



Providing Applied Behavior Analysis Services of the Highest Quality

INTERVENTIONS UNLIMITED, INC. 848 Executive Dr. Oviedo, FL 32765
Tel:407-678-8889, 407-278-0940 Toll Free: 1-866-569-7395 Fax: 407-678-8885
Email: info@interventionsunlimited.com Website: www.interventionsunlimited.com

School Enrollment Application

Instruction: Please complete this document to the best of your ability.

Areas of Information:

- General Information
- Medical and Health Information
- Educational and Other Therapy Information
- Behavior Information
- Communication Skills Information
- Functional Skills Information
- Reinforcer Information
- Goals
- Supplemental Information
- Application Fee

Date Received: _____

Date Reviewed: _____

Please indicate the programs you would like to enroll your child

<input type="checkbox"/> Advanced Learner Program	<input type="checkbox"/> Year Round (Regular school year plus summer school) <input type="checkbox"/> Include therapies	<input type="checkbox"/> Regular School Year <input type="checkbox"/> Include therapies
<input type="checkbox"/> Intermediate Learner Program	<input type="checkbox"/> Year Round (Regular school year plus summer school) <input type="checkbox"/> Include therapies	<input type="checkbox"/> Regular School Year <input type="checkbox"/> Include therapies
<input type="checkbox"/> Intensive Teaching Program	<input type="checkbox"/> Year Round (Regular school year plus summer school) <input type="checkbox"/> Include therapies	<input type="checkbox"/> Regular School Year <input type="checkbox"/> Include therapies

MEDICAL AND HEALTH INFORMATION

Does the student have a medical diagnosis? YES _____ NO _____

Student's Primary diagnosis: _____ Age at Diagnosis: _____
 Secondary diagnosis: _____ Age at Diagnosis: _____
 Other diagnosis: _____ Age at Diagnosis: _____
 Other diagnosis: _____ Age at Diagnosis: _____

Health History

(Check all that apply)			
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Mumps	<input type="checkbox"/> Heart conditions
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Enuresis (bed wetting)	
<input type="checkbox"/> Severe stomach aches	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Sun sensitivity	<input type="checkbox"/> Other health condition

If you checked any of the above please explain in detail:

Please be specific in answering the following:

- Does the student have physical restrictions/limitations? YES ___ NO ___
 If YES, explain: _____

-
- Does the student suffer from any allergic reactions to :
Penicillin:_____ Other drugs:_____ Bee or wasp sting:_____ Foods:_____
Others : _____

Please specify which foods he/she is allergic to:

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- Any dietary restrictions? YES ___ NO___
If YES, explain: _____

-
- Is the student's vision within normal limits? YES ___ NO___
If NO, explain: _____

-
- Is the student's hearing within normal limits? YES ___ NO___
If NO, explain: _____

-
- Is the student's weight within normal limits? YES ___ NO___
If NO, explain: _____

-
- Is the student currently on any medications? YES ___ NO___
If YES, please list medications below:

Name of Medication	Date Prescribed	Dosage	Purpose

- Are there any medical conditions to consider when delivering ABA/Educational services? YES ___ NO___
If YES, explain: _____

-
- Are there any other medical treatment interventions? YES ___ NO___
If YES, explain: _____

-
- Student's Primary Physician: _____
Address of the physician: _____

EDUCATIONAL AND OTHER THERAPY INFORMATION

Please list the services the student is currently receiving (or the last place attended):

- Public School (K – 12) County:_____ Name of School:_____
- Grade:_____ ESE Program: _____
- Has current IEP

Current Services: OT PT Speech Other:_____

Private School County:_____ Name of School:_____

Grade:_____ ESE Program: _____

Has current IEP

Current Services: OT PT Speech Other:_____

Pre-School or Daycare Name of Program: _____

Home School Provided by: School Therapist Parents

Early Steps Program Services:_____

Other Previous and Current Treatments or Interventions:

Type of Treatment:_____

Start Date:_____ End Date: _____

Treatment effect: _____

Type of Treatment:_____

Start Date:_____ End Date: _____

Treatment effect: _____

Type of Treatment:_____

Start Date:_____ End Date: _____

Treatment effect: _____

BEHAVIOR INFORMATION

Behavior: Does the student engage in the following behaviors?

