

Please complete and mail to:



Attn: Patient Access
2222 Welborn Street
Dallas, Texas 75219
Phone 214-559-7477

PATIENT APPLICATION

1-A	FOR HOSPITAL USE ONLY: Clinic: _____ Medical Record # : _____
2-AB	
3-B	
4-BB	
5-CD	

PLEASE PRINT OR TYPE

1 Has this child ever been a patient at Texas Scottish Rite Hospital for Children? Yes No Year _____ MR# _____

2 Child's name _____ Male Female
Last First Middle Suffix (Jr. Sr. Etc)

3 Date of child's birth _____ / _____ / _____ Social Security Number _____ - _____ - _____
Mo Day Yr Age

4 Religious preference _____ No preference

5 Does this child speak English? Yes No If no, child's primary language _____

6 Child's address _____
Street Apt #

_____ *City State County ZIP*

Home phone number (____) _____

7 The child's biological/adoptive parents are: Single Married Divorced Widowed Separated

8 Father's name _____
Last First Middle Suffix (Jr. Sr. Etc)

Father's address _____
Street Apt #

_____ *City State County ZIP*

Father's home phone (____) _____ Cell phone (____) _____

E-mail _____ Work phone (____) _____ Ext _____

Father's employer _____
Employer Job Title

Father's primary language _____ Hearing impaired Speech impaired
If other than English: Speaks English Reads English Understands English

9 Mother's name _____
Last First Middle

Mother's address _____
Street Apt #

_____ *City State County ZIP*

Mother's home phone (____) _____ Cell phone (____) _____

E-mail _____ Work phone (____) _____ Ext _____

Mother's employer _____
Employer Job Title

Mother's primary language _____ Hearing impaired Speech impaired
If other than English: Speaks English Reads English Understands English

10 Relative or friend who may be contacted in case of emergency

Name _____
Last First Middle Suffix (Jr. Sr. Etc.) Relationship to child

Address _____
Street Apt #

_____ *City State County ZIP*

Home phone (____) _____ Cell phone (____) _____ Work phone (____) _____

Primary Language _____ Hearing Impaired Speech Impaired Ext

If other than English: Speaks English Reads English Understands English

11 If there has been a court decision creating or affecting the legal custody (managing conservatorship) of the child, please provide a copy of the court order and complete the following:
 Conservator(s) listed is/are Sole Managing Conservator Joint Managing Conservator

_____ *State and County of Court Date Case Number*

Managing Conservator #1:	Managing Conservator #2:
_____ <i>Name Relationship to child</i>	_____ <i>Name Relationship to child</i>
_____ <i>Address</i>	_____ <i>Address</i>
_____ <i>City County</i>	_____ <i>City County</i>
_____ <i>State ZIP</i>	_____ <i>State ZIP</i>
(____) _____ <i>Home phone</i>	(____) _____ <i>Home phone</i>
(____) _____ <i>Work phone Ext</i>	(____) _____ <i>Work phone Ext</i>
(____) _____ <i>Cell phone</i>	(____) _____ <i>Cell phone</i>
E-mail _____	E-mail _____
Primary Language _____	Primary Language _____
If not English: <input type="checkbox"/> Speaks/ <input type="checkbox"/> Reads/ <input type="checkbox"/> Understands English	If not English: <input type="checkbox"/> Speaks/ <input type="checkbox"/> Reads/ <input type="checkbox"/> Understands English
<input type="checkbox"/> Hearing impaired <input type="checkbox"/> Speech impaired	<input type="checkbox"/> Hearing impaired <input type="checkbox"/> Speech impaired

12 If child does not live with parent(s) or managing conservator(s), please indicate where appointment information should be sent.

