



Benhaven Academy

50 North Plains Highway
Wallingford, CT 06492
Telephone: (203) 774-0008
Fax: (203) 774-0031

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
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: _____



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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 aggressive behaviors? 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, too verbal, responds to directions, good vocabulary, etc.).

How does your child express needs, desires, and fears (i.e. tantrum, gesture, crying, and request)?

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?

Please 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.)



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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:

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)

Name: _____

Phone Number: _____

Phone Number: _____

Relationship to Student: _____

Name: _____

Phone Number: _____

Phone Number: _____

Relationship to Student: _____

Name: _____

Phone Number: _____

Phone Number: _____

Relationship to Student: _____



STUDENT EMERGENCY INFORMATION

Student Name: _____

Address: _____

Parents/Guardian's Names: _____

Parents/Guardian's Phone numbers (list all): _____

Does your child have?

Sleep Apnea Heart Problems History of Seizures (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 Company: _____

Policy Holders Name #: _____ Policy #: _____



INSURANCE INFORMATION

Student Name: _____

INSURANCE INFORMATION:

Insurance Company: _____
Policy #: _____
Secondary Insurance (If Any): _____
Policy #: _____
Dental Insurance Company: _____
Policy #: _____

DOCTORS INFORMATION:

Pediatrician Name: _____
Address: _____
Phone #: _____
Psychologist / Psychiatrist Name: _____
Address: _____
Phone #: _____
Dentist Name: _____
Address: _____
Phone: _____

PARENTS/GUARDIAN INFORMATION:

Parents/Guardian Name: _____
Address: _____
Email Addresses: _____
Phone (List All): _____



AUTHORIZATION FOR EMERGENCY-MEDICAL AND/OR SURGICAL TREATMENT

Student: _____ Date of Birth: _____
Last Name First Name

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

_____ (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: _____

Parent/Guardian Signed: _____

Parent/Guardian Print: _____

Address: _____

Phone: _____



AUTHORIZATION FOR NURSING/MEDICAL SERVICES

Student: _____
Last name First name

Date of Birth: _____

I hereby authorize Benhaven, Inc. and the nursing/medical personnel to take those actions that its professional staff deem appropriate for nursing and medical services (routine or of a monitoring nature).

Parents/Guardians will be kept informed of nursing and medical issues and will be contacted as the need arises.

Signature of Parent/Guardian

Date



CONSENT FORM

I hereby authorize Benhaven to take photographs, movies, or television film of my child

_____ and to use them, at their professional discretion,

to aid in the learning of other students and training of school and district staff.

Signature of Parent/Guardian

Date



CONSENT TO TRANSPORT

I, _____, hereby acknowledge that vehicles belonging to Benhaven are used to transport many of Benhaven's students on community outings and field trips. Expecting that Benhaven will exercise reasonable control and judgment, I give my permission for _____ to be transported by Benhaven staff. I understand that I have a role in determining what means of transportation is most suitable and that I can withdraw this general approval at any time.

Signature of Parent/Guardian

Date



PERMISSION SLIP

I give my permission for official visitors of Benhaven to observe my child _____
with the understanding that the visitors will not reveal my child's identity to individuals not employed by
Benhaven.

Signature of Parent/Guardian

Date



EARLY DISMISSAL

In the event of an early dismissal, if I cannot be reached for notification, I have made arrangements with the person listed below. This person has agreed, in writing, to wait for and accept responsibility for my child until I am able to pick up my child.

Signature of Parent/Guardian

Date

PERSON ACCEPTING RESPONSIBILITY:

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

I agree to wait for and accept responsibility for _____ at such time when the parents cannot be reached. I will keep the child until the parent comes for him, provided the school has contacted me before sending the child to me.

Signature of Alternate Person

Date



AUTHORIZATION FOR THE RELEASE OF INFORMATION TO BENHAVEN ACADEMY

I _____, authorize _____
(name of person granting permission) _____ (name and address of person, institution or
organization in possession of records) to disclose to Benhaven Academy and _____ (social
worker) information/records pertaining to:

(Name and DOB of person who is the subject of the record)

Type of information/records to be released (**check all that apply**):

- Psychiatric Psychological Medical Education Medication
- Psycho-therapy notes (NOTE: a request for psycho-therapy notes cannot be combined with a request for any other records).
- All of the above
- Other (**specify**)

The purpose of this authorization/disclosure is to provide information to Benhaven Academy for use in case planning and development/implementation of an educational program or any other purpose for which this information can be lawfully used.

The nature and extent of the information to be disclosed is the entire record unless otherwise specified below: This authorization, if not revoked, will expire on _____ or in one year, whichever occurs first.

Signature of person giving permission or authorized representative Date

Check if this form has been signed by a person other than the subject of the record:

- parent/guardian attorney guardian ad litem other (**explain**)

NOTE: Confidentiality of psychiatric, medical, and behavioral records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization.