

# BROOKLYN AUTISM CENTER ACADEMY

A not-for-profit, non-public school for children with autism aged Kindergarten through 5<sup>th</sup> grade

## APPLICATION FOR ADMISSION

The Brooklyn Autism Center Academy admits students of any race, color, national origin, and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national origin and ethnic origin in administration for its educational policies, scholarship and loan programs, and athletic and other school-administered programs.

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's first and last name: \_\_\_\_\_

Father's first and last name: \_\_\_\_\_ Parent's marital status: \_\_\_\_\_

Primary mailing address:

Contact Information:

Home number: \_\_\_\_\_

Work number: \_\_\_\_\_

Cellular number: \_\_\_\_\_

Email address: \_\_\_\_\_

How did you find out about the Brooklyn Autism Center?

What are your main concerns?

Please list any sibling's names, ages, and gender

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Any concerns with sibling's development?

Any additional concerns?

Any complications with pregnancy?

Childhood illnesses?

Any current medications? Yes/No. If yes, please list them: \_\_\_\_\_

Any dietary supplements? Yes/No. If yes, please list them: \_\_\_\_\_

Any dietary restrictions? Yes/No. If yes, please list them: \_\_\_\_\_

What is his/her pain threshold? High/Low/Typical

Any sensitivities or fear to certain sounds? (e.g. vacuum): \_\_\_\_\_

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

How does he/she respond when you leave? \_\_\_\_\_

Does he/she show interest in toys? Tasks? Other activities? \_\_\_\_\_

Does he/she have a favorite activity or toy? \_\_\_\_\_

Does he/she show interest in other children? If so, please provide description of interactions? Non-verbal?

Verbal? \_\_\_\_\_

Other comments on emotional development: \_\_\_\_\_

What is the primary language spoken at home? \_\_\_\_\_ Are there any other languages spoken on a regular basis at home? \_\_\_\_\_

Does he/she vocalize? \_\_\_\_\_

When? \_\_\_\_\_

What sounds or words does he/she make? \_\_\_\_\_

How is his/her articulation? \_\_\_\_\_

Who can understand him? \_\_\_\_\_

Is your child toilet trained? \_\_\_\_\_

Can your child dress themselves? \_\_\_\_\_

Does your child have any feeding issues/concerns? \_\_\_\_\_

Does he/she tantrum? \_\_\_\_\_

How long/frequent are tantrums? \_\_\_\_\_

Describe the tantrum behavior: \_\_\_\_\_

When your child becomes upset, does he/she display aggressive behaviors such as biting, hitting, and/or pinching? \_\_\_\_\_

Any aggressive behaviors towards self? \_\_\_\_\_

Towards others? \_\_\_\_\_

Towards property? \_\_\_\_\_

Does he/she engage in behaviors in a repetitive or ritualistic manner? Yes/No

With body? \_\_\_\_\_ With objects? \_\_\_\_\_

Does he/she seem to need things done in a particular way or perform elaborate actions in a repetitive way? \_\_\_\_\_

Do you have any additional comments or observations? \_\_\_\_\_

Please describe in detail the services your child currently receives:

\_\_\_\_\_

\_\_\_\_\_

Any other related services? \_\_\_\_\_

\_\_\_\_\_

Your Child's Diagnosis: \_\_\_\_\_

Name of Diagnosing Doctor: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_