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	___ Yes - Joint ___ No: _____	Legal Custody	___ Yes - Joint ___ 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

410 Totten Pond Road, Floor 2, Waltham, MA 02451
Voice: 781.895.3200 | Facsimile: 781.895.3226

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

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

Sensory Processing:

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

Communication / Hearing

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

Executive Functioning

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

Emotional

☐ Has felt suicidal	☐ Has made a suicide attempt	☐ Has felt like injuring another person
☐ Has been hospitalized	☐ Has frequent mood swings	☐ 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
☐ Hit, Kicked, Scratched, Pinched ___ 1-3 ____4-8 _____9+ ☐ Threw or broke items ___ 1-3 ____4-8 _____9+ ☐ Bite ___ 1-3 ____4-8 _____9+ ☐ Tantrum, yelled, ___ 1-3 ____4-8 _____9+ ☐ Ran away from you ___ 1-3 ____4-8 _____9+ ☐ Instigated siblings ___ 1-3 ____4-8 _____9+ ☐ Injured self on purpose ___ 1-3 ____4-8 _____9+ ☐ Refused to do what you asked ___ 1-3 ____4-8 _____9+ ☐ Lied ___ 1-3 ____4-8 _____9+ ☐ Stole Something ___ 1-3 ____4-8 _____9+	☐ Hit, Kicked, Scratched, Pinched ___ 1-3 ____4-8 ___9+ ☐ Threw or broke items ___ 1-3 ____4-8 _____9+ ☐ Bite ___ 1-3 ____4-8 _____9+ ☐ Tantrum, yelled, ___ 1-3 ____4-8 _____9+ ☐ Ran out of classroom ___ 1-3 ____4-8 _____9+ ☐ Instigated peers ___ 1-3 ____4-8 _____9+ ☐ Injured self on purpose ___ 1-3 ____4-8 _____9+ ☐ Refused to do what you asked ___ 1-3 ____4-8 _____9+ ☐ Lied ___ 1-3 ____4-8 _____9+ ☐ 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_____