



**MILESTONES SCHOOL APPLICATION - Please print!** (updated 3/9/12) TODAY'S DATE: \_\_\_\_\_

*Thank you for taking the time to thoughtfully complete this application for admissions to Milestones Day School so we may better assess and understand the educational and therapeutic needs of your child. At Milestones, our education plans are created to help students acquire new skills that will help them thrive in our community and beyond. This information will only be shared with relevant members of your child's potential team.*

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

Current Grade \_\_\_\_\_ Primary Language: \_\_\_\_\_

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

\_\_\_\_\_  
(town)

\_\_\_\_\_  
(state)

\_\_\_\_\_  
(zip)

\_\_\_\_\_  
(Home Phone)

Sibling(s) name(s) and age(s): \_\_\_\_\_

Parent 1		Parent 2	
Name	_____	Name	_____
Cell Phone	_____	Cell Phone	_____
Work Phone	_____	Work Phone	_____
Email	_____	Email	_____
Primary Language	_____	Primary Language	_____
Legal Custody	<input type="checkbox"/> Yes - Joint <input type="checkbox"/> No: _____	Legal Custody	<input type="checkbox"/> Yes - Joint <input type="checkbox"/> No: _____

**WHO REFERRED YOU TO MILESTONES?**

\_\_\_\_ Friend \_\_\_\_ Advocate (Name: \_\_\_\_\_) \_\_\_\_ School District

\_\_\_\_ Physician or Psychologist (Name: \_\_\_\_\_)

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

**WHERE ARE YOU IN THE REFERRAL PROCESS:**

My child does not currently have a referral.

- \_\_\_\_ We are in the process of meeting with the district
- \_\_\_\_ Our district does not feel our child needs an out of district
- \_\_\_\_ We are paying privately and understand that Milestones does not accept unilateral placement and therefore I can't go back after my town for tuition.

My child has a referral for an out of district placement

- \_\_\_\_ The district is sending packets to other programs
- \_\_\_\_ The district is sending (or has sent) a packet to Milestones

My child is currently placed out of district

**AT MILESTONES**

- I have attended a group or individual tour at Milestones  
Month \_\_\_\_\_ Year \_\_\_\_\_
- My child has applied previously
- My child has visited Milestones





**CHILD'S DEVELOPMENTAL OR PSYCHIATRIC DIAGNOSES (Not medical such as allergies):**

Age Diagnosed	Diagnosis	Name of person who diagnosed child	Is a... (Pediatrician, psychologist, psychiatrist, GI Doctor, etc.)	From (Children's Hospital, etc.)	Does the child know s/he has a diagnosis and what do you call it?

**PLEASE LIST ALL SCHOOL PLACEMENTS**

Grades Attended	Name of School	Town	Reason for Leaving	Who decided the child should leave the school (parent, district, school, etc.)
Current Placement				

**DID YOUR CHILD EVER HAVE A PSYCHIATRIC HOSPITALIZATION?**

Admission Date	Reason for Admission



**CURRENT SERVICES:**

Type of service (i.e, OT, therapy, etc.)	How often (i.e, 2 x 30 minutes)	Is this service through the school or provided privately?	Reason for service	Provider's name & number
		__ school __ private		
		__ school __ private		
		__ school __ private		
		__ school __ private		
		__ school __ private		

**WHAT INTERVENTIONS WERE ALREADY TRIED**

Intervention	Effectiveness		
	Helpful	So-So or Mixed	Not Helpful

**ACADEMIC PROFILE:**

Subject	GRADE LEVEL			ENJOYMENT		Additional Information
	Below	On	Above	Enjoys	Dislikes	
Math						
Science						
History						
English						

Does your child currently do homework? \_\_\_\_\_ If so, how many hours per night: \_\_\_\_\_ Is it a struggle: \_\_\_\_\_



Please provide details:

If your child is in 9-12th grades, Milestones offers two tracks. Please indicate which track you are interested in:

- \_\_\_ College track (students prepare to attend college when they graduate)
- \_\_\_ Internship track (students prepare to work right after they graduate).
- \_\_\_ Unsure at the moment

**RECREATION ACTIVITIES:**

What does your child do for recreation activities: \_\_\_\_\_

How many hours a day of TV/computer/video game time does your child engage in?

- During the week:  none     1/2 hour -1     1-2     over 2-3     over 3
- On the weekends:  none     1/2 hour -1     1-2     over 2-3     over 3

What time does your child go to bed? \_\_\_\_\_ get up \_\_\_\_\_    \_\_\_ wakes up in the middle of the night

**SKILL PROFILE (Please check all skills your child has difficulty with)**

**Social Skills**

<input type="checkbox"/> Initiating Conversations	<input type="checkbox"/> Knowing what to say and when to say things	<input type="checkbox"/> Taking another person's perspective
<input type="checkbox"/> Staying in Conversations	<input type="checkbox"/> Reading nonverbal cues (understanding what other's facial expressions, tone of voice, shoulder shrugs mean)	<input type="checkbox"/> Recognizing that someone is busy or shouldn't be interrupted
<input type="checkbox"/> Ending Conversations	<input type="checkbox"/> Using nonverbal cues (using a shoulder shrug or facial expression to communicate information nonverbally)	<input type="checkbox"/> Understanding the difference between the way you treat your parents vs. peers vs. teachers vs. people of general authority, etc.
<input type="checkbox"/> Joining conversations that are already in progress	<input type="checkbox"/> Negotiating / Compromising	<input type="checkbox"/> Interacting with people outside of our immediate family for pleasure (i.e, local group or plays in the neighborhood)
<input type="checkbox"/> Smiles back when other's smile	<input type="checkbox"/> Asks for help when needed	<input type="checkbox"/> Accepts other's ideas

