Philip J. Rock Center & School
Together for Independence
818 DuPage Blvd., Glen Ellyn, IL 60137
Phone (630)790-2474 Fax: (630)790-4893

APPLICATION

FOR

CONSIDERATION

FOR

PLACEMENT

Welcome!

Thank you for considering Philip J. Rock Center and School (PRC) for your child. The Placement Application should be filled out as thoroughly as possible.

The more information we have about your child, the better we can determine if placement at PRC will meet their needs. Information can be obtained and answered by the Parent, Guardian, Teachers and/or other professionals that work with the student in this application. If a question does not pertain to your child, indicate with an “N/A”.

Feel free to contact us or your student’s Deaf-Blind Specialist if you have any questions or concerns.

Please return this application to the address on the cover of this application.

Thank you!

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APPLICATION FOR CONSIDERATION FOR PLACEMENT

This application must be accompanied by all medical, educational and diagnostic records

APPLICANT'S FULL NAME: _____

BIRTHDATE: _____ SEX: ☐ M ☐ F

PARENT/GUARDIAN NAMES:

1. _____RELATIONSHIP_____

2. _____RELATIONSHIP_____

BACKGROUND INFORMATION

Please answer the following questions based on the parent(s)/guardian(s) with whom the child lives with or who has the legal ability to make decisions for the student.

ADDRESS:_____CITY:_____ZIP:_____

EMAIL: _____ PHONE: _____ CELL PHONE: _____

NATIVE LANGUAGE OF CHILD'S FAMILY?

_____

DOES THE FAMILY NEED THE SERVICES OF A TRANSLATOR? ☐ YES ☐ NO

NAME OF PERSON(S) AND RELATIONSHIP TO THE CHILD COMPLETING THE APPLICATION:

_____

HOW DID YOU LEARN OF THE PHILIP J. ROCK SCHOOL?

_____

WHY ARE YOU INTERESTED IN RESIDENTIAL PLACEMENT FOR YOUR CHILD AT PRC?

_____

What are the names and ages of other children/siblings in your child's family?

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

1. Does your child receive any services from a public/private agency in addition to those in the IEP?
   ☐ Yes ☐ No

   If yes, Name of Service(s)_____

   Name of Providing Agency_____

   Address: _____

   City _____ State_____ Zip_____

   Phone Number _____ Email: _____

   Name of Providing Agency_____

   Address: _____

   City _____ State_____ Zip_____

   Phone Number _____ Email: _____

2. Does your child receive any financial aid? ☐ Yes ☐ No

   ☐ Supplemental Security Income (SSI)

   Medicaid Number: _____

   ☐ Division of Specialist Care for Children (DSCC)
   When: _____

   Office: _____

   Approved medical condition(s)_____

MEDICAL INFORMATION

Please provide the following:

DIAGNOSIS:

_____

_____

_____

_____

_____

ALLERGIES: (Medication and/or Food)

_____

_____

_____

_____

DIETARY RESTRICTIONS:

_____

_____

_____

_____

SURGERIES:

_____

_____

_____

_____

HOSPITALIZATIONS:

_____

_____

_____

_____

ILLNESSES/SURGERIES:

_____

_____

_____

_____

CURRENT MEDICATIION

MEDICATION REASON

_____

_____

_____

_____

_____

_____

MEDICAL EQUIPMENT USED

_____

_____

_____

_____

PREFERRED PHARMACY INFORMATION
(Walgreens, CVS, or Uvanta for automated deliveries)

Name:_____

Behaviors noticed when your child is becoming sick:

_____

Additional Comments/Information that parents/guardians would like to share

_____

_____

FAMILY MEDICAL HISTORY

☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Epilepsy

☐ Cataracts ☐ Hearing Loss ☐ Cerebral Palsy ☐ Mental Illness

☐ Speech Problems ☐ Reading Disorder ☐ Other_____

CURRENT SCHOOL INFORMATION

School district in which parent/guardian resides: _____

Student's present school placement: _____

☐ Residential ☐ Day

School Contact:_____

Primary Teacher (if different from above):_____

School Address: _____City: _____State:_____ Zip_____

Phone: _____ Phone of Teacher: _____

Email of school contact: _____Email of Teacher: _____

Student's Special Education Cooperative: _____

Address:_____City:_____State:_____ Zip _____

Phone: _____ Email: _____

CURRENT EDUCATION PROGRAM

Does your child receive any of the following special services/therapy?

☐ Vision Services ☐ Hearing Services ☐ Physical Therapy

☐ Occupational Therapy ☐ Speech Therapy ☐ Adaptive PE

☐ Other:_____

List any adaptive equipment, technology and/or appliances that the student uses at school or at home.

_____

_____

_____

_____

What educational materials, toys, electronic devices, recreational materials, etc. would you recommend for use with the student?

