# ROYER-GREAVES SCHOOL FOR BLIND

## 118 SOUTH VALLEY ROAD

## PAOLI, PENNSYLVANIA 19301

## FAX: 610-644-8164

# APPLICATION

**PROGRAMS**: _____EDUCATION _____RESIDENTIAL _____ATF _____RESPITE

Name of Individual:

_____

(Complete First, Middle, and Last Name)

County:

_____

State:

_____

Individual's Date of Birth:

_____

Date of Admission:

_____

Date of Discharge:

_____

All the questions asked on this application are important. The objective is to enable us to understand and help the individual in the event he/she is accepted into the program(s) at Royer-Greaves School for Blind. Each group of questions should be answered carefully and completely, to the best of his/her knowledge, be the person specified-parent, guardian, and or supports coordinator.

The school reserves the right to make changes, without prior notice, in the wording and/or contents of this application, depending upon changes occurring in status, terms and client eligibility.

**Royer-Greaves School for Blind**
**PHYSICIAN'S REPORT**

**Name of client:**_____ **Date of Birth**_____

**Address:**_____

**Height**_____ **Weight**_____ **BP**_____ **Pulse**_____

**1. Diagnosis:**_____

**2**. Has the applicant had any history of the following? If so, give date of occurrence and state whether mild or severe.

Scarlet Fever_____ Pneumonia_____ Measles_____ German Measles_____
Spinal Meningitis_____ Typhoid Fever_____ Whooping Cough_____
Encephalitis_____ Chickenpox_____ Influenza_____ Mumps_____
Hepatitis (type (S))_____ Heart Disease_____ Bronchitis _____
Smallpox_____ Diphtheria_____ Tuberculosis (any form)_____
Chorea_____ Any other disease _____ Headaches_____ Enuresis_____
Seizures (spells) any form_____ Vomiting attacks_____ Tonsillitis _____
Any kind of Brain disease_____ Digestive Disturbances _____ U.R.I._____
Otitis media_____ Serous Otitis media_____ Swollen glands_____
Tonsillectomy and adenoidectomy_____

3. Given date of serology and result _____ Successful vaccination_____
4. Mantoux TB Test _____ Date_____ Neg._____ Pos. ____ What is client's blood type?
5. Hepatitis B Surface Antigen test date_____ Results_____
6. Give dates of poliomyelitis immunizations – 3 doses needed:
   1. _____ 2. _____ 3. _____ Booster_____
7. Give dates of DPT or DT immunizations–3 doses needed and DT booster (if last dose 10 yrs. Ago)
   1. _____ 2. _____ 3._____ Booster_____
8. Immunizations: Rubella _____ Measles – 2 doses needed: 1. _____ 2. _____
Mumps _____ Others_____
9. Students not enrolled in education placement prior to 9/1/97 must have Hepatitis B vaccine (3 doses needed): 1. _____ 2. _____ 3. _____
10. List allergies _____
11. Diet:_____
Chewing problem(s)_____ Swallowing problem(s) _____
Is videofluoroscopy recommended?_____
Recommended techniques for safe swallow:_____
Additional recommendation(s):_____
12. What is the condition of the client's teeth/gums?_____
13. Is the client in good health and free from contagious disease? If not, precautions to prevent spread of disease._____
14. Has the client ever sustained any severe accident? Has (s)he ever had any head injury (concussion, fractured skull, unconsciousness)? Give details:_____

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Emergency Medical Info:_____

15. Was there any birth injury?_____

16. If any operations have every been performed on client, give complete information regarding them:_____

17. Give any other information concerning client or conditions in his/her family which may have a bearing on placement:_____

18. List any medication – name, strength, dosage, purpose, supply, prescription, special instructions

19. Physical limitations:_____

20. Medical screening (please indicate by an X)

| | **Normal** | **Abnormal** | **If abnormal-explain** |
|---|---|---|---|
| Eyes | | | |
| Ears/Nose | | | |
| Mouth/Throat | | | |
| Lungs | | | |
| Cardio Vascular | | | |
| Abdomen | | | |
| Genitalia/Breasts | | | |
| Extremities/Joints | | | |
| Spine | | | |
| Skin/Lymph Nodes | | | |
| Prostate/Gynecological | | | |

21. Visual Acuity: Normal_____ Abnormal_____
22. Hearing (Audiometry or Equivalent): Normal _____ Abnormal _____
23. Health maintenance needs:_____
24. Recommended lab work:_____
25. Personal health recommendations (exercise, hygiene, weight control)_____
_____

26. This person is in need of ICF-MR level of care_____

Date of examination _____ Signature of Physician _____
Printed name, address and telephone number of physician_____
_____

