Enrollment Package

Please complete the following form as thoroughly and accurately as possible.

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

About us: Bacot Academy is a non-profit, private, Christian-based school for children with Autism and other disabilities. Although autism is our specialty, we also welcome students with multiple disabilities. We provide year-round specialized education based on the science of Applied Behavior Analysis (ABA) as well as B.F. Skinner’s analysis of verbal behavior.

Our Mission: Our mission is to give each student a comprehensive education not otherwise available in our community. We believe that each child deserves the opportunity to reach their full potential and become productive members of society.

Our Approach: All Bacot Academy’s staff are trained in the principles of Applied Behavior Analysis (ABA), which serves as the basis for its educational program. ABA has long been considered the most effective and scientifically validated approach for teaching individuals with autism and other disabilities. The program is both evidence-based and innovative, using tried and tested methods to teach students new skills in creative and inventive ways. Our students receive a quality, well-rounded, and functional education that will help them lead productive, meaningful lives with as much independence as possible.

Student’s name:

Student information:

Student’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nickname (if any):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address City State Zip

Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Language(s) Spoke at Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Students Primary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Diagnosis was received: \_\_\_\_\_\_\_\_\_\_

Students Secondary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Diagnosis was received: \_\_\_\_\_\_\_\_\_\_

Other Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Diagnosis was received: \_\_\_\_\_\_\_\_\_\_

Other Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Diagnosis was received: \_\_\_\_\_\_\_\_\_\_

Does your child have any allergies and/or dietary concerns? (Please circle) Y N

If so, please list/explain below

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

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

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

Parent/family information:

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip

Home Phone: ( ) Cell Phone: ( ) \_\_\_\_\_\_

Email Address:

Parents Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: ( )

S.S Number of the Guardian who applied for the Family Empowerment/ UA Scholarship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Second Parent/Guardian information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip

Home Phone: ( ) Cell Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_\_

Sibling Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibling Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibling Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibling Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medial information:

Is the student currently on any medications? (Please circle) Y N

If yes, Please list medications below:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | Dosage | Administration Time | Purpose |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Does your child require medication(s) during school hours? (Please circle) Y N

Please list the medication information below:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | Dosage | Administration Time | Purpose |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Does your child have seizures? (Please circle) Y N

Does your

Have there been any recent changes to medications? (Please circle) Y N

If yes, please explain

Has the student ever been admitted to a hospital or treatment center? (Please circle) Y N

If yes, please explain

Are there any other medical conditions to consider when delivering ABA services? (Please circle) Y N

Please explain:

Are there any other medical treatment interventions? (Please circle) Y N

If yes, please explain

Student’s Primary Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education and therapy information:

Current School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been suspended or expelled from another school? (Please circle) Y N

If so, briefly explain:

Any Previous Schools Attended:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade they attended\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child received one on one instruction at their current school? (Please circle) Y N

Was your child suspended or expelled from that school? (Please circle) Y N

Is so, briefly explain

Any Previous Schools Attended:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade they attended\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your child suspended or expelled from that school? (Please circle) Y N

Is so, briefly explain

Any Previous Schools Attended:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade they attended\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your child suspended or expelled from that school? (Please circle) Y N

Is so, briefly explain

What services does your child receive or did at their last school?

Speech Therapy

Occupational Therapy

Physical Therapy

ABA Therapy Where does your child receive ABA therapy and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have an IEP or 504Plan? (Please circle) IEP 504Plan

LEARNING READINESS:

EYE CONTACT

Makes spontaneous eye contact

\_\_\_\_\_\_When asked

\_\_\_\_\_\_Does not make eye contact

APPROPRIATE SITTING

\_\_\_\_\_\_Sits when asked to do so

For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Sits with minimal prompting

\_\_\_\_\_\_Does not sit appropriately

\_\_\_\_\_\_Does your child elope when possible?

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOLLOWING DIRECTIONS

\_\_\_\_\_\_Follows complex directions (2 or more steps)

\_\_\_\_\_\_Follows simple directions (“clap hands”, “sit down”)

\_\_\_\_\_\_Can follow simple directions with minimal direction

\_\_\_\_\_\_Does not follow any directions

LANGUAGE SKILLS

\_\_\_\_\_\_Reciprocates information using sentences

\_\_\_\_\_\_Speaks in full sentences: approximate number of words in a sentence

\_\_\_\_\_\_Speaks in phrases

\_\_\_\_\_\_\_approximate number of words in a phrase

\_\_\_\_\_\_Uses single words

\_\_\_\_\_\_Uses manual signs

\_\_\_\_\_\_Does not use words or signs

TOILETING

\_\_\_\_\_\_Is completely trained

\_\_\_\_\_\_Is night trained

\_\_\_\_\_\_Is bowel trained only

\_\_\_\_\_\_Is urine trained only

\_\_\_\_\_\_Does not wear diapers but is taken to the toilet

\_\_\_\_\_\_Wears diapers but can use the toilet

\_\_\_\_\_\_Wears diapers all the time and never uses toilet

DRESSING

\_\_\_\_\_\_Can dress independently

\_\_\_\_\_\_Assists in dressing

\_\_\_\_\_\_Needs to be dressed

\_\_\_\_\_\_Resists dressing

EATING

\_\_\_\_\_\_Uses all/some utensils appropriately

\_\_\_\_\_\_Uses fingers to feed self

\_\_\_\_\_\_Can drink from a straw

\_\_\_\_\_\_Has strong food aversions and preferences

If so, what are they?

PLAY SKILLS

\_\_\_\_\_\_Can use crayons/pencils

\_\_\_\_\_\_Strings Beads

\_\_\_\_\_\_Plays with manipulative toys

\_\_\_\_\_\_Builds with blocks

\_\_\_\_\_\_Takes turns with peer or parent

BEHAVIORS:

Have you ever observed self-stimulatory behavior(s)? (e.g. rocking, hand regard, excessive jumping, spinning, repetitive behaviors) (Please circle) Yes No

Please describe:

Have you ever observed self---injurious behavior(s)? (e.g. biting, scratching, head banging, head hitting) (Please circle) Yes No.

Please describe

Have you ever observed aggressive behavior(s)? (e.g. hitting, pinching, kicking, biting) (Please Circle) Yes No.

Please describe:

Please lists your child’s likes and dislikes:

Likes

Dislikes

List below any activities/behaviors you have observed your child to engage in independently while at home

ATTACHMENTS:

Please attach the following items as they apply to you. At a minimum, we will require a public-school IEP reflecting eligibility for Autism Spectrum Disorder (ASD) services and placement.

REQUIRED DOCUMENTS:

1. (a) Copy of the most recent public-school IEP completed for your child documenting eligibility for ASD and any other related services if applicable.

(b)If your child presently attends private school, please submit the last IEP done by the public school your child attended reflecting the ASD diagnosis.

2. Please provide your child’s birth certificate, immunization records, and yearly physical exam.

SUGGESTED DOCUMENTS:

2. Latest Psychological Evaluation (if you have one)

3. Most recent ABLLS evaluation (Assessment of Basic Learning and Language Skills) (if you have one)

4. Any behavioral evaluations or behavior plans, prepared privately or by Public School System (if you have one)

5. Any Speech, Occupational, or Physical Therapy evaluations, conducted privately or by Public School System (if you have one)

6. You may include any other information you wish such as additional private evaluations, etc.

To the best of my knowledge, the above information is accurate and complete.

In the event of a change of address, phone number, name, etc.; I will notify the school.

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completion of Enrollment Packet Does Not Guarantee Admission

You will be notified by Bacot Academy’s Administration.