FOUR WINDS COMMUNITY APPLICATION FOR ADMISSION

Date of Application: ____/____/____

Applicant's Name: ____

Date Of Birth: ____/____/____ **Present Age:** ________

Home Address: ____

City / State / Zip : ________________________/________/____________

Contact Person: ____

Telephone: (______)____________________________________

Fax: (______)____________________________________

SOCIAL ATTITUDES

Please make a check mark in the appropriate box, for each category, that best describes the capability level of the applicant. This will assist us in determining the eligibility of the applicant for possible admission into our lifesharing-community program.

Relationship to others:	☐ Works and plays well with others. ☐ Mostly gets along well with others. ☐ Does not get along with others.

Attitude towards group control:	☐ Responds well to group control. ☐ Occasionally resents group control. ☐ Usually is nonconforming.

Attention needs:	☐ Requires an inordinate amount. ☐ Satisfied with reasonable amount. ☐ Self-independent & requires little.

Emotional stability:	☐ Frequent temper outbursts. ☐ Occasional temper outbursts. ☐ Usually well controlled.

Aggressive tendencies:	☐ Overly & continually aggressive. ☐ Moderately aggressive. ☐ Does not assert himself/herself.

Social participation:	☐ Participates actively in group projects. ☐ With encouragement, will participate. ☐ Shy, withdrawn, does not participate.

Observable social “activeness”:	☐ Usually restless or hyperactive. ☐ Normally energetic & outgoing. ☐ Usually lethargic.

SELF-DEVELOPMENT AND MATURITY

Please rate the applicant in each of the following areas by checking the appropriate box. Elaborate on any *Average*, *Fair*, or *Poor* ratings in the “Additional Comments” section on the last page of this form.

	Excellent	Very Good	Average	Fair	Poor
Social maturity:					
Emotional maturity:					
Visual perception and understanding:					
Personal hygiene:					
Grooming Skills					
Personal self-care:					
Dressing skills:					
Eating skills:					
Toileting:					
Motoric Skills					
Gross motor skills:					
Fine motor skills:					

IQ Level_______ **Reading Level_______** **Math Level_______**

GENERAL INFORMATION QUESTIONS

1) Does the applicant have any dietary restrictions? (*If yes, what kind?*)

2) Does the applicant have a tendency to wander off or run away? (*If yes, please explain.*)

3) Does the applicant exhibit any forms of obsessiveness, impulsiveness, or hyperactivity? (*If yes, please elaborate.*)

4) Does the applicant have any SELF-ABUSIVE or SEXUAL behavior disorders or problems? (If yes, please explain.)

5) Does the applicant have or display any AGGRESSIVE, MANIPULATIVE, or ABUSIVE tendencies or behaviors, or have outbursts of this nature? (*If yes, describe in detail. Be sure to include information about frequency and severity.*)

6) Does the applicant have any sleeping problems or difficulties, such as difficulty going to sleep, difficulty staying asleep, or wandering at night? (*If yes, please elaborate*.)

7) Does the applicant understand his/her special needs and accept his/her limitations? *Please discuss applicant's feelings on this issue*.

8) Please describe any problems the applicant may have with COMPREHENSION, HEARING, SPEECH, or VISION.

9) Please comment on the applicant's specific disability and special needs.

10) Please list the applicant's interests, abilities, and talents.

If you have any additional comments, or want to add something of importance that will help us to meet the needs of the applicant, please use the space below.

ADDITIONAL COMMENTS

Completed by: ______________________ ______________________

(*Signature*) (*Printed Name*)

Relationship to applicant: ______________________

Four Winds Community
Applicant's Health Status Report

(F.W.C. OFFICE USE ONLY)	Date of Admisstion: ______________

Date of Application: ______________

Name of Applicant: ____

Date of Birth: ______________

GENERAL MEDICAL INFORMATION

Please list any present illnesses and medical issues:

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Please list all current medications and doses:

Medication	*Dose*	*When Taken*

Please list previous medications and doses:

Medication	*Dose*	*When Taken*

Please list previous illnesses:

Illness	*Date*

Please list all previous surgical procedures:

Procedure	*Date*

Please attach complete immunization record, and also fill in the blanks below:

Last Three Tuberculin Tests:

Type of Test	*Date*	*Result*

Dates of Last Three Tetanus Shots: __________

____

____

Has the applicant ever had, or is there a family history of, any of the following conditions?
(*If yes, please ✓ applicable line*.)

	Applicant	*Family*	*None*
Developmental disability	________	________	________
Epilepsy	________	________	________
Heart attack or CV disease	________	________	________
Stroke	________	________	________
High blood pressure	________	________	________
Diabetes	________	________	________
Pneumonia	________	________	________
Tuberculosis	________	________	________
Asthma	________	________	________
Emphysema	________	________	________
Hay fever	________	________	________
Thyroid disease	________	________	________
HIV-positive status	________	________	________
Ulcers	________	________	________
Cancer	________	________	________
Jaundice	________	________	________
Hepatitis	________	________	________
Concussion or other head injury	________	________	________
Mental illness	________	________	________
Rheumatic fever	________	________	________
Blood transfusion	________	________	________
Allergic reaction to anesthesia	________	________	________
Allergic reaction to latex	________	________	________
Allergic reaction to mold, dust mites, or animals	________	________	________
Glaucoma	________	________	________
Heart murmur	________	________	________
Joint replacement	________	________	________
Need for antibiotics before dental work	________	________	________
Hemophilia or bleeding disorder	________	________	________

PHYSICIAN'S EXAMINATION (*Pages 5–7)*

Date of exam: ______________________

Physician's name: ______________________________ Telephone #: ____________________

(*Please ✓ if normal; describe any abnormalities)*

Height: ___ ft ___ in	Weight: ______ lbs Normal for height?	Blood pressure: ____ / ___ Normal?	Pulse: ____ beats/min Normal?
Vision	Hearing	Neurological	Heart
Eyes	Ears	Nose	Rhythm
Mouth	Teeth	Mucosa	Murmurs
Pharynx	Tonsils	Nodes	Chest
Neck	Abdomen	Masses	Obstruction
Skin	Genitalia	Extremities	Scars

Please discuss medical diagnoses: ____

Please discuss dietary needs: ____

Please discuss capability for self-care: ____

Please discuss functional limitations: ____

Development History

Has the applicant been developmentally impaired since birth? __________

If not, when was a diagnosis made? ____

To what has the developmental impairment been attributed? _________________________________

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At what age did the applicant

- Learn to walk? ____________________
- Learn to talk? ____________________
- Become toilet trained during the day? ____________________
- Become toilet trained during the night? ____________________
- Lose his or her baby teeth? ____________________

General Medical Questions

Has the applicant ever been treated in a psychiatric hospital? ______ If yes, please discuss:

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Does the applicant require close medical supervision? ______ If yes, please discuss:

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Does the applicant have any coordination difficulties? ______ If yes, please discuss:

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Does the applicant have any gross hearing or visual difficulties? ______ If yes, please discuss:

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Is the applicant authorized to accept full responsibility for self-medicating without supervision, and to keep medication in his or her room?

___ Yes ___ No

Is the applicant free of all communicable diseases?

___ Yes ___ No

Other comments and recommendations by examining physician:

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Physician's Signature: ______________________________ *Date:* ____________________

Printed Name: ______________________________ *Physician's Stamp:*

Address: ______________________________

____

Tel: ______________________________

Fax: ______________________________