



**2009—2010**  
**Hearing Impairment**  
**Preschool Enrollment Form**

**Date Enrolled:** \_\_\_\_\_

<p>I would like for my child to attend : check all that apply</p> <p>_____ 2 yr olds T/TH (9:30-12:30)</p> <p>_____ 3's &amp; 4's yr olds M/W/TH (9:30-12:30)</p> <p>_____ Full time care M-F (7:00 am - 5:20 pm)</p> <p>_____ AM Care only 7:00 am - 9:30</p> <p>_____ PM Care only 12:30 to 5:30 pm</p>	<p>Please Check to acknowledge that you have read the following statement:</p> <p>_____ As a condition of enrollment I understand that it is mandatory to attend weekly AVT-Speech therapy with a therapist at the Hearing School with my child.</p>
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**Student Information:**

Student Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Student Address: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

**Parent Information:**

Mother's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Pager: \_\_\_\_\_ Cell: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Pager: \_\_\_\_\_ Cell: \_\_\_\_\_

Marital Status of Parents: \_\_\_\_\_ Custody Of Student: \_\_\_\_\_

Which School District do you live in? \_\_\_\_\_

Primary caregiver of student in non-school hours? \_\_\_\_\_

**Brothers and Sisters of Student:** How many siblings? Names and ages:

**Child's Educational Information:**

Is your child receiving any educational services from your school district? If so, please describe.

Have you had an ARD? NO or Yes if yes, please explain the outcome of the ARD.

Is your child receiving any type other types of therapy, speech, or OT? If so, please describe.

What services has your child received in the past, please include services from ECI and or private sources:

Considering your child's age, are there any developmental issues or concerns you can tell us about?

**Child's Audiological History:**

Diagnosis's of Hearing Loss or Cause, If Known: \_\_\_\_\_

Degree of Loss:           **Right Ear:**    Normal      Mild      Moderate      Severe      Profound

**Left Ear:**    Normal      Mild      Moderate      Severe      Profound

Did they pass the newborn hearing screening?    Yes    or    No    (if NO, briefly explain what you were told)

What age was the child identified? \_\_\_\_/\_\_\_\_/\_\_\_\_    Age of amplification? \_\_\_\_/\_\_\_\_/\_\_\_\_

What amplification device(s) are being used? \_\_\_\_\_

Activation date(s)    Hearing Aides \_\_\_\_/\_\_\_\_/\_\_\_\_

1st CI Left or Right \_\_\_\_/\_\_\_\_/\_\_\_\_    2nd CI Left or Right \_\_\_\_/\_\_\_\_/\_\_\_\_

How many hours a day do they use their amplification device? \_\_\_\_\_

Agencies, Clinics, or doctors you have seen ( names and phone):

Pediatrician \_\_\_\_\_

ENT: \_\_\_\_\_

Audiologist: \_\_\_\_\_

ECI: \_\_\_\_\_

Speech Therapist: \_\_\_\_\_

OTHER: \_\_\_\_\_

Any deaf family members? \_\_\_\_\_    Other languages used in the family: \_\_\_\_\_

Was the birth normal? Yes \_\_\_\_ No \_\_\_\_    If NO, describe: \_\_\_\_\_

What illnesses has your child had since birth, when? \_\_\_\_\_

IF your child is an implant user were there any surgical or post-surgical complications with your child's implantation?

List of any other handicaps: \_\_\_\_\_

**Other information or concerns:**

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