BENHAVEN

Benhaven Academy
50 North Plains Highway
Wallingford, CT 06492
www.benhaven.org
T: 203 774-0008
F: 203 773-0031

Dear Parent or Guardian:

Thank you for your interest in Benhaven Academy.

Enclosed is an Admission Application. Please fill out the application and send it back to me as soon as possible in order for us to consider your child for admission. Please be sure to fill out all the areas that apply to your child so that we can make appropriate admission decisions.

If you have any questions, please feel free to call me and I will be glad to help you.

Sincerely,

Melissa Soybel

Melissa Soybel
msoybel@benhaven.org
Student Services Facilitator
Enc.

Application for Admission

Benhaven Learning Center does not discriminate based on gender, race or national origin. BLC does not accept students with severe behavioral or aggressive issues.

Date: ______________________________ **Requested Start Date** ________________________

Name of Child:

____

(First) **(Middle)** **(Last)**

Date of Birth: ________________ **Age:** _________ ___ **Male** ___**Female**

Current School

Present School: __________________________ **District:** __________________ **Grade:** ___________

Source of referral: ____

Reason for referral: ____

____

Describe the most recent educational services: ____

____

____

Current related services (and hours): Speech/language _____**Counseling** ________**OT** _____

PT _____ **Other** ____

Parent/Guardian One (Student Lives With)

Parent / Legal Guardian: ____

Home Address: ____

City: ___________________________________ **State:** ______________ **Zip:** ____________________

Home Phone: (_____) ____________ **Work Phone: (_____)** ___________ **Cell: (_____)** ___________

Email: ____

Occupation: _________________________________ **Employer:** ______________________________

Parent/Guardian Two:

Parent / Legal Guardian: ____

Address: ____

City: ___________________________________ State: ________________ Zip: __________________

Home Phone: (_____) ___________ Work Phone: (_____) ____________ Cell: (_____) ______________

Email: ____

Occupation: _____________________________ Employer: ____________________________________

Applicant's Siblings:

Name:	Age:	Gender:
Name:	Age	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:

Are there any other adults involved in this child's life (i.e. step parent, live-in grandparent)?

Please indicate whether there is a recent separation, divorce, and/or custody that may be pertinent to your child's education?

Other Schools Attended by Applicant:

Name	Length of stay	Reason for leaving

Does your child have any behaviors that have been of concern in any of his/her previous schools? If so, please describe.

Does your child have any sexual behavior problems?

Has your child been suspended? If so, please describe.

Has your child ever been hospitalized in a psychiatric facility? If so, please describe.

Medical Information:

Primary diagnosis: Secondary Diagnosis:

Please list any allergies:

Please list current special diets, food restrictions:

Please list any childhood diseases your child experienced:

Please list any chronic or recurring problems:

Is there any other medical information that might impact your child's education?

Please list all medical/psychological professionals that are involved with your child:

Name	Address	Phone	Specialty

Please list current medications:

Medication	Reason	Dosage	Administration During School?	Date Started

Personal Skills:

Please describe any home/living skills your child has particular difficulty with or that may interfere with their school day (i.e. toileting, washing hands, blowing nose, sleeping through the night, safety, etc.).

Does your child eat a variety of foods? _____ yes _____ no

What foods will he/she REFUSE to eat?

Learning Profile:

Please describe the child's current level of functional communication (i.e. uses PECS, age appropriate, literal, too verbal, responds to directions, good vocabulary, etc.).

How does your child express needs, desires, fears (i.e. demands, loudly, behaviorally)?

Please describe your child's current behavioral issues in teaching situations. What does the current team use to reinforce desired behavior (i.e. praise, stickers, food, computer access, etc)? Are they effective?

Please describe your child's current behavioral issues in the home/community. What do family members use to reinforce desired behavior? Are they effective?

What is your child's behavior like while traveling in vehicles?

Please describe your child's current social relationships. Does he/she have friends? Wish for friends? Relate better to adults? Would you describe your child as lonely?

Pleases describe your child's current academic level and areas of need (i.e. above grade level in math, trouble staying on task, hates to read, etc.).

Please describe your child's sensory needs (i.e. doesn't eat variety of foods, can't stand touch, moves constantly, loves deep pressure, etc.).

What are your child's emotional issues (low frustration tolerance, depression, severe anxiety, etc.)?

Please list any items your child fears/dislikes to a degree that might interfere with learning (fear of large spaces, loud voices, criticism, movement, etc.)

Goals

Please list any short term and long-term goals you would like to see your child achieve.

- ____
- ____
- ____
- ____

What are your long-term **vocational** goals (if appropriate)?

- ____
- ____
- ____
- ____

Additional Information

What is one thing your child likes about school?

What does your child dislike most about school?

Please describe any additional information you would like us to know about your child.

Do you have any reason to believe that your child might pose a danger to others? If so, please explain.

PLEASE NOTE: In order for your child's experience at Benhaven Learning Center to be a success, we ask each family to attend team meetings and parent workshops so that effective follow through may occur at home.

Information sheet prepared by:

PARENT/GUARDIAN: ____ **Date:** ______________________

PARENT/GUARDIAN: ____ **Date:** ______________________

Signature of person (other than parent) who prepared or helped prepare this sheet, and relationship to child: ____ **Date:** ______________________

Emergency Contact Persons

(other than parents)

Student name: ______________________________

Name: ___________________________________

Phone numbers: ___________________________________

Relationship to Student: ___________________________________

Name: ___________________________________

Phone numbers: ___________________________________

Relationship to student: ___________________________________

Name: ___________________________________

Phone numbers: ___________________________________

Relationship to student: ___________________________________

Student Emergency Information

Student Name: _____________________________Address: _________________________

Parents/Guardian's names and ____

Phone numbers (list all): ____

____

Does your child have?
___ Sleep apnea ___ Heart problems
___ Any seizure history (Describe) ___ Respiratory problems

Has your child ever had surgery? If so, for what? Please give dates:

Please list current medications:

Medication	Reason	Dosage	Administration During School?	Date Started

Please list any allergies and allergic reactions (if has experienced, reacted to what and at what age?):

Medical Insurance Co.: ____

Policy #: _______________________Policy Holder (whose name is it in): ______________

Insurance Information

Student Name: ____

Insurance:

Insurance company: ___________________________________

Policy #: ____

Secondary Insurance (if any): ___________________________

Policy #: ____

Dental Insurance Co.: _________________________________

Policy #: ____

Doctors:

Pediatrician Name: ____

Address: ____

Phone #: ____

Psychologist / psychiatrist Name: ____

Address: ____

Phone #: ____

Dentist Name: ____

Address: ____

Phone: ____

Parents / Guardian:

Parents/Guardian Name:

Address:

Email addresses:

Phone (list all):

Authorization for Emergency-Medical and/or Surgical Treatment

Student: ____ Date of Birth: ___________
Last name First

Allergies: ____

Date of last
Tetanus shot: ____

This form will be used ***only*** in an emergency situation, ***only*** when a parent or guardian ***cannot*** be readily contacted.

IN CASE OF EMERGENCY, I HEREBY AUTHORIZE DOCTORS AT EITHER
____ (medical facility or personal physician)
(and whomever they may designate as their assistants) TO PERFORM ANY EMERGENCY PROCEDURE; OR TO ADMINISTER ANESTHESIA AND/OR TO ADMIT, IF NECESSARY, MY DAUGHTER/SON.

Medical Insurance Co.: ____

Policy #: ____

Policy Holder: ____

Signed: ____

Parent/Guardian: ____

Address: ____

____

Phone: ____