

St. Mary's Home
For Disabled Children

Please Attach
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Application

Information about child:

Applicant's Name:

First	Middle	Last	Nickname
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Applicant's Address:

Street

City	State	Zip Code
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Contact Numbers: (home, work, cell phone, pager and email address)

Applicant's Diagnosis: (for example, cerebral palsy, gastrostomy tube, surgeries, seizures)

Applicant's Date of Birth: _____

Race: _____ Sex: _____

Social Security #: _____

Place of Birth: (City, State, Name of hospital and address)

Religious Preference: _____ Baptized? _____

Virginia Medicaid # _____ Medicaid worker's name & phone # _____

Social Service agency address:

Street	City	State	Zip Code
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Name of Person Requesting Admission & Relationship: _____

Referred by (please check one) Physician { } Hospital { } Social Services { }

Community Services Board { } Public School { }

Name and Phone # of Referring Agency: _____

Has a guardianship or custody hearing ever been held for applicant? Yes { } or No { }

If so, date of hearing _____ and Name and Address of court appointed guardian

Please include copy of court order with application.

Family Information

Father's Name: _____

Address:

Street City State Zip Code

Date of Birth: Place of Birth:

Home Phone: Business phone: Other Contact #'s:

Race: Social Security Number: E-mail Address:

Educational Level: Please indicate highest level attained [Grammar, High School (1,2,3,4), College (1,2,3,4) Graduate School] Other: _____

Occupation: Place of Employment:

Marital Status Date of Marriage:

Mother's Name: _____

Address:

Street City State Zip Code

Date of Birth: Place of Birth:

Home Phone: Business Phone: Other Contact #'s:

Race: Social Security #: E-mail Address:

Educational Level: Please indicate highest level attained [Grammar, High School (1,2,3,4) College (1,2,3,4) Graduate School] Other: _____

Occupation: Place of Employment:

Marital Status Date of Marriage:

Marital History:

If spouse is deceased, give date of death: _____ If divorced, give date of divorce: _____

If remarried, give date of marriage: _____

Mother: _____ Date of Marriage: _____

Stepfather's Name: _____ Stepfather's Date of Birth: _____

Educational Level: (Grammar, High School (1,2,3,4), College (1,2,3,4), Grad school

Occupation: _____ Place of Employment: _____

Business Phone: _____

Father: _____ Date of Marriage: _____

Stepmother's Name: _____ Stepmother's Date of Birth: _____

Educational Level: (Grammar, High School (1,2,3,4), College (1,2,3,4), Grad School

Occupation: _____ Place of Employment: _____

Business Phone: _____

Siblings

Name	Sex	Date of Birth	General Health

Family History

Please check below if anyone related to the applicant has the following (i.e. seizures, Dad; heart condition, maternal grandmother; mental retardation, uncle, etc.)

	<u>Mother Side</u>	<u>Father Side</u>
Seizure Disorder	_____	_____
Mental Retardation	_____	_____
Birth Problems/Disorders	_____	_____
Other Hereditary (Genetic) or Family Disorders	_____	_____

Pregnancy/ Labor/ Delivery

What number pregnancy was this?

Onset of prenatal care:

Name and address of attending obstetrician:

Did you have the following when pregnant with this child? Check below

German Measles { } X-Rays { } High Blood Pressure { } Measles { }

Mumps { } Excessive Weight Gain { } Hepatitis { } Vaginal Bleeding { }

Other infections (list below)

Describe any complications and treatment received: _____

Were any of the following used during pregnancy?

Medications:

Drugs:

Cigarettes:

Alcohol/ Beer:

Emotional Upsets:

Onset of labor was early/late/on due date (circle one)

Was labor artificially induced?

Length of labor

Complications

Type of delivery (C-section, Vaginal)

Complications of delivery

Birth weight

Length

Head circumference

APGARS

Were respirations spontaneous or did child need assistance?

Did applicant experience any of the following? (Check)

Convulsions { } Jaundice { } Infections { } Cyanosis (Blueness of skin) { }

Explain above items: _____

Length of applicant's hospital stay after birth: _____

St. Mary's requires all copies of birth records including the hospital discharge summary. Please complete one of the enclosed releases with the Dr.'s name, address and name of the hospital where applicant was born and request birth information.

Applicant's Social and Developmental History:

Were there feeding problems? Yes [] No { } If yes, explain

Was there adequate weight gain? Yes { } No [] If no, explain

Was child irritable? Yes [] No [] If yes, explain

Were there any: Accidents [] Convulsions [] Frequent Infections [] High Fever []
Other, explain:

At what age did applicant do the following?

ACTIVITY	YEARS	MONTHS	ACTIVITY	YEARS	MONTHS
Rolled Over			Cut First Teeth		
Smiled			Stood		
Held Head Up			Walked Alone		
Reached Successfully			Ate With Spoon		
Sat Without Support			Used Single Words		
Crept			Used Sentences		
Pulled to Stand			Toilet Trained		

Is the applicant still able to perform any skills checked above? If not, at what age were these skills lost?

What is applicant's current height?

Weight?

Please describe applicant's hearing, whether hearing has been tested, name of Doctor with reports and what reports indicated:

Does your child have a hearing aide? If so, what type? How well is it tolerated? How long does your child wear it? How old is it?

Please also describe applicant's vision (as above):

Does your child wear glasses? If so, what type? How well is it tolerated? How long does your child wear it? How old is it?

What are applicant's normal sleep hours? What type of bed does applicant use? Are side rails used?

What medical equipment does applicant currently use? (for ex., kangaroo pump, apnea monitor, SAT machine, oxygen, Pulmo Aide or Nebulizer)

What prescribed positioning equipment does applicant use? (such as standers, splints, AFO's, etc.)

