



1600 Riverfront Drive  
Little Rock, AR 72202

# Easterseals Academy at Riverdale

## Application Questionnaire

Student  
Name:

\_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle

Parent/Guardian(s) \_\_\_\_\_

Address \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

**Current  
School:**

\_\_\_\_\_ **Grade:** \_\_\_\_\_

Name of person completing this  
form:

\_\_\_\_\_

Relationship to student:

\_\_\_\_\_

Who referred you to the Academy  
at Riverdale?

\_\_\_\_\_

### Student Information

DOB: \_\_\_\_\_ Current Age: \_\_\_\_\_ Male  Female

SSN: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Does your student have a primary diagnosis? Yes No

If so, please check all that apply

- |                                     |   |  |  |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> ADD        | <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Visually Impaired |
| <input type="checkbox"/> ADHD       | <input type="checkbox"/> Down's Syndrome    | <input type="checkbox"/> Moderate MR         |  |
| <input type="checkbox"/> Asperger's | <input type="checkbox"/> Head Injury        | <input type="checkbox"/> Mild MR             |  |
| <input type="checkbox"/> Autism     | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Severe MR           |  |

Other, please explain:

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If undiagnosed please explain learning issues/difficulties:

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Has your student been seen by a psychologist,  therapist,  or psychiatrist?   
(Click on appropriate box(es))

If yes, please explain:

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(Check all that apply)

Does your student need:  Speech Therapy  Occupational Therapy  Physical Therapy?

### **INSURANCE INFORMATION**

Name \_\_\_\_\_

Group Number \_\_\_\_\_

Policy Number \_\_\_\_\_

PCP \_\_\_\_\_

Medicaid Waiver? Yes  No

Provider Name:

Medicaid Number \_\_\_\_\_

AR Kids Number A \_\_\_\_\_

AR Kids Number B \_\_\_\_\_

Tefra Number \_\_\_\_\_

**MEDICAL INFORMATION**

List all current medical issues:

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List all medications, how often and for what?

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Does student require administration of medication during school hours? If yes, which medications?

Yes  No

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Are all immunizations up to date? Yes  No  (check appropriate box)

(School will need a copy of immunization record upon acceptance)

List any allergies: \_\_\_\_\_

Last hearing and vision exam and results: \_\_\_\_\_

(Check all that apply).

Does student wear: orthopedic appliances,  special shoes or inserts,  glasses or contacts,  dentures,  braces,  or retainers,  hearing aids  or cochlear implant,  other?

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Does student have any history of convulsions, seizures, or epilepsy?  Yes  No

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If yes, date of last seizure? \_\_\_\_\_

Does student have any feeding issues? (Check box)  Yes  No

If yes, please explain: \_\_\_\_\_

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Does student have any sensory issues?  Yes  No

If yes, please explain:

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**FAMILY INFORMATION**

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Home email \_\_\_\_\_ Home email \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Place of Business \_\_\_\_\_ Place of Business \_\_\_\_\_

Work email \_\_\_\_\_ Work email \_\_\_\_\_

Parents' Marital status: Married  Separated  Divorced  Widowed

Who has legal custody of student? \_\_\_\_\_

Please list two persons to notify in case of emergency:

Name \_\_\_\_\_ Name \_\_\_\_\_

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

Telephone \_\_\_\_\_ Telephone \_\_\_\_\_

Cell phone \_\_\_\_\_ Cell phone \_\_\_\_\_

List all persons living in the home:

Name	Age	Relationship to child

## Developmental History

Describe your student's activity level

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Does your student have any unusual or extreme reactions or behaviors?  Yes  No

If yes, please describe:

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Is your student extremely sensitive to noises, crowds, touch, bright lights, or clothing?  Yes  No

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Does your student enjoy swinging, spinning, or firm hugs?  Yes  No

**Thinking about your student, *in general*, please mark the appropriate response:**

### **Awareness Skills**

Ability to focus on an activity (check one)  15 min  20 min  30 min

Explain any difficulties in this area \_\_\_\_\_

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### **Communication Ability**

- Communicates needs  verbally  non-verbally
- Communicates needs with one or two words  partial sentences  complete sentences
- speech device  sign language

