



Application for Student Enrollment

*The Guild School admits students of any race, color, sex, gender identity, sexual orientation, religion or national origin.
All information provided in this application as well as in documents supporting a student referral will be kept strictly confidential.*

Person(s) completing this application and relationship to student:	Date:

Student Information

Last name:	First Name:	Middle Name:	Gender:
Street Address:	City:	State:	Zip Code:
Date of Birth:	Place of Birth:	Citizenship:	
Last 4 digits Social Security Number:	Phone Number:	Relationship to Parent/Guardian:	
XX-XXX-		<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Foster	
Diagnosis (primary and secondary):			

Parent/Guardian Information

Parents' Marital Status:	
Please describe the marital status of the student's parents:	
Parent Information:	Parent Information:
Name	Name
Address (if different from student's):	Address (if different from students):
Home Phone Number:	Home Phone Number:
Cell Phone Number:	Cell Phone Number:
E-mail:	E-mail:
Date of Birth:	Date of Birth:
Business Name and Address:	Business Name and Address:
Work Phone:	Work Phone:
Occupation:	Occupation:

GUARDIANSHIP: If the student is UNDER 18 years old:

Who has guardianship? Parents, Joint Parent, Sole Other _____
 DCF - If DCF, please circle one: *Voluntary* *Care and Protection* *APPL*
 If DCF, what is the goal of the family action plan for reunification (FAP)?

Name of legal guardian(s) if other than parent:		Relationship to student:		Phone Number:	
Address:		City:	State:	Zip:	

GUARDIANSHIP: If the student is OVER 18 years old:

Has a legal guardian been appointed? Yes No, but process has started No, process has NOT started Not sure

Name of legal guardian(s):		Relationship(s) to student:		Phone Number:	
Address:		City:	State:	Zip:	

Has a Roger's Monitor/Guardian been appointed?
 Yes (fill in information below) No Not sure Not Applicable

Name of Roger's Monitor/Guardian		Relationship(s) to student:		Phone Number:	
Address:		City:	State:	Zip:	

Family Information

Please complete the following information for all members of the student's household(s).

Name:	Age:	Gender:	Relationship to Child:

Does the student have other significant people in her/his life? If yes, please provide name(s) and relationship:

What is the primary language spoken in the home? _____

What other languages are spoken at home? _____

Do the parents, siblings, or other extended family members have particular conditions or medical problems (e.g., emotional, mental illness, intellectual disabilities, neurological or congenital defects, diabetes, allergies)? Please include how the specified person is related to the student.

Service Agency Partners

List any agencies and contact person(s) involved in advocating for the student (DDS, DCF, DMH, etc.):

Agency Name:	Contact Person:	Phone Number:	Type of Service/Involvement:

Student's Current School Information

School District:	Street Address:	City:	State:	Zip:
Current placement:	Street Address:	City:	State:	Zip:

Date of last signed IEP:

SPED Director Name/District Contact name:	Phone Number:	Fax Number:

Is the school district aware you are interested in an outside placement? Yes No

How did you hear about The Guild School?

Is the student currently attending school? Yes No If no, date of last attendance: _____

Name of School (if not currently in school, last school attended):

What is your reason(s) for looking for a new school –or- what is the reason for leaving/termination the current placement?

Educational History

Did the student receive Early Intervention Services? Yes No

Please list all Educational Programs in which the student has been enrolled:

Program Name:	Enrollment dates:	Hours/day:	Reason for Change:

Please list all other services the student has received or is CURRENTLY receiving
(after school care, speech services, PT/OT, home training)

Provider (person or agency)	Service and model	How often	Start /End Dates

Medical Information

Please provide the name and contact information for **CURRENT** physicians and service providers
(ex: pediatrician, mental health provider, neurologist, dentist, OB/gyn, etc)

Name of Professional Contact	Type of Service/Specialty:	Phone Number:	
Address:	City:	State:	Zip:

Name of Professional Contact:	Type of Servicer/Specialty:	Phone Number:	
Address:	City:	State:	Zip:

Name of Professional Contact:	Type of Service/Specialty:	Phone Number:	
Address:	City:	State:	Zip:

Name of Professional Contact:	Type of Service/Specialty:	Phone Number:	
Address:	City:	State:	Zip:

Current Medications

Medication name:	Dosage:	What is it prescribed for?	Prescribing physician:

Other Health Information

Weight: _____ **Height:** _____ **Any scars or marks?** _____

Eye Color _____ **Hair color:** _____

Allergies:

Does the student have any allergies to foods, insects, drugs/medications, animals, pollen/mold, latex? Yes No

Does the student require an Epi-pen? Yes No

Please specify type of allergy and symptoms:

Seizures:

Does the student have a history of seizures? Yes No

If yes, please specify and include the date of last seizure:

Choking/Aspiration:

Does the student have a history of choking or aspiration? Yes No

If yes, please provide additional information:

Ambulation:

Does the student require assistance for ambulation? No Yes - please specify _____

Hearing/Vision:

Does the student have a vision impairment? No Yes - please specify: _____

Does the student have a hearing impairment? No Yes - please specify: _____

Hospitalizations:

Has the student ever been hospitalized for **health** issues such as illness, injury or surgical procedures? Yes No

If yes, please specify:

Strengths and Needs Information

STRENGTHS and INTERESTS:

What are the student's strengths, hobbies and/or special interests? Please use back of page if needed.

COMMUNICATION:

Please describe the student's current skill levels. Use back of page to provide more elaborate answers if needed.

How does the student communicate Verbally? Check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Good conversational skills | <input type="checkbox"/> Single word responses or utterances | <input type="checkbox"/> Verbal Approximations |
| <input type="checkbox"/> 2-3 word utterances | <input type="checkbox"/> Echolalia | <input type="checkbox"/> Expresses needs and wants |
| <input type="checkbox"/> Perseverative Speech | <input type="checkbox"/> Difficult to understand | <input type="checkbox"/> Makes choices |
| <input type="checkbox"/> Uses computer for writing | <input type="checkbox"/> Good articulation | |

How does the student communicate Non-Verbally?

Pictures: Check all that apply

- | | | |
|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Uses line drawings | <input type="checkbox"/> Independent | <input type="checkbox"/> Assisted |
| <input type="checkbox"/> Uses color photographs | <input type="checkbox"/> Independent | <input type="checkbox"/> Assisted |
| <input type="checkbox"/> Uses representational objects | <input type="checkbox"/> Independent | <input type="checkbox"/> Assisted |
| <input type="checkbox"/> Uses actual objects | <input type="checkbox"/> Independent | <input type="checkbox"/> Assisted |

Sign Language: Check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Uses multiple signs in combinations | <input type="checkbox"/> Answers yes and no questions |
| <input type="checkbox"/> Uses single signs | <input type="checkbox"/> Uses sign approximations |
| <input type="checkbox"/> Communicates primarily through pointing and gestures | |

Uses an Augmentative/Alternative system: Does the student use a system? Check all that apply

- | | | |
|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Communication Book... | <input type="checkbox"/> Independent | <input type="checkbox"/> Assisted |
| <input type="checkbox"/> Choice Board..... | <input type="checkbox"/> Independent | <input type="checkbox"/> Assisted |
| <input type="checkbox"/> Electronic device..... Independent <input type="checkbox"/> Assisted - Please include name of device/program: _____ | | |

ACTIVITIES OF DAILY LIVING:

Please describe the student's current skill levels for the following areas. Use back of page if needed.

Eating: Does the student have eating issues such as food refusal, selectivity, rigidity, swallowing or pacing concerns?

Toileting/Bathroom Hygiene: Is the student independent in requesting and using the bathroom? Yes No
If no, please specify:

Does the student have toileting accidents? If yes, please provide additional information: Yes No

Does the student have menstrual periods? Yes, since age _____ No, not yet Not applicable
If yes, is the student able to use sanitary products independently? Yes No - please specify level of assistance needed.

Dressing/Bathing/Tooth brushing: Does the student perform hygiene routines such as bathing, hand washing, and brushing teeth independently? Is the student able to dress him/herself? Is the student able to choose clothes for the weather? Manipulate closures?

Sleeping/Nighttime Habits or Disruptions: Does the student sleep through the night? Yes No
Does the student have any nighttime behaviors? Ex: wakefulness, disruptions, wandering, aggressive/self-injurious, need for supervision.
If yes, please provide additional information. Yes No

Chores: Does the student help with cooking, laundry, cleaning or other house or outside chores?

Community: How often does the student go out into the community? What are some preferred places to go? Where does the student not want to go/avoid going? Can the student ride in vehicles safely?

SCHOOL/VOCATIONAL:
Complete the following. Please use the back of the page if needed.

SCHOOL:
Does the student like school? Why or why not?

What is the student's favorite part of school? What is the student's least favorite part of school?

VOCATIONAL:
What are the student's current vocational skills and interests?

Does the student currently have a job? If so, where and for how many hours per week? What type of supports are needed?

SOCIAL/EMOTIONAL/BEHAVIORAL:
Complete the following. Please use the back of the page if needed.

The student:

Gets along with siblings:	_____ Consistently	_____ Sometimes	_____ Not usually
Gets along with other students:	_____ Consistently	_____ Sometimes	_____ Not usually
Needs close supervision:	_____ Consistently	_____ Sometimes	_____ Not usually
Disrupts group activities:	_____ Consistently	_____ Sometimes	_____ Not usually
Accepts direction from parents:	_____ Consistently	_____ Sometimes	_____ Not usually
Accepts direction from teachers:	_____ Consistently	_____ Sometimes	_____ Not usually

Does the student have a Behavior Support Plan? Yes No Not sure

Does the student engage in any of the following?

Aggressive Behavior? Yes No
If yes, which behaviors? Check all that apply:

<input type="checkbox"/> Biting	<input type="checkbox"/> Scratching	<input type="checkbox"/> Head-butting	<input type="checkbox"/> Hitting/slapping/pinching
<input type="checkbox"/> Hair pulling	<input type="checkbox"/> Kicking	<input type="checkbox"/> Property Destruction	<input type="checkbox"/> Pushing

___ Other: _____

Self-Injurious behavior? Yes No

If yes, which behaviors? Check all that apply:

___ Bites ___ Face Slaps ___ Head bangs ___ Scratches/picks ___ Body strikes

___ Other: _____

Tantrum behavior? (outbursts with or without other behaviors such as aggression, non-compliance, destruction, etc.) Yes No

If yes, please describe the behavior to include how often and duration of episodes:

Pica behavior? (ingesting non-edible items) Yes No

If yes, please specify to include how often the behavior occurs:

Bolting behavior? Yes No Does the student attempt to exit a building? Yes No

If yes to either question, please specify:

Does the student have use of their own device(s) such as a smart phone, laptop, or iPad for leisure? Yes No

If yes, please specify:

Does the student use the internet? Yes No

If yes, are controls, rules or limits placed on internet access? Are there any concerns about the student's use of the internet such as online safety/vulnerability, difficulty transitioning away from use, etc.?

Does the student use social media or visit social media platforms? Yes No

If yes, are controls, rules or limits placed on social media access? Are there any concerns about the student's use of social media such as safety/vulnerability, difficulty transitioning away from use, etc.?

Has the student received any sexual education in school? Yes No Not sure

Has the student received any sexual education at home? Yes No Not sure

Has the student experienced any challenges with puberty or dealing with their changing bodies? Yes No

If yes, please specify:

Does the student engage in sexualized behaviors? Yes No

If yes, please specify (Ex: public displays, sexualized behavior towards peers, verbalizations)

Other? Please provide information on other challenging behaviors not previously mentioned:

When challenging behaviors occur, what strategies are used at home? What strategies are used at school?

What coping skills does the student use? What coping skills would you like to see the student use?

Does the student have any psychiatric diagnoses? Yes No

If yes, please specify below:

Has the student expressed suicidal thoughts or made suicidal attempts? Yes No

If yes, please specify below:

Has the student ever been hospitalized due to behavioral or psychiatric concerns? Yes No

If yes, please provide the name of the hospital, dates of hospitalization and reason for being admitted:

What are some of the student's preferred items, activities or reinforcers? Please use back of page if needed.

What else would you like us to know about the student? Please use back of page if needed.

Thank you for completing the Application for Student Enrollment. Please submit to the admissions team via email at admissions@guildhumanservices.org or via fax at 781-795-7450 or via mail to:

The Guild School
Attn: Admissions
521 Virginia Road
Concord, MA 01742