What type of wheelchair does applicant have? What is the age of the wheelchair? From what company did you get your wheelchair?

Immunizations:

St. Mary's must have current shot record prior to admission. This can be faxed to the social worker by the physician's office.

Describe any abnormal reactions to any immunization and date event occurred.

Past Conditions: Check all items that apply and comment on back if needed.

<input type="checkbox"/> German Measles	<input type="checkbox"/> Anemia	<input type="checkbox"/> Visual Difficulty
<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Polio	<input type="checkbox"/> Frequent Anxiety
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Gallstones or Gallbladder Problems
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chronic Constipation	<input type="checkbox"/> Overweight
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Underweight
<input type="checkbox"/> Mumps	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Head Injury w/ Unconsciousness	<input type="checkbox"/> Weakness or Paralysis
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Dizziness or Fainting
<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Disease or Injury to Joints	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Frequent Sore Throat	<input type="checkbox"/> Other Accidents or Injuries	<input type="checkbox"/> Encephalitis
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Chronic Skin Condition	<input type="checkbox"/> Stroke
<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pain/Pressure in Chest
<input type="checkbox"/> Blood Infection	<input type="checkbox"/> Jaundice	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Stomach or Intestinal Trouble	<input type="checkbox"/> Abnormal Size of Head	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Infectious Diarrhea	<input type="checkbox"/> Cleft Lip, Palate	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Parasites	<input type="checkbox"/> Dilantin Gum Overgrowth	<input type="checkbox"/> Edema
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other Dental Problems	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Trick Knee or Shoulder	<input type="checkbox"/> Congenital Heart Defect
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other Orthopaedic Problem	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Hay Fever, Asthma
<input type="checkbox"/> Herpes Virus (cold sores)	<input type="checkbox"/> Tumor	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Cyst	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chronic Lung Disease
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Poisoning	

Hospitalizations:

List all hospitalizations from birth on. St. Mary's requires all medical records prior to admission. The doctors at St. Mary's who will be working with your child need to have as complete a record as possible in order to better work with your child. Releases are enclosed with the application to facilitate getting the information. Please complete all releases and mail or fax to each doctor/ hospital. (Faxes usually speed up the process, as well as a phone call to expedite mailing the information). St. Mary's social worker is available to assist with this process. Please complete the information below as completely as possible.

1. Date of first hospitalization:	From	To
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Name of Hospital

Address

Name of Physician	Address
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Reason for Hospitalization

2. Date of second hospitalization:	From	To
------------------------------------	------	----

Name of Hospital

Address

Name of Physician	Address
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Reason for Hospitalization

Etc

Etc

Food and Drug Allergy History:

List all foods, drugs, and other substances to which applicant has been diagnosed as allergic. (Include any items known such as surgical tape, animals that cause a reaction, pollen, dust, mold, etc.).

Name	When diagnosed	Reaction

Medication History:

List Current Medications:

Name of Medication	Dosage	Times Given	Reason Prescribed	Name of Doctor

Discontinued Medications:

List all discontinued prescription, non- prescription and illicit (illegal) drugs that your child has taken:

Name of Medication	Dosage	Times Given	Reason Prescribed	Reason Stopped	Doctor

Dentist:

Date last seen _____

Name, Address & Phone number of dentist:

Current problems:

Infant stimulation / Education programs

Has applicant been involved in either of the above? Yes [] No []

What is the applicant's current educational district?

List Programs applicant has been involved in, beginning at birth if applicable, listing name of program, address, teacher's name and program phone number. St. Mary's also requires a current IFSP or IEP. Enclose with application or have school fax to social worker.

Sensory integration questions

Is applicant sensitive to noise, sounds, light, touch, and movement/handling?

Is child easily upset, slow to calm?

Does applicant have self-stimulation behaviors? (i.e. rocking, hitting self, repetitive actions, screaming)?

Does applicant hit self or others?

Does applicant bite himself or others or injure self/others by any other means?

Does applicant have a history of or is currently on medications to help with behavior?

Does applicant have difficulty tolerating any part of daily routine i.e. dressing, bathing, handling, feeding or oral care?

Does applicant chew on inappropriate items i.e. bedding, clothes, equipment?

Are these behaviors listed above predictable or unpredictable?

Did child have regular sleeping patterns? Yes [] No [] If no, explain. Were medications or other non-prescription drugs used to aide in sleeping?

Has applicant ever required a behavior plan?

Does or **has** applicant used any devices to control behavior such as arm/elbow restraint, helmet, mitts, gloves or any other such equipment?

When were/are these used? Were/Are they effective?

Does or has applicant ever had skin irritation to hands from mouthing?

St. Mary's Home for Disabled Children
6171 Kempsville Circle
Norfolk, VA 23502
PHONE: 757.622.2208
FAX: 757.627.7339

PLEASE MAIL AUTHORIZATION FOR RELEASE OF INFORMATION FORM TO HOSPITAL, INSTITUTION, ETC. IN WHICH CHILD WAS ADMITTED. DO NOT MAIL IN WITH APPLICATION.

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____

to release to St. Mary's Home for Disabled Children, 6171 Kempsville Circle, Norfolk, Virginia 23502 the following information from their records concerning (my child, my ward):

- Psychological Records
- Medical/physical Records
- Social History
- Other (Specify) _____

This information is requested for the purpose of _____

I hereby acknowledge that this consent is given voluntarily, with my informed consent, and is valid until _____.

(365 DAYS MAXIMUM)

I further acknowledge that I may revoke this consent (in writing) at any time except to the extent that action based on this consent has been taken.

CLIENT'S NAME: _____ D.O.B. _____

Signature of Parent or Guardian

Date

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibits you from making any further disclosure of it without the specific written consent of the person it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.