### **Expressive Communication Ability**

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|---|---------------------------------|------------------------------------|--------------------------------|
| • Makes verbal conversation                           | <input type="checkbox"/> Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| • Family understands the student                      | <input type="checkbox"/> Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| • Others understand the student                       | <input type="checkbox"/> Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| • Makes eye contact                                   | <input type="checkbox"/> Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| • Uses words to describe objects, pictures            | <input type="checkbox"/> Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| • Makes gestures (smiles, waves, hugs)                | <input type="checkbox"/> Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| • Makes sounds (to get attention, to point out needs) | <input type="checkbox"/> Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| • Makes sounds regarding needs                        | <input type="checkbox"/> Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| • Imitates sounds (dog, cat, cow, etc.)               | <input type="checkbox"/> Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| • Points out or says name                             | <input type="checkbox"/> Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |

- Points out or says age  Always  Sometimes  Never
- Points out or names objects  Always  Sometimes  Never

Explain any difficulties in these areas:

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### Receptive Communication Ability

- Recognizes own name when called  Always  Sometimes  Never
- Reacts or responds when spoken to  Always  Sometimes  Never
- Responds appropriately to simple one-step instructions  Always  Sometimes  Never
- Responds appropriately to two or three step instructions  Always  Sometimes  Never
- Responds appropriately to instructions  Always  Sometimes  Never
- Responds appropriately to instructions given in a small group situation (e.g. line up for snack, lunch, and/or to go home, or transition from reading to math, etc)  Always  Sometimes  Never
- Names objects when asked  Always  Sometimes  Never
- Points out objects and pictures correctly when asked  Always  Sometimes  Never
- Matches objects and pictures when asked  Always  Sometimes  Never

Explain any difficulties in these areas:

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### Dressing and Undressing

- Your student dresses, undresses without assistance  Yes  No  Sometimes
- Requires some assistance with dressing, undressing  Yes  No  Sometimes
- Requires total assistance with dressing, undressing  Yes  No  Sometimes

Explain any difficulties in these areas:

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### Eating and Drinking

- Does your student have any issues with chewing or swallowing?  Yes  No  Sometimes
- Requires pureed and/or soft foods from a spoon  Yes  No  Sometimes
- Uses a cup for drinking  Yes  No  Sometimes
- Chews semi-solid food  Yes  No  Sometimes
- Eats finger foods if pre-cut  Yes  No  Sometimes

- Uses a straw for drinking  Yes  No  Sometimes
- Uses utensils easily  Yes  No  Sometimes
- Unwraps and/or opens containers  Yes  No  Sometimes
- Opens drink containers  Yes  No  Sometimes

Explain any difficulties in these areas:

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### Motor Skills

Is student right or left handed? \_\_\_\_\_

- Moves objects from one hand to another  Yes  No  Sometimes
- Catches a rolled ball  Yes  No  Sometimes
- Catches a bounced ball  Yes  No  Sometimes
- Catches a ball from a short distance  Yes  No  Sometimes
- Catches a ball from a long distance  Yes  No  Sometimes
- Kicks a ball that is positioned on the ground  Yes  No  Sometimes
- Kicks a ball that is rolling  Yes  No  Sometimes
- Walks with some assistance  Yes  No  Sometimes
- Rides a bike  Yes  No  Sometimes
- Walks up and down steps with assistance  Yes  No  Sometimes

Explain any difficulties in these areas:

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### Social/Behavioral

- Demonstrates awareness of others  Yes  No  Sometimes
- Interacts with others  Yes  No  Sometimes
- Initiates interaction with others  Yes  No  Sometimes
- Does not interact with others  Yes  No  Sometimes
- Interacts cooperatively with one participant  Yes  No  Sometimes
- Interacts cooperatively with a small group of participants  Yes  No  Sometimes
- Takes responsibility for personal belongings  Yes  No  Sometimes
- Is aware of safety concerns when at school and out in the community (traffic, staying with group, etc.)  Yes  No  Sometimes
- Understands how to take turns  Yes  No  Sometimes
- Understands and engages in competitive behavior appropriately  Yes  No  Sometimes
- Aggressive in competitive behavior  Yes  No  Sometimes
- Passive in competitive behavior  Yes  No  Sometimes



