HEARTSONG®

APPLICATION

(To be completed by a parent or guardian)

Please ***PRINT*** all information.

Please submit a copy of your child's most recent IEP with your application

Child's Name:____Date of Birth: __________

First Last

Gender: _____ Race/Ethnicity: ____________

Last (4) Four Digits of Child's Social Security#: ___________________

Language(s) spoken at home: ____

Which facility will your child attend: Yonkers White Plains Either

Mother's Name:_____________________________ Occupation:____________________

Address: __________________________________ Home phone:___________________

__________________________________ Work phone:____________________

E-mail: _____________________________________ Cell phone:____________________

Father's Name:_____________________________ Occupation:____________________

Address (if different from above):

__________________________________ Home phone:____________________

__________________________________ Work/Cell phone:__________________

Other Children in Family:

Name(s): _______________________________ Date of Birth:__________________

__________________________________ Date of Birth:__________________

_______________________________ Date of Birth:__________________

What is your child's diagnosis/special need? Who made this diagnosis? At what age?

___

Who referred you to Heartsong?

Is your child currently on medication? If yes, please specify medication and purpose.

Are there any other health issues we should be aware of?

Does your child attend a school program?   ___ Yes   ___ No

If Yes, name of school and type of program:

____

If No, does your child have a home-based program?   ___ Yes   ___ No

Other therapy services
received:____

Describe your child's communication skills (e.g., understanding, speech, reading and writing, ability to make needs known)
____

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Describe your child's social skills (e.g., relationships with peers and adults, play routines, ability to make transitions)

Describe your child's daily living skills (e.g., caring for self, toileting)

Describe your child's gross motor skills (e.g., walking, running, jumping, keeping balance, and coordination)

Describe your child's fine motor skills (e.g., manipulating objects, drawing)

____

Describe your child's capabilities, interests, and special characteristics:

____

____

____

____

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Describe any emotional or behavioral issues: ____

____

Describe any sensory issues: ____

____

____

Parent's Signature: --Date: _______________

Heartsong, Inc., charges program fees that are based upon family income

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Rev. 11-12-09

Physician's Authorization

This release is valid for up to three (3) years from the date of signature unless otherwise noted.

Patient Name:____Date of Birth:________________

1. Patient Diagnosis:____
____
2. Does this patient have any physical disabilities related to:

	Disability	Extent
Ambulation	__________________	_______________________
Hearing	__________________	_______________________
Vision	__________________	_______________________
Speech	__________________	_______________________
Balance & Coordination	___________________	________________________

3. Patient History:
   a. Chronic diseases: Heart_______Diabetes______other___________
   Describe:____
   b. Seizures____________degree____________frequency____________
   Known Antecedent____
   c. Frequent colds____________________frequency________________
   d. Ear infections_____________________frequency________________
   e. Allergies (food restrictions)___________________________________
   f. Hepatitis_____________________________type:_________________
4. Has this patient benefited from all recommended immunizations:________________
   a. Diphtheria/Tetanus Toxoid (4 doses) Dates:________,_______,_______,_______
   b. Oral Polio Vaccine (3 or more doses) Dates: _______,________,_______,_______
   c. Live Measles Vaccine (2 doses) Dates:___________ ___________________
   d. Live Rubella Vaccine (2 doses) Dates:____________ ___________________
   e. Live Mumps Vaccine (2 doses) Dates:____________ ___________________
   If no, what immunizations are lacking: ___________________________________
   ____
5. I recommend this patient for:
   a. ______full participation in the Heartsong program
   b. ______participation in the Heartsong program with the following limitations:____
   ____
   c. ______no participation in any of Heartsong's programs due to:
   ____
   ____
6. Signature of Physician:____
   Date: ____

Return to: Heartsong, Inc.
P.O. Box 195, Bronxville, NY 10708 or
590 Central Park Avenue, Suite C, Scarsdale, NY 10583

FOR OFFICE USE ONLY
Date Completed:__________________________ Date Expired:__________________________

CONFIDENTIAL

Information Regarding Persons with Seizure Disorder

Please Print

Name:____

Doctor's name and phone number:____

Type of seizure:____
(briefly describe)____

Typical duration:____

Is there an aura before the seizure occurs (an aura is an usual sensation or feeling that occurs before the seizure i.e.
seeing colors, hearing sounds, strange taste or smell or an urgent need to get to safety):___
if so, what:____

Date of last seizure:________________# of seizures:_________(within the last year)
How would you like our staff to respond to a seizure while your son/daughter is at program?

Procedure:

_______ Call 911 immediately
_______ Call 911 if convulsions last more than_________minutes
(fill in number)
_______ Call parents/guardian to report seizure immediately following seizure (if individual needs to go home or hospital)
_______ Handle seizure by cushioning head and creating a safe surrounding – no follow up necessary

Any other comments:
____
____
____

__________________________ __________________________
Parent/Guardian/Agency Signature Date

Please let us know if this information should change

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