupation | Employer

Parent / Guardian Information: Parent #2

Last Name | First Name

Address *(if different from child)*

Home Phone Number | Cell Phone Number | E-mail

Work Phone Number | Occupation | Employer

☐ [Application Fee $50]

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Client's History:

☐ Yes ☐ No Does your child live with both parents?

If not, with whom does your child live?

What languages are spoken in your home?

Briefly describe a typical day for your child.

☐ Yes ☐ No Was your child adopted?

If so, at what age did your child join your family?

☐ Yes ☐ No Does your child know he/she is adopted?

☐ Yes ☐ No Does your child have a history of ear infections?

If so, please describe how frequently (e.g., 1-2 times a year):

Toileting (check all that apply):

☐ Wears diapers ☐ Toilet trained
☐ Uses toilet when prompted ☐ Self-initiates

How does your child communicate (check all which apply):

☐ Sign Language ☐ Gestures ☐ Single Words
☐ Short Phrases ☐ Complete Sentences ☐ Non-verbal
☐ Picture Communication Exchange
☐ Augmentative Device (such as a *Go Talk*)

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Educational History:

Where does your child go to school/daycare?

How often does your child attend classes?

☐ Yes ☐ No Does your child currently have a behavior intervention plan?

Please indicate if your child has been diagnosed with any of the following:

Condition	Yes	No	Date of diagnosis & name of professional who gave diagnosis
Autism spectrum disorder			
Asperger's Disorder			
Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS)			
Fragile X Syndrome			
Food Allergies			
Sinus Infection			
Convulsions/seizures/Epilepsy			
Head injury			
Apraxia/Dyspraxia			
Dysarthria			
Heart problems			
Hearing Loss			
Vision Loss			
Seasonal Allergies			
Other			

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Family History:

Please indicate if any relative of your child has a history of the following conditions.
Please include parents, siblings, cousins, aunts, uncles, and grandparents:

Condition	Yes	No	Relationship to Child
Autism spectrum disorder			
Asperger's Disorder			
Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS)			
Fragile X Syndrome			
Tics			
Mixed Receptive-Expressive Language Disorder			
Dyspraxia			
Celiac Disorder			
Depression			
Dysarthria			
Psychiatric Disorder			
Emotional/Behavior Difficulties			
Late Talker			
Convulsions/seizures/Epilepsy			
Hearing Loss			
Intellectual Disability			
Muscle Disorder			
Learning Disorder or Learning Difficulties			
Attention Deficit Hyperactivity Disorder			
Blindness			
Other (please describe)			

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Please indicate all that apply to your child:

Condition	Yes	No	Remarks
Sleeping Problems			
Difficulties with feeding			
Toileting Problems			
Needs lots of structure			
Interactive			
Behavior is difficult to manage			
Overactive			
Stays with an activity			
Generally happy			
Self-injurious (e.g., bangs head)			
Injurious to others (e.g., hits, kicks others)			
Frequent Tantrums			
Difficulty with transitions			
Frequently runs/ wanders away			
Other			

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Please list the interventions that your child is currently receiving:

Current Intervention	Frequency (length of session, times per week)	Provider Name and Affiliated Organization
Speech-Language Therapy		
Occupational Therapy		
ABA/AVB		
Psychological or Behavior Counseling		
Physical Therapy		
Educational Intervention/Tutoring		
Others (please specify)		

Please list all previous evaluations that your child has received

Previous Evaluation	Date of Evaluation	Provider Name and Affiliated Organization
Speech-Language Therapy		
Occupational Therapy		
ABA/AVB		
Psychological or Behavior Counseling		
Physical Therapy		
Educational Intervention/Tutoring		
Others (please specify)		

Please list the date of your child's most recent vision screening: _____

☐ Yes ☐ No Were the results within normal limits?

Please list the date of most recent hearing screening: _____

☐ Yes ☐ No Were the results within normal limits?

Please attach a copy of all of your child's previous evaluations and reports, including current and previous IEPs, IFSPs, behavior intervention plans, progress reports, diagnostic reports, audiology evaluations, and report cards. Services cannot be initiated until all documentation has been submitted for review.

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Please describe your child's play. Please indicate all that apply to your child:

Type of Play	Yes	No	Remarks
Pretend Play			
Cause and Effect Toys (e.g., pop-up toy, push button toy)			
Computer Games			
Books			
Rough and Tumble Play			
Repetitive Play (e.g., lining up items)			
Drawing/ Arts and Crafts			
Building			
Singing/ Listening to music			
Prefers to play with others			
Puzzles			
Other			

Please list some of your child's favorite toys, TV shows, movies, games:

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Please let us know in which programs you are interested (please check all that apply):

- ☐ Classroom Programming
- ☐ ABA / VB Therapy
- ☐ Individual Speech-Language Therapy
- ☐ Speech-Language Small Group
- ☐ Occupational Therapy
- ☐ Potty Training
- ☐ Parent Power Series (Free Parent Workshops)
- ☐ Kids' Club (Free Saturday playdate program)
- ☐ Reach for the Stars Program (Saturday program)
- ☐ Best Buds Summer Camp
- ☐ Behavior Consultation Services
- ☐ Connect XYZ Program
- ☐ Bridge Building Program
- ☐ Bridge Blackboard Program

☐ Yes ☐ No Would you like to be added to our mailing list and receive updates about upcoming events such as free parent trainings and open houses?

Who referred you to The Shafer Center? _____

What do you hope to accomplish by coming to The Shafer Center?

_____

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Please attach a copy of all of your child's previous evaluations and reports, including current and previous IEPs, IFSPs, behavior intervention plans, progress reports, diagnostic reports, audiology evaluations, and report cards. Services cannot be initiated until all documentation has been submitted for review.

Please return the Application for Admission, $50 application fee (checks or cash only), and all attachments to The Shafer Center at :

11500 Cronridge Drive, Suite 130
Owings Mills, MD 21117

P 410-517-1113
F 410-517-2113

Application Checklist:

☐ Application Fee $50 ☐ Diagnostic Reports and Evaluations ☐ IEP/IFSP ☐ Application