_____

_____

PAST EDUCATION INFORMATION

Did your child receive early intervention services? ☐ Yes ☐ No

If yes, which of the following services were provided?

☐ Developmental Therapy for Vision ☐ Developmental Therapy for Hearing

☐ Developmental Therapy ☐ Physical Therapy ☐ Occupational Therapy

☐ Speech Therapy ☐ Music Therapy ☐ Auditory Training

☐ Orientation and Mobility ☐ Oral Motor Therapy ☐ Nutrition

☐ Other: _____

At what age did your child first receive any type of training or education program including Early Intervention? _____

List all Previous Programs/Schools the student has been in since turning 3 years of age:
(Please feel free to add another sheet as needed)

Program Name	City/State	Contact Person	Date From	Date To	Services Received	Residential Program Y/N?	Day Program Y/N?

DAILY ROUTINE

The following questions concerns the child's daily routine. Please be accurate as possible.

1. When does your child usually wake up in the morning? _____

2. Do you have to wake him or her up? ☐ Yes ☐ No Explain how you wake your child up.

   _____

3. When does your child go to bed at night? _____

4. Does he or she sleep through the night? ☐ Yes ☐ No How well? _____

5. Does he or she take medication to help sleep? ☐ Yes ☐ No If yes, please list

   _____

6. Please describe any special bedtime routine(s) your child might have.

   _____

   _____

7. Is there any special bedtime characteristic such as restlessness, restless dreaming, crying, lying in a preferred position, etc.?_____

   _____

8. Does your child take a nap? ☐ Yes ☐ No
   When?_____

9. Does your child sleep in a bed or a crib? ☐ Bed ☐ Crib

10. Are bed rails needed if sleeping in a bed? ☐ Yes ☐ No

11. Does your child disturb the sleep of any other family members? ☐ Yes ☐ No

12. What does your child do when he or she wakes up at night? Does he or she stay in bed? Does he or she make a lot of noise? Please describe.

    _____

    _____

    _____

13. What does your child usually do if left to amuse himself or herself? _____

    _____

    _____

14. What are your child's favorite things?_____

Favorite toy, recreational item, electronic device for amusement: _____

_____

Favorite people: _____

Favorite activities: _____

What does your child like the most? _____

15. What is the child's least favorite thing? _____

Most disliked toy, recreational item, electronic device for amusement: _____

_____

Most disliked people: _____

Most disliked activities: _____

What does the student dislike the most? _____

16. Are you able to include your child in family outings? ☐ Yes ☐ No

If yes, what are some of these outings and any special things you do to make them enjoyable for everyone?

_____

_____

_____

If no, is there anything we might be able to teach your child so that he or she can go with you on these outing?

_____

_____

17. Are you able to leave your child with a caregiver/babysitter while you go out? ☐ Yes ☐ No

Who usually provides this service (relative, neighbor, daycare, or respite care center?)

_____

How long can you leave your child? _____

How frequently can you leave your child? _____

18. Does your child know how to swim? ☐ Yes ☐ No If yes, how well does the child swim?

_____

Does your child need some type of floating device? ☐ Yes ☐ No
If no, does your child like to be in water? ☐ Yes ☐ No
Does the temperature or depth of the water make a difference for your child? ☐ Yes ☐ No

Explain: _____

SELF-CARE SKILLS

Eating

1. Please check all statements that describe your child most accurately at the present time.

☐ Uses fork and knife correctly and neatly
☐ Feeds self with spoon and fork
☐ Feeds self with spoon
☐ Must be fed by adult
☐ Feeds self with fingers
☐ Drinks only a bottle held by caregiver
☐ Other _____

☐ Drinks only a bottle held independently
☐ Drinks from glass with assistance
☐ Drinks from glass without help
☐ Chews food
☐ Eats too fast
☐ Takes food off other's plate

2. What would you like more for your child to be able to do in the area of eating skills? _____

_____

_____

3. Does your child have any favorite foods? ☐ Yes ☐ No Please list them.

_____

_____

4. Does your child totally refuse to eat any foods? ☐ Yes ☐ No Please list them.

_____

_____

5. Does your child have any food allergies? ☐ Yes ☐ No What are they?

_____

_____

6. Is there anything else that you feel we should know about your child's eating habits?

_____

_____

Toileting

1. Please check all the statements which describe your child most accurately at the present time.

☐ Remains dry all night

☐ Remains dry during the day

☐ Is frequently constipated

☐ Uses toilet tissue

☐ Soils self

☐ Sits on toilet willingly

☐ Plays in feces

☐ Flushes Toilet

☐ Frequently has loose or runny bowel movements

☐ Needs no assistance in toileting

☐ Lowers and raises pants at toilet without help

☐ Other_____

_____

2. Is there anything else you feel we should know about your child's toilet habits?

_____

_____

Cleanliness

1. Please check all statements which describe your child most accurately at the present time.

☐ Washes/dries face and hands without help

☐ Allows others to wash/dry face and hands

☐ Dries self after shower without help

☐ Takes a shower without help

☐ Brushes teeth without help

☐ Allows others to brush teeth

☐ Will not permit tooth brushing at all

☐ Is completely independent in cleanliness skills

2. If your child is a girl, does she menstruate? ☐ Yes ☐ No

   Will she wear a sanitary pad? ☐ Yes ☐ No

   Does she have menstruation symptoms? ☐ Yes ☐ No If yes, describe.