Non compliance (not following directions): YES ___ NO___

How often does this behavior occur? _____ Per Hour _____ Per Day _____ Per Week

How long does this behavior last? _____

How intense is this behavior? _____

Tantrum (combination of screaming, yelling, dropping on the floor, etc.): YES ___ NO___

How often does this behavior occur? _____ Per Hour _____ Per Day _____ Per Week

How long does this behavior last? _____

How intense is this behavior? _____

Aggression (hitting, kicking, hair pulling, etc.): YES ___ NO___

How often does this behavior occur? _____ Per Hour _____ Per Day _____ Per Week

How long does this behavior last? _____

How intense is this behavior? _____

Self Injurious Behaviors (head banging, self biting, hitting, etc.): YES ___ NO___

How often does this behavior occur? _____ Per Hour _____ Per Day _____ Per Week
How long does this behavior last? _____
How intense is this behavior? _____

Running Away: YES _____ NO _____
How often does this behavior occur? _____ Per Hour _____ Per Day _____ Per Week
How long does this behavior last? _____
How intense is this behavior? _____

Stereotypical Behaviors (hand flapping, flicking, toe walking, rocking, twirling, etc.)
YES _____ NO _____
How often does this behavior occur? _____ Per Hour _____ Per Day _____ Per Week
How long does this behavior last? _____
How intense is this behavior? _____

Difficult with transitions or change in routine: YES _____ NO _____

Unusual interest in the sight, feel, sound or smell of things: YES _____ NO _____

Unusual preoccupations/obsession: YES _____ NO _____

Verbalizing in a repetitive manner: YES _____ NO _____

Other problem behaviors the student engages in: _____

COMMUNICATION SKILLS INFORMATION

1. What are the primary ways the student communicates with other people?

2. On the following chart, indicate the behaviors the child uses to achieve the communicative outcomes listed:

Communicative Functions	Complex speech	Multiple-word phrases	One-word utterances	Echolalia	Other verbalization	Complex signing	Single signs	Pointing	Leading	Shakes head	Grabs/reaches	Gives objects	Increased movement	Moves close to you	Moves away or leaves	Fixed gaze	Facial expression	Aggression	Self-injury	Other
Request attention																				
Request help																				
Request preferred Food/objects/activities																				
Request break																				
Show you something or some place																				
Indicate physical pain																				
Indicate confusion or unhappiness																				
Protest or reject a Situation or activity																				

3. Does the student follow spoken requests or instructions? If so, approximately how many?

4. Does the student respond to signed or gestural requests or instructions? If so, how many?

5. Can the student imitate sounds, words, or phrases? If so, what are they?

6. How does the student indicate “yes” or “no” when asked if she or he wants something, wants to go somewhere?

FUNCTIONAL SKILLS INFORMATION

Please describe the student’s current level of functioning on the following skills by checking the appropriate level:

Skills	Physical assistance needed	Verbal prompts needed	Independent	Incapable
Feed self				
Drink from a cup				
Pour liquid into a cup				
Open juice box				
Open packaged food				
Initiate using the bathroom				
Use the bathroom				
Clean up after using the bathroom				
Wash hands				
Put on clothes				
Take off clothes				
Brush teeth				
Tie shoes				

NOTE: we accept children who have bladder and/or bowel control difficulties, but would appreciate the following information in order to insure proper care.

Does your child wet___ or soil___ during the day? YES___ NO___

Do you use Pull-Ups, diapers etc... at home ? YES___ NO___

If "Yes" please describe: _____

IMPORTANT: For health and sanitary reasons, children who are not toilet trained must wear protective undergarments.

REINFORCER INFORMATION

Please list the things that the student likes:

1. Food:

2. Objects:

3. Activities:

4. Other:

GOALS

Please list some goals that you would like the student to achieve by attending Interventions Unlimited Academy.

SUPPLEMENTAL INFORMATION

Please provide additional information to this Enrollment Application.

- Student current or most recent IEP
- Other psychological or educational evaluations
- Other applicable medical evaluations

Please See Next Page for Application Fee Information!

APPLICATION FEE

A \$200.00 nonrefundable application fee must be submitted with the application.
Please find enclosed my check in the amount of: \$_____
I would like the amount of \$_____ to be charged to my credit card account:
Visa/Master card # _____ Exp. Date: _____ 20_____
Name as It Appears On The Card: _____

Billing Address: _____

Card Holder Signature Date