



Providing Applied Behavior Analysis Services of the Highest Quality

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## 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

Office use only:

**Date Received:** \_\_\_\_\_

**Date Reviewed:** \_\_\_\_\_

On behalf of my son( ) daughter( ) \_\_\_\_\_ / \_\_\_\_\_  
(first or given name) (last or family name)

I wish to apply for admission to Interventions Unlimited's School Program.

**Parent/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**GENERAL INFORMATION**

**Student's Name:** \_\_\_\_\_  
First Middle Last Date of Application

S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: M F Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

<p><b>Parent/Guardian Name:</b> _____</p> <p>Relation to Student: _____</p> <p>Home Address: _____ _____</p> <p>Daytime Phone: (_____) _____</p> <p>Evening Phone: (_____) _____</p> <p>Cell Phone: (_____) _____</p> <p>Email: _____</p>	<p><b>Parent/Guardian Name:</b> _____</p> <p>Relation to Student: _____</p> <p>Home Address: _____ _____</p> <p>Daytime Phone: (_____) _____</p> <p>Evening Phone: (_____) _____</p> <p>Cell Phone: (_____) _____</p> <p>Email: _____</p>
<p><b>Emergency Contact #1:</b> _____</p> <p>Relation to Student: _____</p> <p>Daytime Phone: (_____) _____</p> <p>Evening Phone: (_____) _____</p> <p>Cell Phone: (_____) _____</p>	<p><b>Emergency Contact #2:</b> _____</p> <p>Relation to Student: _____</p> <p>Daytime Phone: (_____) _____</p> <p>Evening Phone: (_____) _____</p> <p>Cell Phone: (_____) _____</p>

**With whom does the child live with?** \_\_\_\_\_

**Please list the name(s) of individuals authorized to pick up your child:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Please indicate the programs you would like to enroll your child.**

<input type="checkbox"/> 3:1 Ratio	<input type="checkbox"/> Year Round (Regular school year plus summer school)	<input type="checkbox"/> Regular School Year
<input type="checkbox"/> 2:1 Ratio	<input type="checkbox"/> Year Round (Regular school year plus summer school)	<input type="checkbox"/> Regular School Year
<input type="checkbox"/> 1:1 Ratio	<input type="checkbox"/> Year Round (Regular school year plus summer school)	<input type="checkbox"/> Regular School Year

**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):

- \_\_\_ Chicken Pox                      \_\_\_ Measles                      \_\_\_ Epilepsy                      \_\_\_ Hepatitis
- \_\_\_ Kidney disease                      \_\_\_ Asthma                      \_\_\_ Mumps                      \_\_\_ Heart conditions
- \_\_\_ Diabetes                      \_\_\_ Ear infections                      \_\_\_ Enuresis (bed wetting)
- \_\_\_ Severe stomach aches                      \_\_\_ Seizure disorder                      \_\_\_ Sun sensitivity                      \_\_\_ 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:

\_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

Daytime Phone number of the 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: \_\_\_\_\_

Is the student eligible for McKay Scholarship? YES \_\_\_\_\_ NO \_\_\_\_\_

**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 student uses to achieve the communicative outcomes listed:

<b>Communicative Functions</b> Communicative Methods	<b>Request attention</b>	<b>Request help</b>	<b>Request preferred Food/ objects/ activities</b>	<b>Request break</b>	<b>Show you something or some place</b>	<b>Indicate physical pain</b>	<b>Indicate confusion or unhappiness</b>	<b>Protest or reject a Situation or activity</b>
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								

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

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

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

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

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**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 students 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, students who are not toilet trained must wear protective undergarments.**

**REINFORCER INFORMATION**

Please list the things that the student likes:

Food: \_\_\_\_\_

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Objects: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Activities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GOALS**

**Please list some goals that you would like the student to achieve by attending Interventions Unlimited, Inc.'s school program.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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

**APPLICATION FEE**

**A \$50.00 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: \_\_\_\_\_

\_\_\_\_\_  
Card Holder Signature

\_\_\_\_\_  
Date