**Sensory Processing:**

EARS	TASTE	SMELL	TOUCH	MOVEMENT
<input type="checkbox"/> difficulty with loud noises or certain sounds	<input type="checkbox"/> Has limited food preferences or restricted diet	<input type="checkbox"/> Is offended easy by odors that don't bother most people	<input type="checkbox"/> Does not enjoy being touched <input type="checkbox"/> Certain clothes bother your child	<input type="checkbox"/> Does not like long car rides <input type="checkbox"/> Does not like being upside down
<input type="checkbox"/> Makes extra noise	<input type="checkbox"/> Craves spicy foods	<input type="checkbox"/> Seeks out smells that may seem noxious or harsh	<input type="checkbox"/> Seeks to crashes into others or objects <input type="checkbox"/> Seems clumsy or unaware of surroundings	<input type="checkbox"/> Seeks spinning or twirling sensations

**Communication / Hearing**

<input type="checkbox"/> says a lot of “um” “uh” or other filler words while talking or stutters	<input type="checkbox"/> Other can’t understand my child	<input type="checkbox"/> Can hear what is being said, but doesn’t seem to always understand
<input type="checkbox"/> Leaves out certain consonants, sounds or distorts sounds	<input type="checkbox"/> my child’s voice sounds different from his/her peers or siblings	<input type="checkbox"/> Hearing Impairment

**Executive Functioning**

<input type="checkbox"/> Trouble organizing	<input type="checkbox"/> When doesn’t know something seeks answers from people	<input type="checkbox"/> Remembering to bring items home from school or to school / remembering homework
<input type="checkbox"/> Getting stuck on certain tasks	<input type="checkbox"/> Ignoring things that are not relevant in the moment	<input type="checkbox"/> Learns from mistake
<input type="checkbox"/> Flexibility	<input type="checkbox"/> Seeing the big picture “forest for the trees”	<input type="checkbox"/> Other:

**Emotional**

<input type="checkbox"/> Has felt suicidal	<input type="checkbox"/> Has made a suicide attempt	<input type="checkbox"/> Has felt like injuring another person
<input type="checkbox"/> Has been hospitalized	<input type="checkbox"/> Has frequent mood swings	<input type="checkbox"/> Other:

**Behavior: In the past year my child has engaged in the following behavior (and please indicate the number of times 1-3, etc.)**

At home	In School
<input type="checkbox"/> Hit, Kicked, Scratched, Pinched ___ 1-3 ___ 4-8 ___ 9+	<input type="checkbox"/> Hit, Kicked, Scratched, Pinched ___ 1-3 ___ 4-8 ___ 9+
<input type="checkbox"/> Threw or broke items ___ 1-3 ___ 4-8 ___ 9+	<input type="checkbox"/> Threw or broke items ___ 1-3 ___ 4-8 ___ 9+
<input type="checkbox"/> Bite ___ 1-3 ___ 4-8 ___ 9+	<input type="checkbox"/> Bite ___ 1-3 ___ 4-8 ___ 9+
<input type="checkbox"/> Tantrum, yelled, ___ 1-3 ___ 4-8 ___ 9+	<input type="checkbox"/> Tantrum, yelled, ___ 1-3 ___ 4-8 ___ 9+
<input type="checkbox"/> Ran away from you ___ 1-3 ___ 4-8 ___ 9+	<input type="checkbox"/> Ran out of classroom ___ 1-3 ___ 4-8 ___ 9+
<input type="checkbox"/> Instigated siblings ___ 1-3 ___ 4-8 ___ 9+	<input type="checkbox"/> Instigated peers ___ 1-3 ___ 4-8 ___ 9+
<input type="checkbox"/> Injured self on purpose ___ 1-3 ___ 4-8 ___ 9+	<input type="checkbox"/> Injured self on purpose ___ 1-3 ___ 4-8 ___ 9+
<input type="checkbox"/> Refused to do what you asked ___ 1-3 ___ 4-8 ___ 9+	<input type="checkbox"/> Refused to do what you asked ___ 1-3 ___ 4-8 ___ 9+
<input type="checkbox"/> Lied ___ 1-3 ___ 4-8 ___ 9+	<input type="checkbox"/> Lied ___ 1-3 ___ 4-8 ___ 9+
<input type="checkbox"/> Stole Something ___ 1-3 ___ 4-8 ___ 9+	<input type="checkbox"/> Stole Something ___ 1-3 ___ 4-8 ___ 9+
What is your best guess for why your child engages in these behaviors (e.g., transitions, change in schedule, sensory, etc.)	What is your best guess for why your child engages in these behaviors (e.g., transitions, change in schedule, sensory, etc.)

What interventions have you tried: ignoring redirection time out  the “I mean it” face loss of privileges breaks relaxation program visuals repeated directions verbally processed Other (please explain)

How do you discipline your child at home?



**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**

I hereby authorize Milestones, Inc. to have two- way information sharing with the people/agencies listed below. Information may include:

- Medical, Psychological, Developmental, or Educational evaluations/records
- Diagnostic, Medical, Psychological, or Educational Testing
- Telephone Conversations
- Other (please specify) \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Role	Person's Name	Phone Number
School District		
Pediatrician		
Psychologist		
Neuro-psychologist		
Psychiatrist		
Occupational Therapist		
Speech Pathologists		
Other		
Other		

I have carefully read and understood the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records, including psychiatric and alcohol/drug abuse records, if relevant, to/by those persons /agencies named above. I understand that this information may be protected by Federal Regulation 42 CFR, Part 2. I understand that my protected health information used or disclosed pursuant to this authorization may or may not be subject to re-disclosure by the recipient. I understand that this consent is subject to revocation at any time except after the information has already been released.

Print Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship: Mother Father Other\_\_\_\_\_