Name _____
Last First Middle Suffix (Jr. Sr. Etc.) Relationship to child

Address _____
Street Apt #

_____ *City State County ZIP*

Home phone (____) _____ Cell phone (____) _____

E-mail _____ Work phone (____) _____ Ext _____

Primary Language _____ Hearing Impaired Speech Impaired

If other than English: Speaks English Reads English Understands English

- 13 For the purpose of coordinating appointments and records, please list any children in your immediate family who are, or have been, patients of Texas Scottish Rite Hospital for Children

Name _____ Date of birth / / MR # _____
Mo Day Yr

Name _____ Date of birth / / MR # _____
Mo Day Yr

AGREEMENT AND ACKNOWLEDGMENT OF PARENT(S) OR MANAGING CONSERVATOR(S)

- 14 I acknowledge that I/my child/ my ward need(s) medical care and treatment. I voluntarily consent to the performance of hospital services and the use of all means of diagnostic tests and procedures and laboratory work of any kind (including but not limited to the taking of blood, tissues, fluids and other body samples; videotapes, x-rays, or other radiographic procedures; and psychological tests) upon me/my child/my ward, which are deemed necessary or prudent by an attending physician or any other member of the staff of Texas Scottish Rite Hospital for Children.

Provisions of state law protect patients as well as the Hospital and its doctors, enabling the Hospital to continue using its resources to provide excellent care to children throughout the state. In accordance with Texas law, in any civil action brought against Texas Scottish Rite Hospital for Children, its employees, officers, directors, or volunteers, the liability of Texas Scottish Rite Hospital for Children is limited to money damages in a maximum amount of five hundred thousand dollars (\$500,000) for any act or omission resulting in death, damage, or injury to me/my child/my ward. I understand and acknowledge on behalf of me/my child/my ward that: 1) Texas Scottish Rite Hospital for Children is providing medical care and treatment that is not administered for or in expectation of compensation; and 2) the limitations on the recovery of damages from the Hospital are in exchange for receiving the health care services.

By signing below, I or we, hereby certify that as natural or adoptive parent(s) and/or managing conservator(s), I am/we are legally authorized to consent to medical care of the child herein named. I agree to notify the Hospital in the event that there is a change in the above mentioned relationship.

15 _____
MOTHER'S SIGNATURE **DATE**

16 _____
FATHER'S SIGNATURE **DATE**

17 _____
Or Managing Conservator's Signature (if appropriate) **DATE**

- 18 Since its inception in 1921, Texas Scottish Rite Hospital for Children has never presented any patient family or third party payor with a bill for services. Occasionally, a patient may need care at another facility for a procedure not available at the hospital. In this case, third-party payments will be accepted by the facility performing the procedure.

To help us plan to meet the future needs of our patients, the following information is collected during the application process, but will not influence our decision to treat your child. Please check the type of health coverage that applies to your child:

No coverage Medicaid CHIP Medicare CSHCN

Other coverage: _____
Insurance Company Name

- 19 Recommendation by a Texas Master Mason
NOTE: Application may be submitted without this signature if no Mason was involved in the referral (see instruction # 19).

Signature *Please print name* *Lodge number*

PHYSICIAN REFERRAL

NOTE: Application cannot be processed without physician referral

ATTENTION: Referring Physician - the following is REQUIRED data:

- 1) **Child's Name** and **Date of Birth**
- 2) **Section A** and/or **Section B** completed in its **ENTIRETY** for determination of child's eligibility
- 3) **Physician Signature**, **Date**, **Medical License Number**, and **Demographics**

If you have any questions regarding the referral and/or services that TSRHC provides, please contact the Patient Access RN at (214) 559-7559 or 1 (800) 595-7604.

Child's name _____ Date of birth _____
Last First Middle (Suffix) Mo Day Yr

Section A - REQUEST FOR ORTHOPEDIC/MUSCULOSKELETAL EVALUATION (*completed by MD*)

Diagnosis _____	Date of onset _____
Describe problem or need _____	

Pertinent exam findings and history* _____	

Developmental status (Cognitive, Motor, Social)** _____	

* Please attach related X-rays, medical records or other clinically significant information	
** Please attach a copy of a developmental screening test, if applicable	

PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S NAME _____ MEDICAL LICENSE # _____
Print or Type

PHYSICIAN'S ADDRESS _____
Street Suite #

City State County ZIP

PHONE (____) _____ FAX (____) _____

E-MAIL _____

Section B - REQUEST FOR LEARNING DISABILITY EVALUATION (*completed by MD*)