- Appropriate communication and behavior in an argument/conflict situation (maintains emotional and physical control and verbally responds appropriately)  Yes  No  Sometimes
- Responds appropriately to authority  Yes  No  Sometimes
- Defies or actively resists authority  Yes  No  Sometimes
- Overly passive with authority  Yes  No  Sometimes
- High tolerance for frustration  Yes  No  Sometimes
- Average tolerance for frustration  Yes  No  Sometimes
- Low tolerance for frustration  Yes  No  Sometimes
- Displays frequent frustration behavior  Yes  No  Sometimes

Explain any difficulties in these areas:

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### Toileting/Hygiene Skills

- Wears a diaper  Yes  No  Sometimes
- Verbalizes need to use toilet  Yes  No  Sometimes
- Uses toilet with assistance  Yes  No  Sometimes
- Uses toilet with verbal instruction  Yes  No  Sometimes
- Uses toilet without assistance  Yes  No  Sometimes
- Washes hands with assistance  Yes  No  Sometimes
- Washes hands with verbal instruction  Yes  No  Sometimes
- Washes hands without instruction  Yes  No  Sometimes

Explain any difficulties in these areas:

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### Behavior Management

- Has your student ever been placed on a behavior plan? Yes  No
- Has your student been placed on a behavior plan in the last 6 months? Yes  No
- Does your student interact appropriately with peers? Yes  No

Please list technique that has been used at home or school to proactively manage your student's behavior (for example, describe a reward system, pinpoint things that may cause behavior changes, give words or phrases used to reduce negative behavior, etc.)

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Name some activities used to promote and/or reward positive behavior

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**Recreation**

My student has played and enjoys the following sports: (Indicate years of participation)

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What recreation skills would you like to see your student develop?

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Does student have a hobby? (Please describe)

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**Other Information** (If not applicable, please write N/A)

Please provide detailed information regarding any other information the school would need to know about your student:

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## SCHOOL HISTORY

Is student attending school now?      Yes       No

**Please list the schools your student has attended, beginning with the current school and the reason for leaving.**

School	Reason for leaving

Current reading level: \_\_\_\_\_

Does student enjoy reading?      Yes       No

Does student enjoy being read to?      Yes       No

***Check the appropriate box:***

<b>Reading</b>	Yes	No	N/A
Has problems reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has trouble with comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has trouble sounding out letters or words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spells poorly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loses place while reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slows down when reading aloud	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits poor sight word vocabulary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Language</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty with articulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has poor expressive language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses vocabulary poorly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses poor grammar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Handwriting</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has poor fine motor skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty tracing and drawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Reasoning</b>	Yes	No	N/A
Has poor logical reasoning or thinking skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty with abstract concepts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is slow in completing tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Mathmatics</b>	Yes	No	N/A
Has difficulty with math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has poor number concepts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has trouble with math computation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doesn't understand word problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't apply math skills to solve problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain any other reading problems:

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Explain any other math problems:

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Does student like school?    Yes             No

Does student enjoy any particular subject or activity at school?    Yes             No

If yes, please explain:

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Does student enjoy interacting with other students at school?    Yes             No

List anything that has caused problems for student in the classroom. Please try to be very specific and include issues as you think necessary (i.e. too loud, too many students, boring, couldn't see the board, etc.)

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Does student currently have an aide in the classroom? Yes  No

If yes, please explain:

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Was there any history of behavior problems in school? Yes  No

If yes, please explain:

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How were they handled?

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Did you agree with the way in which problems were handled? Yes  No

If no, what would you do differently?

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What do you like best about your student's current educational setting?

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What do you like least about your student's current educational setting?

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Please explain your educational goals and expectations for this student:

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What are your expectations for your student's school?

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Please give any additional information that you think might be important, or anything that might help your student succeed:

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Why do you think Easterseals Academy at Riverdale might be a good fit for your student?

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List student's interests and hobbies:

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List extracurricular activities in which student has participated:

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In what areas does student have the greatest difficulties:

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What are some of student's strengths?

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What are some things that motivate your student?