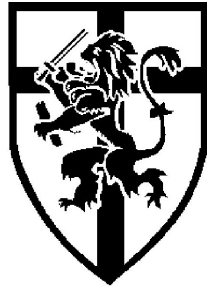


F.L. Chamberlain School



*Preparation for Life*

# **APPLICATION FOR ADMISSION**

## **F.L. Chamberlain School**

1 Pleasant Street PO Box 778

Middleborough, MA 02346

Telephone: 508-947-7825

Fax: 508-947-0944

[www.chamberlainschool.org](http://www.chamberlainschool.org)



**SCHOOL INFORMATION & HISTORY**

School District Information:

School Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Are they responsible for funding?       Yes                       No

Agency Involvement (if applicable): \_\_\_\_\_

Do you work with Educational Consultant(s) or Advocate(s)?:       Yes                       No

Name: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**School History:**

Current Grade: \_\_\_\_\_ School/Location: \_\_\_\_\_

Grade completed?    Yes    No

Grade(s): \_\_\_\_\_ School/Location: \_\_\_\_\_

Grade(s): \_\_\_\_\_ School/Location: \_\_\_\_\_

Grade(s): \_\_\_\_\_ School/Location: \_\_\_\_\_

Grade(s): \_\_\_\_\_ School/Location: \_\_\_\_\_

Grade(s): \_\_\_\_\_ School/Location: \_\_\_\_\_

Grade(s): \_\_\_\_\_ School/Location: \_\_\_\_\_

Grade(s): \_\_\_\_\_ School/Location: \_\_\_\_\_

Grade(s): \_\_\_\_\_ School/Location: \_\_\_\_\_

Strongest Subject: \_\_\_\_\_

Weakest Subject: \_\_\_\_\_

Does the student have learning disabilities?       Yes                       No

What is the student's future educational goals?       Complete High School    College

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

Is the student on IEP (Individual Educational Program)?       Yes                       No

Current IEP Cycle: \_\_\_\_\_

Suspensions/Expulsions:       Yes                       No

When? \_\_\_\_\_ Why? \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Hospitalizations/Treatment History (most recent to least recent):

Admission Date: \_\_\_\_\_ Length of Stay: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Precipitating Factors: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Admission Date: \_\_\_\_\_ Length of Stay: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Precipitating Factors: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Admission Date: \_\_\_\_\_ Length of Stay: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Precipitating Factors: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Admission Date: \_\_\_\_\_ Length of Stay: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Precipitating Factors: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\* Please submit a copy of Discharge Summaries from Hospitals or psychological evaluations.**



**REFERRAL INFORMATION**

How did you hear about our school?

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Website                | <input type="checkbox"/> Public Schools | <input type="checkbox"/> Advocates    |
| <input type="checkbox"/> Lawyer                 | <input type="checkbox"/> Conferences    | <input type="checkbox"/> Other Family |
| <input type="checkbox"/> Educational Consultant | <input type="checkbox"/> Hospital       | <input type="checkbox"/> Magazine     |
| <input type="checkbox"/> Program                | <input type="checkbox"/> Other: _____   |                                       |

Please list name of specific referral source indicated above (e.g. Educational consultant's name, magazine where you saw an advertisement, school): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Would you like us to send further information about the school?                       Yes       No

*If Yes, please fill out the following contact information:*

Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

**Please Check Below the Following Symptoms/Behaviors Which Apply:**

- \_\_\_\_\_ HEADACHES
- \_\_\_\_\_ HEART PALPITATIONS
- \_\_\_\_\_ EXCESSIVE ANXIETY
- \_\_\_\_\_ SUICIDAL IDEATION
- \_\_\_\_\_ SUICIDE ATTEMPTS  
(Indicate Methods)
- \_\_\_\_\_ SELF ANNIHILATIONS

- \_\_\_\_\_ ISOLATIVE
- \_\_\_\_\_ PSYCHOSIS:
  - A. HEARING VOICES
  - B. PARANOIA
  - C. RAPID THOUGH PROCESS
  - D. VISUAL HALLUCINATIONS
  - E. POOR REALITY TESTING

- \_\_\_\_\_ RUNNING AWAY
- \_\_\_\_\_ SLEEP DYSFUNCTIONS
  - A. INSOMNIA
  - B. FATIGUE
  - C. EXCESSIVE SLEEP
  - D. NIGHTMARES

- \_\_\_\_\_ POOR HYGIENE SKILLS
- \_\_\_\_\_ POOR APPETITE
- \_\_\_\_\_ OVEREATING
- \_\_\_\_\_ BULIMIA
- \_\_\_\_\_ ANOREXIA
- \_\_\_\_\_ PHYSICAL DISABILITY
- \_\_\_\_\_ SCAPEGOAT

**ACTIONS**

- \_\_\_\_\_ EXCESSIVE SOMATIC CONCERNS
- \_\_\_\_\_ RESTLESSNESS
- \_\_\_\_\_ LOW FRUSTRATION TOLERANCE
- \_\_\_\_\_ ATTENTION DEFICIT/HYPERACTIVITY

- \_\_\_\_\_ CRIMINAL ACTIVITY
- \_\_\_\_\_ KNOWN LEARNING DISABILITIES (describe):  
\_\_\_\_\_  
\_\_\_\_\_

- \_\_\_\_\_ DIARRHEA
- \_\_\_\_\_ CONSTIPATION
- \_\_\_\_\_ ENCOPRESIS
- \_\_\_\_\_ ENCOPRESIS
- \_\_\_\_\_ ENEURESIS
- \_\_\_\_\_ STOMACH PROBLEMS
- \_\_\_\_\_ FAINTING
- \_\_\_\_\_ SHORTNESS OF BREATH
- \_\_\_\_\_ DIZZINESS
- \_\_\_\_\_ ALCOHOL ABUSE
- \_\_\_\_\_ DRUG ABUSE (state drugs) \_\_\_\_\_
- \_\_\_\_\_ CRIES FREQUENTLY
- \_\_\_\_\_ PROBLEMS IN SCHOOL
- \_\_\_\_\_ VIOLENT/AGGRESSIVE
- \_\_\_\_\_ FIGHTING
- \_\_\_\_\_ FOLLOWER
- \_\_\_\_\_ DIFFICULTIES W/ AUTHORITY

- \_\_\_\_\_ OBSESSIVE/COMPULSIVE TENDENCIES (describe):  
\_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_ IDENTIFIES WITH FAILURE
- \_\_\_\_\_ STEALING
- \_\_\_\_\_ FREQUENT RESTRAINTS
- \_\_\_\_\_ SEXUAL ACTING OUT
- \_\_\_\_\_ VICTIM OF SEXUAL ABUSE
- \_\_\_\_\_ VICTIM OF PHYSICAL ABUSE
- \_\_\_\_\_ OPPOSITIONAL DEFIANT
- \_\_\_\_\_ DIFFICULTY WITH PEERS
- \_\_\_\_\_ POOR MEMORY
- \_\_\_\_\_ WITHDRAWN
- \_\_\_\_\_ DEPRESSED
- \_\_\_\_\_ LOW SELF-ESTEEM