NOTE: The enclosed Educational Background form <u>MUST</u> be completed for application to be processed.	
Grade level _____	School name _____ School district _____
Special Education Placement? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Purpose of referral _____	

Describe learning problem(s) _____	

Has previous testing been done? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, note date, place of testing and attach records)	

INSTRUCTIONS FOR COMPLETING PAPER PATIENT APPLICATION

1. If your child has ever been seen at Texas Scottish Rite Hospital for Children, please indicate this by checking yes or no. Any other information you can provide us, such as the year seen and Texas Scottish Rite Hospital for Children (TSRHC) medical record patient number (MR#), will also be helpful.
2. Print child's name as it appears on the birth certificate and check the box to indicate gender.
3. Enter child's date of birth, age and social security number. If no social security number exists, enter "none".
4. If you have a religious preference, please note here.
5. Please indicate if child is able to speak English by checking yes or no. If no, indicate what language is spoken. We will strive to provide needed translation services.
6. Print the address and phone number where the child presently lives.
7. To assist us in identifying the person who may legally sign consents, please check marital status of parents. If child's mother was not married to child's father at the time of birth, check "single." If biological parents are divorced, we will look to the person designated as the managing conservator for consent to evaluate and treat child.
8. Father's Name: biological or adoptive. If adoptive, complete section 11. Foster parents and stepparents are not considered adoptive parents until adoption is final, at which time there will be a new birth certificate issued and/or legal papers signed by a judge. Please print address where biological or adoptive father resides, even if it is the same as the child's. Please include the information about the father's employer; if not employed, write "none." Please indicate father's/mother's primary language. If either father or mother are hearing or speech impaired, please check the boxes that apply. We will strive to provide needed translation services.
9. Mother's Name: (use the same instructions as in # 8 above)
10. To provide a person who can be contacted in the case of an emergency, please print the name and address of a relative or friend who does not live with you. Also, enter the relationship of this person to the child. Please provide as much contact information as possible.
11. Complete this portion if biological parents are divorced, or another person or agency has been named managing conservator(s). List state and county of court, date of the decree and case number.

Please print the current address and phone number of the person(s) who was named as managing conservator(s) as specified in the legal papers as well as provide a copy of the court order.
12. If child lives in a residential facility or with someone other than parent or managing conservator, please include the name and address to which the appointment information is to be mailed. Please provide as much contact information as possible.
13. To help in the coordination of appointments and treatment plans, please print the full name and date of birth of any other children in your family who are now or have ever been patients at Texas Scottish Rite Hospital for Children. If you know their TSRHC medical record patient numbers (MR#), this information will also be helpful.
14. This agreement and acknowledgment gives the hospital staff permission to evaluate your child and explains certain provisions of state law.

15. and/or 16
Biological or adoptive parent(s) should sign the application. If a managing conservator has been appointed, that individual should complete section 17. Other relatives, such as stepparents, grandparents, and foster parents may not sign in this space.
17. If an individual other than a parent has been appointed as the child's managing conservator, that individual should sign here and assure that Section 11, specifying the court ruling, is completed.
18. Texas Scottish Rite Hospital for Children does not charge families or "third parties" for services performed at the hospital. However, if arrangements must be made for a patient to be seen at another facility for a procedure not available here, the facility performing the procedure will bill for their services. This information about such third party coverage is being collected to assist in planning to meet future needs of our patients and will not influence our decision to treat your child.
19. Because the Hospital was founded by Texas Scottish Rite Masons, many Masons actively support the Hospital's purpose by recommending children for treatment here. This space was provided for the signature of a Mason who recommended the child for treatment, if there was one involved. If there was no Mason involved in your referral, Hospital staff will complete this section as necessary.

INSTRUCTIONS FOR REQUEST FOR EVALUATION OF LEARNING DISABILITIES

Please see insert titled "For Evaluation of Learning Disabilities" for information regarding having your child tested at Texas Scottish Rite Hospital for Children's Luke Waites Center for Dyslexia and Learning Disorders.

