



Early Learning Program Enrollment Packet

Dear Parents:

Thank you for your interest in the Early Learning Program (ELP) at Mitchell's Place. We look forward to working with you and your child. In order to initiate the enrollment process, we need for you to complete this packet and return it with a \$50.00 nonrefundable check. Once this information is received, if we have not already done so, we will contact you to set up a time to meet with you and your child to determine how we can best meet your needs. Completion of this packet does not guarantee admission into the Early Learning Program.

- () Completed Enrollment Packet – [enclosed]
- () Most Recent Evaluations including Current IEP – if applicable

Schedule Monday – Friday 7am – 3pm

The ELP is a year round program; however, we close for the week of spring break, the week of July 4th, the week of Christmas and on Federal Holidays.

Again, we would like to thank you for your interest. We look forward to the continued growth of your child in all areas of development. After the above information has been returned, we will contact you to set up a time to discuss how we can best meet your child's needs and further develop your child's strengths. Please feel free to contact us with any questions by calling 205.957.0294. The above information can be mailed or delivered to:

Mitchell's Place
c/o Sandy Naramore, M.A., Admin. Cert.
4778 Overton Road
Birmingham, AL 35210

Sincerely,

Sandy Naramore, M.A., Admin. Cert.
Executive Director

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Child Case History Form

General Information

Child's Name: _____
Address: _____
Home Phone: _____
Mother's Name: _____
Mother's Age: _____
Father's Name: _____
Father's Age: _____
Referred by: _____

Date of Birth: _____
City, State, Zip: _____
Cell Phone: _____
Mother's Occupation: _____
Business Phone: _____
Father's Occupation: _____
Business Phone: _____
Referral Phone: _____

Child's Legal Guardian:
 Both Birth Parents
 Birth Mother
 Birth Father
 Adoptive Parents
 Department of Human Resources
 Other (please explain)

Marital Status of Natural Parents:
 Not Married
 Married
 Separated
 Divorced
 Father remarried
 Mother remarried

Brother's & Sister's (include half-brothers/sisters)	Age	Learning &/or Medical Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child have a diagnosis of Autism or Asperger's disorder? If so, who made the diagnosis and when was it made? _____

Describe the concerns you have that prompted your referral for services in the ELP. For example, describe your child's behavior problems, problem solving skills, personal/social skills, and/or speech/language development. _____

When did you first become concerned with your child's development? _____

Since you first noticed the delay in your child's development, how has your child's development changed? _____

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Please provide the following information regarding specialists (speech/language pathologists, physicians, psychologists, special education teachers, etc) who have evaluated your child?

Type of Service Provider	Agency/Provider Name	Agency/Provider COMPLETE address	Date(s) Seen
Hospitalizations:			
Pediatrician:			
Family Physician:			
Neurologist:			
Psychiatrist:			
Psychologist:			
Eye Specialist:			
Hearing Specialist:			
Speech Language Therapist:			
Occupational Therapist:			
Physical Therapist:			
Geneticist:			
Children's Rehab. Services:			
Public Health Dept.:			
Dept. of Human Resources:			
Others specify:			
Others specify:			
Others specify:			
Others specify:			

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Schools Attended	Address	Date Attended (mm/yy) to (mm/yy)

Family History

Is there any family history of the following? Please specify who by using the following abbreviations:
 (m) mother (f) father (s) sibling (o) others – please specify

Speech or Language Impairment _____	Visual Impairments _____
Hearing Impairment _____	Drug or Alcohol Abuse _____
Learning Disabilities _____	Seizure Disorder _____
Behavior Problems _____	Chronic Illness _____
Emotional Difficulties _____	ADHD/ADD _____
Diabetes _____	Thyroid Problems _____
Tics or involuntary movements _____	
Other (please specify) _____	

Prenatal and Birth History

Mother's general health during pregnancy (illness, accidents, medications, etc...) _____

Length of Pregnancy _____	Length of Labor _____
General Condition _____	Birth Weight _____
Miscarriages _____	
Type of Delivery	
Head First Feet First Caesarian	

Were there any unusual conditions that may have affected the pregnancy or birth?

