The Darnell School for Educational and Behavioral Services
15 South Street, Hudson MA 01749
508-298-1639 / fax 508-298-1439

APPLICATION FOR ADMISSION

Students are considered for admission without regard to race, color, age, sex, gender identity, religion, national origin, sexual orientation, disability or homelessness.

THE INFORMATION GIVEN BELOW WILL BE HELD STRICTLY CONFIDENTIAL.

_____ _____
Person completing form Date

Has child been served at any time in the past by Advocates or The Darnell School? ___ Yes ___ No

If "yes" please include which program and the years child received services: _____

Who referred you to The Darnell School for Educational and Behavioral Services? _____

Student's Personal Information

_____ Male/Female/Non-Binary/Other
Last Name First Name Middle Name

_____
Street Address City State Zip

_____
Date of Birth Grade Height Weight

Parent/Guardian Information

Parent/Guardian	**Parent/Guardian**
_____ Name	_____ Name
_____ Address City State Zip	_____ Address City State Zip
_____ Home Phone Number Work Phone Number	_____ Home Phone Number Work Phone Number
_____ Cell Phone Number Email Address	_____ Cell Phone Number Email Address

Parents'/Guardians' Marital Status

Married Separated Divorced Widowed Single

Legal Custody: _____ **SOLE** _____**JOINT**

_____

Name(s) Relationship to child Phone Number

_____

Address City State Zip

Physical Custody: _____ **SOLE** _____**JOINT** _____ **SAME AS ABOVE**

_____

Name(s) Relationship to child Phone Number

_____

Address City State Zip

Family Information (Complete the following information for all members of the child's household)

Name	Date of Birth	Gender	Relationship to Child

What is the primary language spoken in the home? _____

Advocate Information (List any agencies and contact person(s) involved in advocating for the student – DSS, DMR)

Agency	Contact Name	Phone Number

Student's Current School Information

School District | Street Address | City | State | Zip

Current Placement | Street Address | City | State | Zip

Dates of last IEP signed (to/from) | SPED Director | Phone Number | Fax Number

Educational History

Current Services received and hours:

ABA Hours _____ Speech Hours _____ OT Hours _____ PT Hours _____

Group Session Hours _____ In-Home Hours _____

Has child passed MCAS (indicate date): ELA _____ Math _____

Is child eligible to receive diploma from LEA? Yes _____ No _____

Please list child's previous placements beginning with the most recent. Please include reason for discontinuation of placement.

Program Name/Reason for Discharge	Enrollment Dates	Hours/Day	Days/Week	Days/Year

Medical History

Primary Diagnosis?	**How was this determined?**	
Secondary Diagnosis?	**How was this determined?**	
Vision Problems?	**Yes_____ No _____**	
Hearing Problems?	**Yes_____ No _____**	
Sleeping Problems?	**Yes_____ No _____**	
Eating Problems?	**Yes_____ No _____**	
Physical Coordination?	**Yes_____ No _____**	

Describe any medical difficulties (e.g., asthma, allergies, physical handicaps, seizure disorder)

Do the parents, siblings, or other extended family members have particular conditions or medical problems (e.g., mental illness, intellectual/developmental delays, neurological or congenital defects, diabetes, allergies)? Please include the relationship of the person involved to child.

Has child ever had a seizure? If yes, please describe.

Current Medications

Medication Name	Dosage	What is it for?	Prescribing Physician

Allergies

Please list any allergies to medications, foods, animals, bees, etc.

Behavioral and Educational Issues

Describe child's academic skills
Describe child's communication skills (e.g., verbal abilities, signs, pictures/symbols or other augmentative systems)
Describe child's self-help skills (including eating, dressing, bathing, sleeping, toileting)
Describe child's behavior (e.g., aggressive, self-injurious, impulsive, hyperactive)
How does child relate to other people?
Describe community skills
Describe vocational skills, if applicable
What areas are you most concerned about?
Describe any home/family concerns you may have in relation to child

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth:_____
Medical History _____
_____

Pertinent Family History

Current Health Issues

Y	N	
☐	☐	Allergies: Please list: Medications _____ Food _____ Other _____
		History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No
☐	☐	Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)
☐	☐	Diabetes: ☐ Type I ☐ Type II
☐	☐	Seizure disorder: _____
☐	☐	Other (*Please specify)* _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:**_____

Hgt: _____(_____%) Wgt:_____(_____%) BMI: _____(_____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____	☐ Lungs _____	☐ Extremities _____
☐ Skin _____	☐ Heart _____	☐ Neurologic _____
☐ HEENT _____	☐ Abdomen _____	☐ Other _____
☐ Dental/Oral _____	☐ Genitalia _____	

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: ____; Results: ____mm.
Referred for evaluation to: _____ ☐ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:_____

☐Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:**_____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 12/14/04*

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / / **Sex:** ☐ **female** ☐ **male**

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		**Check One**	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)* **Date:** / /

Signature: _____

Facility name: _____