INSTRUCTIONS FOR THE REFERRING PHYSICIAN:

1. For Orthopedic/Musculoskeletal Evaluation: If a definitive or provisional diagnosis has been made, please fill in this information. If condition is the result of illness or injury, please include date of onset. A pertinent summary of the child's problems and your reason for referring the patient to us is essential. Any information you can provide on the patient will assist in our evaluation and treatment.
2. For Learning Disability Evaluation: It is essential that you include a pertinent summary of the child's problems and the reason for referring the patient to us. All the information provided on the patient will assist in our evaluation and treatment. If previous educational, behavioral, or psychological testing has been done, please send copies of all results with the application.

NOTICE CONCERNING COMPLAINTS:

(Texas State Law requires us to include the following statement in its entirety)

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Texas State Board of Medical Examiners
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P. O. Box 2018, MC-263
Austin, Texas 78768-2018
1-800-201-9353

TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN GENERAL INFORMATION

HISTORY

In 1921, there was an urgent need in Texas to help the victims of polio, then the leading cause of disability among children. This need was recognized and met by a group of dedicated Scottish Rite Masons and W.B. Carrell, M.D., an orthopedic surgeon in Dallas at the time. Texas Scottish Rite Hospital for Children was founded to support the care and treatment of these children.

With the welcomed advent of the Salk and Sabin vaccines in the mid 1950s and the almost total disappearance of polio, the Hospital was able to redirect its efforts to the treatment of musculoskeletal deformities resulting from birth defects, accidents and diseases. More recently, the Hospital has expanded its services to include the diagnosis and treatment of various learning disabilities.

The Hospital, which is accredited by The Joint Commission, offers both inpatient and outpatient services to an active patient roster of more than 14,000 children.

WHAT CONDITIONS DOES THE HOSPITAL TREAT?

The Hospital's primary objective is the treatment of children with orthopedic conditions. These include conditions such as scoliosis, clubfoot, dislocated hips, Legg-Perthes, congenital and traumatic limb loss, arthritis, spina bifida, and the orthopedic after-effects of cerebral palsy, encephalitis, meningitis and accidental injury. The Hospital's Luke Waites Center for Dyslexia and Learning Disorders provides evaluation of children, ages 5 through 14, with suspected learning disabilities.

WHO PROVIDES THIS CARE?

The Hospital's clinical staff are recognized as some of the best in their fields. This includes physicians in the specialties of pediatric orthopedics, neurology, developmental disabilities, anesthesiology, rheumatology, and radiology. Working with the medical and nursing staff to provide comprehensive patient care are orthotists, prosthetists, psychologists, social workers, child life specialists, and physical and occupational therapists.

WHAT ARE THE REQUIREMENTS FOR A CHILD TO BE TREATED AT THE HOSPITAL?

1. The child's condition should offer hope of improvement through the services provided by the Hospital.
2. The child must be younger than 18 years of age, except for Luke Waites Center for Dyslexia applicants who must be between the ages of 5 and 14 years.
3. The child must be a resident of the state of Texas.
4. A physician's referral is required for each patient application.
5. Since many Masons recommend patients for treatment, the patient application form includes a space for a Mason's signature. However, if no Mason was involved in the referral, we will secure a signature as necessary.

WHAT TYPES OF CASES ARE NOT ELIGIBLE?

To assure appropriate use of Hospital resources, applications will not be approved for children who:

- * need only prolonged nursing care, respite care and/or residential care;
- * cannot benefit from the specialized treatment offered at the Hospital;
- * have conditions for which the Hospital is not able to provide treatment ; or
- * need emergency services due to accidental injury or acute illness

The Hospital is open to children of all races, colors and creeds. The decision to accept a patient for treatment is based solely on the above criteria, with no consideration of the financial resources of the family. If the hospital cannot provide treatment, our staff will attempt to assist the family to find appropriate care for their child.

WHAT ARE THE CHARGES FOR TREATMENT?

There are NO charges for any service provided at Texas Scottish Rite Hospital for Children nor have there been since its inception. The Hospital's sole source of income has always been voluntary gifts from individuals, civic groups, corporations and foundations. The Hospital accepts no money from any governmental agencies — federal, state or local. It receives no portion of dues paid by any Masonic Order.