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Medical History

If applicable, please provide the approximate age at which your child had the following illnesses/ conditions:

Allergies _____	Asthma _____	Chicken Pox _____
Colds _____	Sleep Problems _____	Croup _____
Dizziness _____	Draining Ear _____	Ear Infections _____
Encephalitis _____	Feeding Problems _____	Headaches _____
High Fever _____	Influenza _____	Growth Problems _____
Measles _____	Meningitis _____	Mumps _____
Pneumonia _____	Seizures _____	Sinusitis _____
Tonsillitis _____	Other _____	

Current Weight _____
Current Feeding Method (check all that apply) Bottle fed _____ Baby food _____
Table food _____ Special diet _____

Does your child have a specific medical diagnosis? Or a significant health problem?

Has your child had any surgeries? If yes, what type and when? _____

Describe any major accidents or hospitalizations, including visits to the emergency room? _____

Is your child taking any medications? If yes, please list the name of the medication, the dose and the frequency. _____

Please describe all allergies your child has (medication, food, environmental). _____

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Developmental History

Provide the approximate ages at which your child began to do the following activities: (you can use early, late, or on-time if age is unknown)

Smile	_____	Crawl	_____
Coo/Babble	_____	Stand Alone	_____
Roll Over	_____	Walk Alone	_____
Sit Alone	_____	Feeds Self	_____
Single Words	_____	Dresses Self	_____
Phrases	_____	Toilet Trained	_____
Short Sentences	_____	Bowel	_____
		Bladder	_____

Your child communicates by which of the following (check all that apply)

Crying	_____	Sentences	_____
Playful Sounds	_____	Sign Language	_____
Pointing with Index finger	_____	Picture Communication	_____
Words	_____		
Phrases	_____		

How much of your child's speech is understandable to you? Some _____ Most _____ All _____
How much of your child's speech is understandable to others? Some _____ Most _____ All _____

Does your child have any problems:

Understanding what someone says	Yes _____	No _____
Talking	Yes _____	No _____

Has your child's hearing been tested? Yes _____ No _____
Was hearing loss reported? Yes _____ No _____

If yes, who tested? _____

If yes, when tested? _____

If yes, what were the results? _____

Has your child's vision been tested? Yes _____ No _____
Was vision loss reported? Yes _____ No _____

If yes, who tested? _____

If yes, when tested? _____

If yes, what were the results? _____

Does your child have difficulty walking, running, or participating in other activities that require small or large muscle coordination? If yes, please describe: _____

Hand Preference: Right _____ Left _____ Both _____ Not Sure _____

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Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc...?) If yes, please describe. _____

Is your child a picky eater? If so, what foods will he/she eat? _____

Is your child on any special diet? Does he/she take any nutritional supplements? If yes, please describe.

Describe your child's response to sound (e.g., responds to all sounds, responds to loud sounds only, extremely sensitive to loud noises, etc...). _____

Does your child have outbursts or "meltdowns" due to anger, frustration, and/or sensory overload? If so, are there strategies that you have used that are helpful in correcting this behavior? _____

How would you describe your child?

- Usually very active
- Active sometimes, but can play quietly
- Usually not active
- Usually happy
- Can be moody
- Demands attention
- Aggressive towards self or others
- Difficulty attending to activities
- Prefers motor activities
- Prefers sit-down activities

Please describe your child's play/social skills? _____

What does your child enjoy doing in his/her free time? _____

What are your child's special interests, likes and dislikes? What rewards or motivates your child? _____

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Educational History

Is your child currently participating in any early learning or day care program? _____

What are his/her strengths and needs?

Name of School: _____ Current Grade: _____

Current Class: _____ Teacher(s) Name: _____

If your child has received any of the following special services, please give age of child when services started and date services ended or current frequency of services.

Physical Therapy _____ Vision Impaired _____

Occupational Therapy _____ Hearing Impaired _____

Speech/language Therapy _____

Special Instruction _____

Other, specify _____

Other pertinent information: _____

Please name three social goals that you would like for your child to accomplish this year?

Please name three academic goals that you would like for your child to accomplish this year?

Please rate your current stress level on a scale of one to five;

1 2 3 4 5
No Stress Moderate Severe Stress

If applicable, what percentage of your stress do you attribute to your child's Autism Spectrum Disorder?
