Grace
CHRISTIAN ACADEMY
WE STRIVE TO BRING OUT CHILDREN'S GOD GIVEN TALENT

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	☐ Non-Compliance	☐ Whine/Cry/Yell
☐ Physical Aggression	☐ Self-Injurious Behaviors	☐ Property Destruction
☐ Self-Stimulatory Behaviors	☐ Throwing/Dumping Objects	☐ Elopement/Running Away

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? _____

_____

_____