HOW DOES A CHILD BECOME A PATIENT AT TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN?

Physicians can refer a patient by calling the Patient Access number listed below or by completing and signing the medical information portion of the application. The remainder of the application should be completed and signed by the parents or legally responsible person(s), thus giving their approval for an evaluation by the hospital's medical staff.

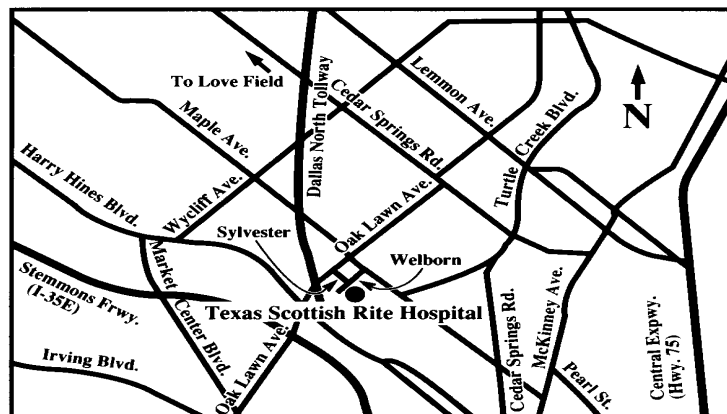
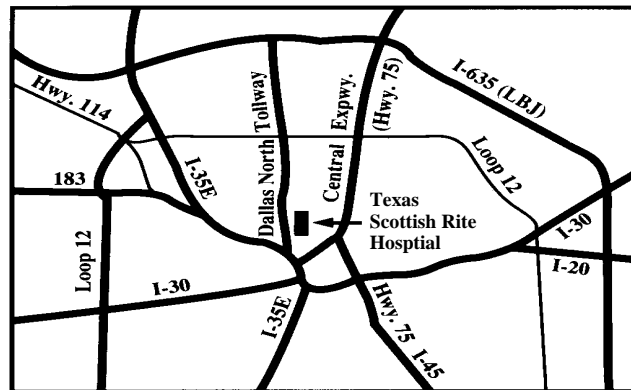
All referrals and applications are reviewed by Hospital staff when received. If the child is eligible for treatment an appointment will be given, and a written notice will be sent to the parents/legally responsible persons as well as to the referring physician.

MAIL COMPLETED APPLICATION AND PHYSICIAN REFERRAL TO:

Patient Access Department
Texas Scottish Rite Hospital for Children
2222 Welborn Street
Dallas, Texas 75219-9982

FOR MORE INFORMATION, PLEASE CALL:

Daytime Business Hours: (214) 559-7477
After Hours: (214) 559-5000



TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN
LUKE WAITES CENTER FOR DYSLEXIA AND LEARNING DISORDERS
EDUCATIONAL BACKGROUND INFORMATION

Complete this form only if you want your child evaluated for a learning disorder. The primary mission of the Luke Waites Center for Dyslexia and Learning Disorders (LWCD) is to evaluate children's learning in order to identify learning disorders, to educate parents about the educational needs of their child, and to support parents in developing an appropriate educational plan with the help of school personnel.

Our center is able to evaluate children who **speak** and **understand English**. We are unable to provide services for children whose learning difficulty is solely because of:

- Low cognitive ability
- Attention problems
- Emotional/behavioral problems
- Autism or pervasive developmental disorders
- Hearing or vision impairment

If you believe your child is eligible for an evaluation through the Luke Waites Center for Dyslexia, please:

1. Complete the "Patient Application" and have it signed by your child's physician.
2. Complete the "Luke Waites Center for Dyslexia Education Background Information" form and attach copies of previous test scores.
3. Mail information to:

Patient Access
Texas Scottish Rite Hospital for Children
2222 Welborn St.
Dallas, TX 75219

After your application and additional information are carefully reviewed, you will receive a letter regarding your child's eligibility. If approved, there is a wait of several months before evaluation. We look forward to serving you and your child in the best possible way.

TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN
INFORMACIÓN ACERCA DE ANTECEDENTES EDUCATIVOS DEL DEPARTAMENTO
DE DESARROLLO DEL NIÑO

Complete esta forma solamente si usted desea que su niño sea evaluado por un trastorno en el aprendizaje. La misión primaria del Centro de Desarrollo para Niños "Luke Waites" (LWCDC, siglas en inglés) es evaluar el aprendizaje de los niños para identificar los trastornos en el aprendizaje, para educar a los padres acerca de las necesidades educativas de su niño y para apoyar a los padres a desarrollar un plan educativo apropiado con la ayuda del personal de la escuela.

Nuestro centro está capacitado evaluar a los niños que **hablan** y **entienden el inglés**. No podemos proporcionar servicios para niños cuyas dificultades en el aprendizaje se deben solamente a:

- Habilidad cognitiva baja
- Problemas de atención
- Problemas emocionales/de comportamiento
- Autismo o trastornos generalizados en el desarrollo (PDD, siglas en inglés)
- Deficiencias auditivas o de la vista

Si usted cree que su niño es elegible para una evaluación a través de LWCDC, por favor:

1. Complete la solicitud para el paciente ("Patient Application") y pídale al médico de su niño que la firme.
2. Complete la forma "Información Sobre Antecedentes Educativos del Departamento de Desarrollo del Niño" y adjunte copias de las calificaciones de pruebas anteriores.
3. Envíe la información a:

Patient Access
Texas Scottish Rite Hospital for Children
2222 Welborn St.
Dallas, TX 75219

Después que su solicitud e información adicional hayan sido cuidadosamente revisadas, usted recibirá una carta con referencia a la elegibilidad de su niño. Si es aprobada, habrá una espera varios meses antes de que la evaluación se lleve a cabo. Esperamos servirle a usted y a su niño de la mejor manera posible.

Name: _____
Nombre
Date of Birth: _____
Fecha de Nacimiento

School Name: _____ Grade: _____
Nombre de la Escuela *Grado*
School District: _____
Distrito Escolar

LUKE WAITES CENTER FOR DYSLEXIA AND LEARNING DISORDERS
EDUCATIONAL BACKGROUND INFORMATION
INFORMACION ACERCA DE ANTECEDENTES EDUCATIVOS DEL
DEPARTAMENTO DE DESARROLLO DEL NIÑO

STOP! Please read the front page first. Complete this form only if you want an evaluation for learning disabilities. *¡ALTO!* Por favor, lea primero la página del frente. Complete esta forma solamente si usted desea una evaluación para las incapacidades en el aprendizaje.

