

**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**

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 & contact information of individuals to whom the child may be released:**

Name/Contact \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Name/Contact \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Name/Contact \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Name/Contact \_\_\_\_\_ 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? \_\_\_\_\_

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

**Fill in the approximate age your child began to:**

- |                                |  |
|--------------------------------|--|
| _____ Roll over                | _____ Drink from cup/straw                     |
| _____ Have full head control   | _____ Reach out for toys and holds them        |
| _____ Sit alone                | _____ Potty train                              |
| _____ Crawl                    | _____ Show an interest in books                |
| _____ Pull to stand            | _____ Recognize self in mirror                 |
| _____ Walk holding furniture   | _____ Look at toys, not just people            |
| _____ Walk alone               | _____ Show a purposeful interest in toys       |
| _____ Give up breast or bottle | _____ Engage in peek-a-boo or finger play game |
| _____ Finger feed              | _____ Clap hands                               |
| _____ Begin baby food          | _____ Imitate gestures                         |
| _____ Begin table food         | _____ Roll a ball and return it in play        |
| _____ Use a spoon to eat       |  |

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

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

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

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**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:**

- |   |   |
|---|---|
| <input type="checkbox"/> General Development  | <input type="checkbox"/> Following directions       |
| <input type="checkbox"/> Cognition (Thinking and Reasoning)                         | <input type="checkbox"/> Use of hands               |
| <input type="checkbox"/> Sensory  | <input type="checkbox"/> Movement                   |
| <input type="checkbox"/> Communication  | <input type="checkbox"/> Behavior                   |
| <input type="checkbox"/> Feeding  | <input type="checkbox"/> Appropriate play with toys |
| <input type="checkbox"/> Socializing (how my child interacts and plays with others) |   |

**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 & Email
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 - \$175.00**

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 1<sup>st</sup>.

If my child enters the program between January 1<sup>st</sup> and March 31<sup>st</sup>, 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 15<sup>th</sup> of each month. The tuition schedule is provided on our website ([www.thebellcenter.org](http://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.

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Name of Child

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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](mailto: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](mailto: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



**PICTURE AND INFORMATION RELEASE FORM**

Child's Full Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, hereby give The Bell Center for Early Intervention Programs and The Service Guild permission to use pictures or video of my child \_\_\_\_\_ (name of child) for the purposes of promoting the program of services offered by The Bell Center for Early Intervention Programs. It is agreeable to use the pictures or video for publicity and promotion purposes in newspapers, newsletters, magazines, brochures, bulletins and other publications. and electronic forms distributed by The Bell Center and The Service Guild. I understand that in signing this form, I release The Bell Center and The Service Guild of all liability in its actions under this permit.

Please Initial:

I DO grant permission for my child's name to be used with the child's picture for publicity. \_\_\_\_\_

I DO NOT grant permission for my child's name to be used with the child's picture for publicity. \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
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 \_\_\_\_\_  
 Menigitis \_\_\_\_\_  
 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				
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: 205-879-3417  
 Fax: 205-584-4559