   _____

   _____

   Does she change her own pad? ☐ Yes ☐ No

3. What would you most like your child to be able to do in the area of cleanliness skills?

   _____

_____

4. Is there anything else you feel we should know about your child's cleanliness habits?

_____

Dressing and Undressing

1. Please check all statements which describe your child most accurately at the present time.

   ☐ Is in complete charge of dressing and undressing

   ☐ Ties own shoes

   ☐ Dresses and undresses self except for fasteners

   ☐ Is dependent on adult for all dressing and undressing

   ☐ Takes off clothes
   (i.e. hangs up coat, puts dirty clothes in hamper, puts clean clothes in drawers)

   ☐ Other_____

2. What would you most like for your child to be able to do in the area of dressing and undressing skills?

_____

3. Does your child wear any special garments in order to make dressing and undressing easier for him or her and for you? Does he or she use any special dressing aids? If yes, please describe.

_____

4. Does your child manage their own hearing aids, glasses and/or other equipment independently? Please describe _____

MOTOR SKILLS

1. Please check all the statements which most accurately describe your child.

☐ Goes up and down stairs on feet without help

☐ Walks alone without falling

☐ Walks with one hand held for guidance

☐ Stands alone

☐ Crawls on hands and knees

☐ Rolls when lying down

☐ Scoots on bottom

☐ Sits alone

☐ Must be supported in sitting position

☐ Does not move freely through space

☐ Has to be carried

2. What would you like most for your child to be able to do in the area of independent movement?

_____

_____

3. Does your child have difficulty traveling by car? ☐ Yes ☐ No
4. Does your child need a harness/car seat when traveling? ☐ Harness ☐ Car Seat ☐ No
5. Does he/she receive medication before trips? ☐ Yes ☐ No

   Name of medication: _____

COMMUNICATION SKILLS

1. How do **you** communicate with your child?

☐ by talking to him or her

☐ by formal sign language

☐ tactile ☐ visual

☐ by touching, tugging, pushing, physically guiding

☐ by gesturing such as pointing

☐ by finger spelling

☐ tactile ☐ visual

2. How does **your child** communicate with you?

☐ by talking to you

☐ by gesturing such as pointing

☐ by formal sign language

☐ by finger spelling

☐ tactile ☐ visual

☐ tactile ☐ visual

☐ by touching, tugging, pushing, physically guiding

☐ pictures

☐ with a device

3. What would you like most for your child to be able to do in the area of communication?

_____

4. What do you think would be the most important thing for you to be able to communicate to your child?

_____

5. What do you think would be the most important thing for your child to be able to communicate to you?

_____

6. If formal signs or finger spelling were taught to the student, would you or any member of your family be willing to learn this system of communication as well?_____

BEHAVIOR

1. Please check all statements which most accurately describe your child.

☐ light gazing

☐ excessive head movement

☐ head banging

☐ body rocking

☐ bizarre body positions

☐ flick hands or objects in front of eyes

☐ poke eyes, ears, face, body

☐ masturbate

☐ dislikes being held or touched

☐ likes being held or touched

☐ excessive crying or laughing

☐ grind teeth

☐ loud vocalizations or screaming

☐ hyperventilation

☐ self-abusive behavior (i.e. bites self)

☐ undress in public

☐ aggressive behavior towards others (i.e. biting)

☐ tantrum for unknown reasons

☐ run away from home or school

☐ deliberately break objects, throw things, tips over furniture

☐ put all objects in mouth, eat things that should not be eaten

2. Please describe the one behavior your child has which you find to be the biggest problem for you.

_____

3. How does your child act when he or she does not get his or her own way?

_____

4. How does he or she react to frustration?

_____

_____

5. What do you do when your child misbehaves? How do you discipline your child? _____

_____

6. Do you think this method works well?

_____

_____

7. Do you wish to add any additional comments? Please do so here: _____

_____

_____

_____

Thank you for taking the time to complete this application!

Please have all persons involved in completing this application sign below:

_____ _____
Signature Date

_____ _____
Print Name Relationship

_____ _____
Signature Date

_____ _____
Print Name Relationship