## OPHTHALMOLOGIC REPORT

## Application for Enrollment in Royer-Greaves School for Blind

The following questions must be answered in duplicate by an *Ophthalmologist, (State Certified)*

Name and Address of attending physician of applicant _____

_____

*Please type or print in all information*

Name of Applicant_____ Date of Birth_____

Address_____
(Street and Number) (City or Town) (State) (County)]

Is there any history of consanguinity or heredity in relation to visual impairment? If so, state briefly:

_____

_____

If there are any members in applicant's family who are visually defective, list below: Note Living (L) or dead (D).

| Relationship | Name | Age | Duration of Defect |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Names and addresses of other attending physicians of applicant_____

_____

Diagnosis: O.D._____

O.S._____

Give exact or reasonable etiologic factors responsible — O.D._____ O.S._____

Date of accident or onset of disease leading to disability — O.D._____ O.S._____

If traumatic or chemical indicate the article or chemical — O.D._____ O.S._____

Secondary diagnosis — O.D._____ O.S._____

If operated on, give type of operation and date — O.D._____ O.S._____

If applicant has received hospital treatment for eye condition, state when, where and by whom

_____

Describe briefly the external Appearance of the eyes (oblique illumination and loupe, etc.)

O.D._____

O.S._____

Describe briefly the fundus if it can be seen

O.D._____

O.S._____

| | | Without Glasses | | With Best Correcting Lens | |
|---|---|---|---|---|---|
| Central Visual Acuity by Snellen Notation | O.D._____ | Distant_____ | Near_____ | Distant_____ | Near___ |
| | O.S._____ | Distant_____ | Near_____ | Distant_____ | Near___ |

If vision is too low to be taken at test card, record the distance at which hand movements (HM) can be seen: Shadows (S), Light Perception (LP), Blind (B).

If visual fields are obtainable with white test object (designate size) hand or light, describe briefly

O.D._____

O.S._____

Give eye history, briefly_____

Prognosis_____

Give brief recommendations for eye care and treatment_____

Date of Examination_____

Signature of Ophthalmologist_____

Address_____

For admission to a Pennsylvania Residential School for the Blind, the definition of the Federal Social Security Authority is used in so far as it relates to the visual acuity of the applicant. This definition is "who has not more than 20/200 of visual acuity in the better eye with correcting lenses; or visual acuity greater than 20/200 but with a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than twenty degrees."

# FAMILY HEALTH HISTORY

| **Individual's Name:** | **Telephone: ( )** |
|---|---|
| **Address:** | |
| **Date of Birth:** | **SSN:** |

In order to provide quality medical services to an individual, it is important to be aware of any familial tendencies toward certain illnesses. When serving a population that at times cannot relate their own family histories, it becomes necessary for an informed famiy ember to help complete an individual's lifetime medical history summary. This must be done in order to inform a primary care physician or other health care professionals about those conditions that are more likely to occur within an individual so that proper testing and screening can be done. For example, when there is a family history of breast cancer, mammograms are done at an earlier age than those with no family history of the disease. This is true for many conditions that may not present clear symptoms or when a person with mental retardation may not be able to verbalize specific symptoms of illness.

All information will become a part of the individual's confidential record and will be available only to those on a "need to know" basis.

*Thank you for your time and interest in helping us to complete the lifetime medical history for your relative.*

| **Name of Individual Requesting Information:** | **Telephone: ( )** |
|---|---|
| **Agency/Organization Name:** | **Fax Number:** |

## Please complete the following information: Please print

| **Mother's Name:** | Date of Birth: |
|---|---|
| Living? ☐ Yes ☐ No | |
| If deceased, cause of death: | |
| If deceased, at what age? | |
| **Father's Name:** | Date of Birth: |
| Living? ☐ Yes ☐ No | |
| If deceased, cause of death: | |
| If deceased, at what age? | |
| Siblings? ☐ Yes ☐ No | |
| If "Yes", number of siblings: | |
| Is there any family history of mental problems? ☐ Yes ☐ No<br>If "Yes", please identify relationship of family member(s) and diagnosis/description of mental illness: | |

## FAMILY HEALTH CHART

**Please check the appropriate box for any pertinent information:**

| Disease Type | Mother | Father | Sibling | Sibling | Sibling | Mother's Family | Father's Family |
|---|---|---|---|---|---|---|---|
| Cancer (Note each type) | | | | | | | |
| TB | | | | | | | |
| Heart Disease | | | | | | | |
| Stroke | | | | | | | |
| High Blood Pressure | | | | | | | |
| High Cholesterol | | | | | | | |
| Lung Problems | | | | | | | |
| Stomach Problems | | | | | | | |
| Thyroid Problems | | | | | | | |
| Diabetes | | | | | | | |
| Kidney Diabetes | | | | | | | |
| Sickles Cell Disease | | | | | | | |
| Anemia | | | | | | | |
| Migraine Headaches | | | | | | | |
| Epilepsy | | | | | | | |
| Arthritis | | | | | | | |
| Deafness | | | | | | | |
| Cataracts | | | | | | | |
| Glaucoma | | | | | | | |
| Other (describe) | | | | | | | |
| Other (describe) | | | | | | | |
| Other (describe) | | | | | | | |

| | |
|---|---|
| **Comments:** | |
| **Name of Family Member Providing Information:** | **Relationship:** |
| **Address:** | |
| **Telephone: ( )** | **Date:** |

