Paloma Academy
Behavioral Innovation with Quality Instruction

Today's date: ___________________

Pre-Admission Application

Please print and complete all of the information on this pre-admission application. Your position on our waiting list is determined by: the date that it is submitted, if your child has a developmental delay, and if all required paperwork and screenings are completed by the time an opening is available. Incomplete applications will not be processed. Please note that a child will never be turned away from Paloma Academy for problematic behavior, and this is only for informational purposes to ensure they receive the best possible care.

If applicable, a copy of your child's FSP or IEP is required.

Is your child diagnosed with a disability?: Yes ____ No_____

If no, are you interested in getting your child tested?: Yes ____ No_____

Are you interested in your child receiving ABA Therapy while attending Paloma Academy?: Yes ____ No_____

Child's name: ____
First Middle Last

Child's DOB: _________________ **Current age of your child:** ___ **years** ____ **months** **Male**____ **Female**_____

Child's address: ____
Street Apt # City Zip

Person filling out application:________________________ **Relationship to child:** _________________________

Phone: _______________ **Cell:**__________________ **Who is the legal guardian?**_______________________

How did you hear about us? Website ______ Agency _____ Another parent ______ Referred by ______________

Parent Information

Mother's Name:____ **Email:**______________________________
Address: ____
Street City/State Zip

Home phone: ________________ **Work:** ____________________ **Ext.:** _____ **Cell:** ________________________

Place of Employment/Occupation: ____

Father's Name:__________________________________ **Email:**____
First Last
Address if different: ____
Street City/State Zip

Home phone: ________________ **Work:** ____________________ **Ext.:** _____ **Cell:** ________________________

Place of Employment/Occupation:____

Primary Residence: ☐ **Mothers home** ☐ **Father's home** ☐ **Both** ☐**With Guardian:** ______________________

Parents' Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced**

Please check ALL options you are interested in. When do you want to start? Date:__________________________

______ **Full Day 8:00am to 3pm**
______ **Extended Day (Before Care) 7:00am to 3pm**
______ **Extended Day (After Care) 8am to 5:30pm**
______ **Extended Day (BOTH Before and After Care) 7:00am to 5:30pm**

Please describe your main concern(s) for your child and what you want them to learn from our program:
____
____

(Required) Child's Medical Information

Please list and describe any special needs, diagnoses, behaviors, or medical conditions your child has:
____
____
____

List Allergies:
____

Does your child have seizures? ____ **If yes, what kind:** ____________________ **How often:** ________________

List medications your child must take and for what:
____

Do medications need administered during school hours? ☐ **Yes** ☐ **No How often are they given?** _____________

(Required) Child's Developmental Information

Is your child potty trained? ☐ **Yes** ☐ **No** ☐ **Daytime only**

If yes, can your child communicate their need to use the toilet? ☐ **Yes** ☐ **No** ☐ **Sometimes**

How does your child communicate? (Select all that apply)

☐ **My child uses words to communicate**
☐ **My child is using sign language to communicate**
☐ **My child uses a communication device or app (such as Proloquo2Go) to communicate**
☐ **My child pulls me, guides me, or points to communicate**
☐ **My child does not communicate their wants and needs**

Does your child need help eating? ☐ **Yes** ☐ **No**

If yes, what kind of help? (Select all that apply)

☐ **Spoon feeding**
☐ **Prompts to continue/remain on task**
☐ **Behavioral (my child fights eating)**
☐ **My child eats through a G/J tube**

Does your child have a special diet? If so, explain:____
____

Is your child currently receiving therapies? ☐ Yes ☐ No (If yes, select all that apply)
☐ Speech ☐ Occupational ☐ Physical ☐ Sight ☐ Hearing ☐ Behavioral
Do you get therapies through your Individual Education Plan (IEP)? ☐ Yes ☐ No
(NOTE: If yes, please attach most current IEP.)
Do you get therapies through your Family Support Plan (FSP) through Early Steps? ☐ Yes ☐ No
(NOTE: If yes, please attach FSP.)
Where are these services provided now? ☐ In the home ☐ At a school/daycare
What daycare(s) or pre-school(s) has your child attended? (please list) ______________________________________
What is the name of your child's Early Interventionist? (I.E. Early Steps?):

Behavioral Information/Concerns

Does your child have any special fears or behaviors that can harm them or others? List all that apply:
____
____
Is your child aggressive? ☐ Yes ☐ No
If yes, do they: (please select all that apply) ☐ Bite ☐ Hit ☐ Run Away ☐ Argue ☐ Drop ☐ Meltdown
☐ Other, Please list:____
Are you using behavioral therapy?: ☐ Yes ☐ No
If yes, who oversees your program?:

Parent/Caregiver Signature: ____

Date: ____