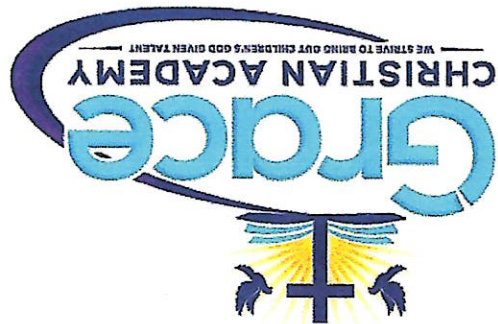




ENROLLMENT PACKAGE

Possibilities Academy

for Autism

and

Other Related Disabilities

590 NW Peacock Blvd. Suite #4
Port St. Lucie, FL 34986
772-905-8096

Student's Name: _____



Areas:

☐ Family Information

☐ Student Information

☐ Medical Information

☐ Educational and Therapy Information

☐ Functional Behavioral Assessment

☐ Student Learning Level Assessment

☐ Student Reinforcement Inventory

☐ Student Narrative

☐ Expectations

☐ Supplemental Information

Date Received: -----/-----/-----

Family Information

Parent/Guardian Name _____
First _____ M.I. _____ Last _____
Relationship to child _____

Home Address _____
Address _____
City _____ St _____ Zip _____

Home Phone () _____
Work Phone () _____
Cell Phone () _____
E-mail Address _____

Parent/Guardian Name _____
First _____ M.I. _____ Last _____
Relationship to child _____

Home Address _____
Address _____
City _____ St _____ Zip _____

Home Phone () _____
Work Phone () _____
Cell Phone () _____
E-Mail Address _____
SS# of Parent Filing McKay: _____

Sibling Name _____
First _____ Last _____ Age _____

Sibling Name _____
First _____ Last _____ Age _____

Sibling Name _____
First _____ Last _____ Age _____

Student Information

Student Name _____

DOB _____ Age _____

First _____ Middle _____ Last _____

Nickname _____

Sex: _____ M _____ F _____

SS# _____

Home Address _____

Address _____

City _____

State _____

Zip _____

Student's Primary Diagnosis _____

Date of Diagnosis _____

Secondary Diagnosis _____

Date of Diagnosis _____

Other Diagnosis _____

Date of Diagnosis _____

Other Diagnosis _____

Date of Diagnosis _____

Medical Information

Does the Student have any allergies? YES NO

If so, please list/explain below:

Please list any special dietary needs/concerns:

Is the student currently on any medications? YES NO

If yes, please list medications below:

Type of Medication	Dosage	Administration Time	Purpose

Have there been any recent changes in medication? YES NO

If yes, Please explain

Has the student ever been admitted to a hospital or treatment center? YES NO

If yes, Please explain

Are there any medical conditions to consider when delivering ABA services? YES NO

If yes, Please explain

Are there any other medical treatment interventions? YES NO

If yes, please explain

Student's Primary Physician

Educational and Therapy Information

Please list the services the student is currently receiving (or the last attended):

☐ Public School (K-12) School Name _____ County _____

Grade _____ ESE ☐ Current IEP ☐

Services: OT ☐ PT ☐ SPEECH ☐ OTHER: _____

☐ Private School (K-12) School Name _____ County _____

Grade _____ ESE ☐ Has Current IEP ☐

Services: OT ☐ PT ☐ SPEECH ☐ OTHER: _____

☐ Pre-School or Daycare Name of Program _____

☐ Home School ☐ Provided by School ☐ Provided by Therapist ☐ Provided by Parents ☐

☐ Early Intervention Program Services: _____

☐ Other Therapies or Previous Services: _____

Functional Behavior Assessment

Please list the student's behaviors that interfere with learning or make them less successful at home:

☐ Attention Seeking Behaviors ☐ Physical Aggression ☐ Self-Stimulatory Behaviors	☐ Non-Compliance ☐ Self-Injurious Behaviors ☐ Throwing/Dumping Objects	☐ Whine/Cry/Yell ☐ Property Destruction ☐ Elopement/Running Away
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Please describe these behaviors:

Please describe the frequency of these behaviors (How many times per day/week, etc.)

Are there situations where the behavior is most likely to occur?

Are there situations where the behavior is least likely to occur?

How are you currently dealing with the behaviors?