# Royer-Greaves School for Blind

118 South Valley Road
Paoli, PA 19301
Phone (610) 644-1810
Fax (610) 644- 8164


Student name: _____

Date: _____

I affirm that _____ has/has not previously been suspended or
(name of student)
expelled from any public or private school of this Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person, or for any act of violence committed on school property.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Date | Place | Act | Result |
| _____ | _____ | _____ | _____ |
| Date | Place | Act | Result |

This statement is accurate and true in accordance with Pennsylvania School Code, Act 26 of 1995.

_____ _____
Signature of parent/guardian Date

_____ _____
Witness Date

**Royer-Greaves School for Blind**
**118 South Valley Road**
**Paoli, Pa 19301**

Please paste a recent photo of child here

**Identifying Information:**

| | |
|---|---|
| **Name:** | **Date:** |
| (Last) (First) (Middle) | |
| **Social Security Number:** | **Date of Birth:** |
| **Place of Birth:** | |
| (Hospital, city, county, state) | |
| **Religious Preference:** | **Nickname:** |

**Information About Client's Father or Stepfather** (Circle One)**:**

| | |
|---|---|
| **Name:** | **Date of Birth:** |
| (Last) (First) (Middle) | **SSN:** |
| **Address:** | **Home Phone:** |
| | **Work Phone:** |
| | **Cell Phone:** |
| **Occupation:** | **Place of Employment:** |
| | |

**Information About Client's Mother or Stepmother** (Circle One)**:**

| | |
|---|---|
| **Name:** | **Date of Birth:** |
| (Last) (First) (Middle) | **SSN:** |
| **Maiden Name:** | **Home Phone:** |
| **Address:** | **Work Phone:** |
| | **Cell Phone:** |
| **Occupation:** | **Place of Employment:** |
| | |

**Insurance Information:**

| | |
|---|---|
| **Insurance Company:** | **Type of Coverage:** |
| | |
| **Policy Number:** | **Phone Number:** |
| | |
| **If Medical Assistance,**<br>**Please give Number and Board of Assistance Address:** | **Date of Coverage:** |
| | |
| | |
| | |

**Emergency Contact Information:**

| **Name:** | **Phone:** |
|---|---|
| **Address:** | **Relationship:** |
| | |

**Family and Social History:**

1. Prior Placement:

   ___Special Education Classes Public School
   ___Regular Grade Placement
   ___At Home
   ___Regular Kindergarten Placement
   ___Private Day School
   ___Other_____

2. Social Behavior: (Please cite incidents on back)

   ___No history of behavioral difficulties
   ___History of property destruction in the home
   ___History of property destruction in the community
   ___History of sexual behavior issues
   ___History of physically aggressive behavior
   ___History of fire setting
   ___Other_____

3. Income to Client:

   ___Supplemental Security Income Amount_____Claim #_____
   ___Social Security Benefits Amount_____Claim #_____
   ___Other Amount_____Claim #_____

4. Marital Status of Natural Parents:

   ___Married
   ___Separated
   ___Divorced
   ___Single

5. Number of Living Siblings: _____

| **Name of Sibling** (Include deceased siblings) | **Date of Birth** | **Age** | **Education** |
|---|---|---|---|
| | | | |
| | | | |
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**Developmental History**

1. Birth History:

___Normal delivery
___Caesarean section
___Induced labor
___Operative delivery
___Post mature
___Premature
___Presentation – breech

Length of Pregnancy_____
Length of Labor_____
Was the Client injured at birth?_____
Comments_____
_____

2. Condition at Birth:

___Normal
___Artificial respiration
___Asphyxia
___Convulsion
___Cyanosis
___Incubator
___Paralysis
___Other (please describe)_____

3. Neurological Development:

When did Client : Control head movement_____
Roll over_____
Sit up_____
Crawl_____
Creep_____
Take first steps_____
Walk alone_____
Swallow_____
Eat solid food_____
Say first words_____

