For Administrative Use Only

Class Name: _____
Team: _____
Class Time: _____
Number of Days: _____
EI Provider: _____

Program Start Date: _____
Eval Date:_____
Marketing Release: Yes No

E ____ DS ____ TS ____ SPF ____ CEF _____ EDL ____ BB ____ EIDB _____ GS_____

GENERAL INFORMATION APPLICATION

Child's Name _____
Last First Middle

Preferred Name _____

Address _____
Street City State Zip Code County

Gender _____ Date of Birth _____

Present Age _____ Present Height _____ Present Weight _____

Reason for Referral/Diagnosis (if known) _____

Referring Physician _____ Pediatrician (if different) _____

FAMILY BACKGROUND

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

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

If the child does not live with both parents, with whom does the child live? _____

Father's Name _____ Date of Birth _____

Address _____
Street City State Zip Code County

Employer _____
Name Address City State

Home Phone _____ Work Phone _____ Cell Phone _____

Mother's Name _____ Date of Birth _____

Address _____
Street City State Zip Code County

Employer _____
Name Address City State

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Is this email checked regularly? □ Yes □ No

Sibling Information:

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

Primary Physician/Pediatrician _____ Phone Number _____
Address _____
Street City State
Emergency Contact _____
Name Relationship to child
Address _____ Phone _____
Street City

Names of individuals to whom the 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 with this child, did the mother experience any unusual illnesses, conditions or accidents?
□ Yes □ No
If yes, please explain. _____
_____
_____
List medications that were taken during pregnancy. _____
_____
Length of pregnancy (weeks) _____ Duration of labor _____
Where was the child born? _____
Hospital Address City
State
Delivery was □ Vaginal □ C-section
Please describe any complications during labor or delivery. _____
_____
_____
Birth weight _____ Birth length _____
Was the child on a ventilator? □ Yes □ No
If yes, for how long? _____
Please list any other problems or special conditions present at birth. _____
_____
_____
_____

GENERAL MEDICAL INFORMATION

Has the child ever had trouble breathing? □ Yes □ No
If yes, please describe. _____

_____

Does the child have vision challenges? □ Yes □ No Glasses □ Yes □ No
If yes, please describe. _____

_____

Does the child have hearing loss? □ Yes □ No
If yes, please describe. _____

_____

Hearing aid(s) □ Yes □ No Cochlear implant(s) □ Yes □ No
Has the child had any seizures/convulsions? □ Yes □ No If yes, at what age did they start? _____ If yes, please describe.

_____

Is the child taking medicine at this time? □ Yes □ No

Type of Medication	Amount and Time Given

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

_____

_____

Has the child had any significant injuries? □ Yes □ No
If yes, please describe. _____

_____

Does the child have allergies? □ Yes □ No Is the child allergic to latex? □ Yes □ No
If yes, please describe reaction(s). _____

_____

_____

What illnesses has the child had? _____

_____

_____

DEVELOPMENTAL PROFILE

Fill in the approximate age your child began to:

_____ Roll over

_____ Have full head control

_____ Sit alone

_____ Crawl

_____ Pull to stand

_____ Walk holding furniture

_____ Walk alone

_____ Give up breast or bottle

_____ Finger feed

_____ Begin baby food

_____ Begin table food

_____ Use a spoon to eat

_____ Drink from cup/straw

_____ Reach out for toys and holds them

_____ Potty train

_____ Show an interest in books

_____ Recognize self in mirror

_____ Look at toys, not just people

_____ Show a purposeful interest in toys

_____ Engage in peek-a-boo or finger play game

_____ Clap hands

_____ Imitate gestures

_____ Roll a ball and return it in play

How does your child communicate? (Examples: cries, babbles, gestures, uses words, uses baby signs, exhibits protest behaviors, such as hitting or biting, to communicate)

_____

_____

Are there any daily routines that are challenging for your child? (Examples: mealtime, sleeping, community outings, etc.) _____

_____

_____

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

_____

_____

Circle all that apply:

Social Behavior

1. Child does not respond to people or things around him/her
2. Child shows some awareness of people and objects (smiles, laughs)
3. Child responds to simple games (peek-a-boo, pat-a-cake)
4. Child plays by himself/herself with simple toys
5. Child uses parallel play (will play alongside other children but does not play with them)
6. Child participates in turn-taking games
7. Child points to a person or thing to gain attention
8. Child enjoys pretend play (feed the doll, comb hair, talk on phone)
9. Child gains an adult's attention to look at something interesting

Behavior Challenges

1. Child does not obey commands
2. Child has frequent tantrums and/or crying
3. Child withdraws (avoids social contact, shy, timid)
4. Child will frequently hit, kick, bite or spit
5. Child shows self–injurious behavior (head-banging, scratching)
6. Child shows self-stimulating behavior (rocking, spinning, finger-movements, other activity)

Check all areas of parental concern:

_____General Development

_____Cognition (Thinking and Reasoning)

_____Sensory

_____Communication

_____Feeding

_____ Socializing (how my child interacts and plays with others)

_____ Following directions

_____ Use of hands

_____ Movement

_____ Behavior

_____ Appropriate play with toys

Describe the major concerns you have for your child. How long have you had those concerns? You can also include any medical conditions you would like us to be aware of (O2, a catheter, a NG tube, G tube, trach, etc.) _____

_____

_____

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

_____

_____

AUTHORIZATION TO DISCLOSE INFORMATION
MEDICAL

Child's Full Name _____

I, _____, hereby authorize the disclosure of information for the purpose of early intervention services from The Bell Center for Early Intervention Programs to the following medical professionals and/or others as indicated:

	Name	Location/Facility	Phone Number
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			
Newborn Follow-Up Clinic			
Nutritionist/Dietician			
Nurse			
Ophthalmologist			
Orthopedist			
Otolaryngologist (ENT)			
Pediatrician			
Physiatrist			
Physical/Occupational Therapist			
Psychiatrist			
Psychologist			
Public Health Dept.			
Social Worker			
Speech/Language Therapist			
Spina Bifida Clinic			

_____ _____

Parent Signature Date

AUTHORIZATION TO DISCLOSE INFORMATION
EARLY INTERVENTION/PUBLIC SCHOOL SYSTEM

Child's Full Name _____

I, _____, hereby authorize the disclosure of information for the purpose of early intervention services from The Bell Center for Early Intervention Programs to the following medical professionals and/or others as indicated:

	Name	Location/Facility	Phone Number
State EI Program			
Service Coordinator			
Special Instructor			
Speech/Language Therapist			
Occupational Therapist			
Physical Therapist			
Other Service Provider			
Public School System			

_____ _____

Parent Signature Date

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

_____
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 April.

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 January 1st and March 31st, this fee is $37.50. (There is no supply fee charged for the program year if enrolled on April 1 or after.)

Tuition Fees

Tuition is due on the 15th of each month. The tuition schedule is provided on our website (www.thebellcenter.org). A late fee of $25 will apply to unpaid balances.
I understand that balances due over 30 days will result in my child not receiving services until the balance is cleared.

_____
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.

If needed, a monthly payment plan for evaluation fees and supply fees can be arranged with Janet Wilson, bookkeeper, at jwilson@thebellcenter.org.

THERAPY PICTURE 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 part of services offered by The Bell Center for Early Intervention Programs. This picture will not be used for marketing.

_____ _____

Signature of Parent/Legal Guardian Date

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
DPaT						
Polio						
Hepatitis B						
MMR						
Rotavirus						
Pneumococcal						
H. Influenzae type B (Hib)						
Varicella						
Influenza						

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 _____ □ CMV _____
□ Menigitis _____ □ Hepatitis B _____
(type) _____ □ Ear Infections _____
□ Pneumonia _____ _____
□ Tonsilitis _____ □ RSV _____
□ HIV _____ □ 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				
Intellectual Disability				
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:

_____

_____

Any Additional Comments? _____

_____

_____

_____

Recommendations:

Upon entering The Bell Center _____ will receive Speech and Language Therapy, Occupational Therapy, Physical Therapy and Early Childhood Special Education Services.

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 occupational 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
P.O. Box 590127
Birmingham, AL 35259
Phone: 205-870-0081
Fax: 205-879-3416