S.T.E.P's Developmental Academy, Inc.

Application for Admission

Date of Application_____ Time_____

Record#_____

Name:

_____
(last) (middle) (first)

Preferred Name:_____
Maiden Name:_____
Address:_____
City/Town: _____
State: _____Zip code: _____

Phone#_____ /_____/_____
(home) (work) (mobile)

Date of Birth:_____
Social Security #:_____
County of Residence:_____
Male:_____ Female:_____ Marital Status_____
Race:
____ White
____ Black
____ American Indian, Alaskan Native
____ Asian
____ Pacific Islander
____ Other;_____

Ethnicity:
____ Not Hispanic
____ Hispanic, Mexican American
____ Hispanic, Puerto Rican
____ Hispanic, Cuban
____ Hispanic, Other

Primary Language: English_____ Spanish_____
Other (specify)_____
Interpreter needed: Yes____ No____

Insurance Company: _____
Policy Number:_____
Expiration Date: _____

Medicaid Number:_____

Highest Grade Completed:_____
School Contact Person: _____

Legal Guardian:_____
Guardian____ Next of Kin:___(please check)
Name:_____
Address:_____
City/Town: _____
State: _____ Zip Code:_____
Phone#_____ /_____/_____
(home) (work) (mobile)

Who referred you to our agency? (check one)
Private Physician_____ Community Agency_____
Family/Friends _____ Court _____
Self _____ School _____
None _____ Other _____

Reason for Coming to our Agency:
_____

_____

Father Name:

_____
(last) (middle) (first)
Address:_____
City/Town: _____
State: _____ Zip Code:_____

Phone#_____ /_____/_____
(home) (work) (mobile)

Mother Name:

_____
(last) (middle) (first)
Address:_____
City/Town: _____
State: _____Zip Code:_____

Phone#_____ /_____/_____

	(home) (work) (mobile)
Application for Admission Consumer Name:	**Record #:**

** In Case of Emergency Contact:
(1.)Name:_____
Address:_____
City/Town: _____
State: _____Zip Code:_____

Phone#_____ /_____/_____
(home) (work) (mobile)

In Case of Emergency Contact:
(2.)Name:_____
Address:_____
City/Town: _____
State: _____ Zip Code:_____

Phone#_____ /_____/_____
(home) (work) (mobile)

List any known allergies/hypersensitivities or any drugs you cannot take:

_____
_____
_____

Medical History:

1. Is Consumer currently under a doctor's care?
   No:____ Yes:___ (if yes, please explain why)

_____
_____

2. Any previous hospitalizations or operations?
No____ Yes___ (if yes, please list the date and procedure) _____
_____
_____

Any history of significant previous disease or recurring illness? Yes___ (please explain) No___
Heart Trouble: Yes___ No___
Convulsions/Seizures: Yes____ No____
Other:_____
_____
_____

Medication:
Does consumer take medication?

List of Medications:
1. _____

2. _____

3. _____

4._____

Emergency Information:

Preferred Hospital:
_____
Address:_____
City/Town: _____
State: _____Zip code:_____

Phone#:_____ /_____
(office) (fax)

Physician:
_____
Address:_____
City/Town: _____
State: _____Zip code:_____

Phone#:_____ /_____
(office) (fax)

Dentist:
_____
Address:_____
City/Town: _____
State: _____Zip code:_____

Phone#:_____ /_____
(office) (fax)

Psychologist/Psychiatrist/Therapist:
_____
Address:_____
City/Town: _____
State: _____Zip code:_____

Phone#:_____ /_____

Yes_____ No_____	(office) (fax)

Application for Admission Consumer Name: Record #:

Emergency Information: If Emergency Medical care needs to be provided and parent, legal guardian or an emergency contact cannot be reached, I give permission for S.T.E.P's Developmental Academy' staff (care provider) or designated person to obtain medical care, and/or treatment for consumer.

**** Emergency Contact Information/Consent for Release of Consumer: In case of emergency, S.T.E.P's Developmental Academy, Inc. will contact the individuals listed as emergency contacts if we are unable to reach parents or legal guardian. In addition, these two individuals are permitted to transport consumer in emergency situations.**

Consumer Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Witness Signature/Title: _____ Date: _____