4. Physical Disabilities:

___Hearing
___Sight
___Speech
___Motor Skills

5. Corrective Devices:

___Hearing Aid
___Glasses
___Dentures
___Braces
___Orthopedic Devices
___Other_____

6. Convulsive Disorders:

___No convulsive disorder
___Petit mal seizures
___Grand mal seizures
___Other_____

7. Other Disabling Conditions:_____
_____
_____

8. Nutritional Status at Time of Admission:

___Well nourished
___Adequately nourished
___Poorly nourished
___Malnourished
___Obese

Height_____ Weight_____
Eye Color_____ Hair Color_____

When was child's retardation first noticed?_____
_____
Was there any predisposing conditions?_____
_____

**Behavioral History:**

1. Level of Measured Intelligence:

   ___Level 1 – Borderline
   ___Level 2 – Mild
   ___Level 3 – Moderate
   ___Level 4 – Severe
   ___Level 5 – Profound

2. Ambulation:

   ___Has not yet learned to walk
   ___Ambulatory
   ___Partially ambulatory, due to disability
   ___Non-ambulatory, due to disability

3. Toilet Training:

   ___Completely
   ___Trained except for nocturnal enuresis
   ___Partially trained
   ___Not trained

4. Eating Skills:

   ___Feeds self completely
   ___Feeds self partially
   ___Does not feed self

5. Dressing Skills:

   ___Dresses self completely
   ___Dresses self partially
   ___Does not dress self

6. Language Skills:

___Speaks in sentences
___Speaks only in words
___Babbles
___No speech

7. Diagnosis:_____
When _____Where_____
By Whom_____
(Please request that report be sent to us)

8. Has the client been examined by a psychologist?_____
When_____Where_____
By Whom_____
(Please request that report be sent to us)

9. Has the client been examined by a neurologist?_____
When_____Where_____
By Whom_____
(Please request that report be sent to us)

10. Has the client been examined by a psychiatrist?_____
When_____Where_____
By Whom_____
(Please request that report be sent to us)

11. Has the client been examined by an audiologist?_____
When_____Where _____
By Whom_____
(Please request that report be sent to us)

12. Educational History:

| School Attended | Type of Placement | Dates | Reason for Termination |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*Please have last school attended submit school report to us.

13. Reading Level_____

14. Math Level_____

**Placement Request:**

1. Funding will come from:

   ___Parents
   ___Parents and relatives
   ___Department of Public Welfare
   ___Mental Health/Mental Retardation_____
   ___Education (County)
   ___Supplemental Security Income
   ___Other

2. Reason for requested placement: Residential placement needed to further facilitate development of ADL, basic communication and socialization skills.

   Legal Status upon Admission:
   ___Voluntary
   ___Ward of the State
   ___Respite

3. Goals to be achieved by placement:_____

   *For agency use only: Give name and address of parent or agency to be involved with child's progress, planning, and visiting:

**Consent List:**

Medical release for emergency treatment by school doctor or nearest hospital

Signature_____
Date_____

Signature of Person completing this form:

(Name) (Date)

(Relationship to Client)

**INFORMATION SHEET**

PICTURE
(FACE)

PICTURE
(FULL)

**GENERAL INFORMATION:**

| | | |
|---|---|---|
| **Resident:** | **Date of Admission:** | |
| **Address:** | **Phone Number:** | |
| | | |
| **SSN:** | **Date of Birth:** | |
| **Sex:** | **Height:** | **Eye Color:** |
| **Age:** | **Weight:** | **Hair Color:** |
| **Race:** | **Language Spoken:** | **Religion:** |
| **Functioning Level:** | **Legal Status:** | |
| **Citizenship:** | **Marital Status:** | |
| **Identifying Marks:** | | |

**PROGRAM INFORMATION:**

| | |
|---|---|
| **Program Director:** | |
| **Case Manager:** | **Case Number:** |
| **Day Program:** | **Contact Person:** |

**CONTACT INFORMATION:**

| | |
|---|---|
| **Parent/Next of Kin:** | **Phone:** |
| **Address:** | |
| | |
| **Parent/Next of Kin:** | **Phone:** |
| **Address:** | |
| | |
| **Representative Payee:** | **Phone:** |
| **Advocate:** | **Phone:** |

**MEDICAL INFORMATION:**

| | |
|---|---|
| **Primary Physician:** | |
| **Dentist:** | |
| **Optometrist/Opthalmologist:** | |
| **Neurologist:** | |
| **Gynecologist:** | |
| **Other Specialists:** | |
| | |
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| **Major Medical Complications:** | |
| | |
| | |
| | |
| **Allergies:** | |
| **Other Concerns:** | |
| | |
| | |
| | |
| **Medical Assistance #:** | **Medicare #:** |
| **Other Insurance:** | |

| | |
|---|---|
| **Date of Transfer:** | **Date of Discharge:** |
| **Transfer Address:** | **Discharge Address:** |
| | |
| | |
| **Contact Person:** | |