RISE Center
Where Special Kids Shine
THE UNIVERSITY OF ALABAMA

Student Admission Forms

Date _____

Child's Name _____
(First) (Middle) (Last) (Preferred Name)

Date of Birth _____ Age _____ Sex _____

School District of Residence _____ Beginning Date at RISE_____

Language Spoken in Home _____ Home Elementary School _____

Parent/Guardian Contact Information:

Name _____ Home Phone _____
Relationship to Child (Please Circle): Mother Father Guardian

Cell Phone _____ Email _____

Address _____
(City) (State) (Zip)

Occupation _____ Business Phone _____

Marital Status (Circle One) ☐ Single ☐ Married ☐ Separated ☐ Divorced

Parent/Guardian Contact Information:

Name _____ Home Phone _____
Relationship to Child (Please Circle): Mother Father Guardian

Cell Phone _____ Email _____

Address _____
(City) (State) (Zip)

Occupation _____ Business Phone _____

Marital Status (Circle One) ☐ Single ☐ Married ☐ Separated ☐ Divorced

Please provide 2 proofs of residency (REQUIRED): ☐ Lease or Mortgage **and** ☐ Power or Water

Emergency Telephone Numbers

Name: _____

Relationship to Child: _____

Cell Phone: _____ Email: _____

Home Address: _____
Street Apt # City State Zip

Name: _____

Relationship to Child: _____

Cell Phone: _____ Email: _____

Home Address: _____
Street Apt # City State Zip

Name: _____

Relationship to Child: _____

Cell Phone: _____ Email: _____

Home Address: _____
Street Apt # City State Zip

Does this child have any siblings?

☐ Yes If yes, please list:

Name: _____Age: _____

Name: _____Age: _____

Name: _____Age: _____

Name: _____ Age: _____

☐ No

DEVELOPMENTAL MILESTONES

PLEASE COMPLETE THE CHART BELOW:

THE FIRST TIME YOUR CHILD WAS ABLE TO:	DID YOUR CHILD REACH THIS MILESTONE? IF SO, WHEN?
ROLL OVER	☐ Yes, approximate date: _____ ☐ No
SIT UP	☐ Yes, approximate date: _____ ☐ No
SLEEP THROUGH THE NIGHT	☐ Yes, approximate date: _____ ☐ No
SMILE	☐ Yes, approximate date: _____ ☐ No
BABBLE	☐ Yes, approximate date: _____ ☐ No
STAND ALONE	☐ Yes, approximate date: _____ ☐ No
TAKE FIRST STEP	☐ Yes, approximate date: _____ ☐ No
SAY FIRST WORD	☐ Yes, approximate date: _____ ☐ No
TOILET TRAINED	☐ Yes, approximate date: _____ ☐ No

MEDICAL HISTORY

1. During pregnancy, did mother experience any unusual illnesses, conditions, or accidents?
   ☐ Yes ☐ No
   If yes, please describe: _____

2. Please list in weeks the length of your pregnancy. _____weeks

3. Did you experience complications during delivery?
   ☐ Yes ☐ No
   If yes, please describe: _____

4. What was your child's birth weight? _____lbs. _____ozs.

5. What is your child's current weight? _____lbs _____ozs Length? _____ inches

6. Delivery: ☐ Vaginal ☐ C-Section

7. Delivered at (hospital name): _____

8. Did the baby have feeding problems?
   ☐ Yes ☐ No
9. If yes, please describe: _____

10. Did the baby have trouble breathing?
    ☐ Yes ☐ No
    If yes, please describe: _____

11. Was the baby on a ventilator?
    ☐ Yes ☐ No
    If yes, length of time: _____

12. Oxygen?
    ☐ Yes ☐ No

13. Did the baby have seizures?
    ☐ Yes ☐ No
    If yes, please describe: _____

14. Were there any other complications?
    ☐ Yes ☐ No
    If yes, please describe: _____

15. Describe any surgeries your child has had:

Surgery	Date	Hospital

16. Please list allergies that your child has (food, medication, substances):
    - _____
    - _____
    - _____
    - _____

17. Please list all **current medications**, including any over-the-counter and/or prescribed by a doctor. If **a medication is required during school hours**, a *School Medication Prescriber/Parent Authorization Form* must be completed and signed by the prescribing doctor and parent/legal guardian.

Medication	Dosage	Time Taken	Prescribing Doctor
1.			
2.			
3.			
4.			
5.			

18. Please check the illnesses that apply:

Illness	Yes	No	Age	Hospitalization
Measles				
Chicken Pox				
Mumps				
Strep Throat				
Scarlet Fever				
Tonsillitis				
Ear Infections				
Seizures				
Meningitis				

19. Were any of the above illnesses followed by noticeable changes in the child's behavior?

_____

Vision

Does your child have difficulty with vision? ☐ Yes ☐ No

If yes, please describe: _____

Date of most recent vision test: _____

Test results: _____

Place tested completed: _____

Hearing

Does your child have difficulty with hearing? ☐ Yes ☐ No

If yes, please describe: _____

Date of most recent hearing test: _____

Test results: _____

Place test completed: _____