- 1) Does your **child** know and speak English? (if not, do not complete 3-13) yes (*sí*) no (*no*)
¿Conoce y habla su niño el idioma del inglés? (sí no, no conteste de la 3-13)
- 2) Is English your child's first language? yes (*sí*) no (*no*)
¿Es el inglés el primer idioma de su niño?
- 3) **CHOOSE ONE:** *Seleccione Una:*
- My child needs testing. There has been no individual educational or psychological testing at school or away from school. *Mi niño necesita ser evaluado. No se ha hecho ninguna prueba educacional o psicológica en la escuela o fuera de la escuela.*
 - My child **has** been tested and is getting special help at school. I need to know if the special services are appropriate for my child's needs. *Mi niño ha sido evaluado y está recibiendo ayuda especial en la escuela. Yo necesito saber si los servicios especiales son apropiados para las necesidades de mi niño.*
 - My child **has** been tested but **does not** get special help at school. I would like a second opinion. *Mi niño ha sido evaluado, pero no recibe ayuda especial en la escuela. Me gustaría obtener una segunda opinión.*
 - My child is participating in or being considered for dyslexia training. I need a specific diagnosis of dyslexia. *Mi niño está participando o está siendo considerado para el entrenamiento de dislexia. Yo necesito un diagnóstico en específico de dislexia.*
- 4) What are you concerned about? Check all that apply.
¿Acerca de qué tiene usted preocupación? Marque todas las que apliquen.
- | | | |
|--|---|---|
| <input type="checkbox"/> Reading
<i>Lectura</i> | <input type="checkbox"/> Distractibility
<i>Distractibilidad</i> | <input type="checkbox"/> Sadness
<i>Tristeza</i> |
| <input type="checkbox"/> Spelling
<i>Ortografía</i> | <input type="checkbox"/> Concentration
<i>Concentración</i> | <input type="checkbox"/> Worry
<i>Preocupación</i> |
| <input type="checkbox"/> Math
<i>Matemáticas</i> | <input type="checkbox"/> Focus
<i>Enfoque</i> | <input type="checkbox"/> Moodiness/Irritability
<i>Irritabilidad/Mal humor</i> |
| <input type="checkbox"/> Handwriting
<i>Escritura a mano</i> | <input type="checkbox"/> Hyperactivity
<i>Hiperactividad</i> | <input type="checkbox"/> Suicidal Tendencies
<i>Tendencias Suicidas</i> |
| <input type="checkbox"/> Writing Stories
<i>Historias Escritas</i> | <input type="checkbox"/> Social Skills
<i>Habilidades Sociales</i> | |
| <input type="checkbox"/> Argues
<i>Discute</i> | <input type="checkbox"/> Developmental Delay
<i>Retraso en el desarrollo</i> | <input type="checkbox"/> Vision
<i>Vista</i> |
| <input type="checkbox"/> Gets in Trouble
<i>Se mete en problemas</i> | <input type="checkbox"/> Speech/Language
<i>Lenguaje/Habla</i> | <input type="checkbox"/> Hearing
<i>Audición</i> |
| <input type="checkbox"/> Temper/Anger Control
<i>Control de temperamento/
Enojo</i> | <input type="checkbox"/> PDD/Autism
<i>PDD/Autismo</i> | |
| | <input type="checkbox"/> Asperger's Syndrome
<i>Síndrome de Asperger</i> | |

Name: _____

Nombre

Date of Birth: _____

Fecha de Nacimiento

5) Which **one** of these are you most concerned about? Check one only.

¿Cuál de las siguientes a usted le preocupa más? Marque una solamente.

- | | | |
|--|---|---|
| <input type="checkbox"/> Reading
<i>Lectura</i> | <input type="checkbox"/> Distractibility
<i>Distractibilidad</i> | <input type="checkbox"/> Sadness
<i>Tristeza</i> |
| <input type="checkbox"/> Spelling
<i>Ortografía</i> | <input type="checkbox"/> Concentration
<i>Concentración</i> | <input type="checkbox"/> Worry
<i>Preocupación</i> |
| <input type="checkbox"/> Math
<i>Matemáticas</i> | <input type="checkbox"/> Focus
<i>Enfoque</i> | <input type="checkbox"/> Moodiness/Irritability
<i>Irritabilidad/Mal humor</i> |
| <input type="checkbox"/> Handwriting
<i>Escritura a mano</i> | <input type="checkbox"/> Hyperactivity
<i>Hiperactividad</i> | <input type="checkbox"/> Suicidal Tendencies
<i>Tendencias Suicidas</i> |
| <input type="checkbox"/> Writing Stories
<i>Historias Escritas</i> | <input type="checkbox"/> Social Skills
<i>Habilidades Sociales</i> | |
| <input type="checkbox"/> Argues
<i>Discute</i> | <input type="checkbox"/> Developmental Delay
<i>Retraso en el desarrollo</i> | <input type="checkbox"/> Vision
<i>Vista</i> |
| <input type="checkbox"/> Gets in Trouble
<i>Se mete en problemas</i> | <input type="checkbox"/> Speech/Language
<i>Lenguaje/Habla</i> | <input type="checkbox"/> Hearing
<i>Audición</i> |
| <input type="checkbox"/> Temper/Anger Control
<i>Control de temperamento/
Enojo</i> | <input type="checkbox"/> PDD/Autism
<i>PDD/Autismo</i> | |
| | <input type="checkbox"/> Asperger's Syndrome
<i>Síndrome de Asperger</i> | |

6) Does your child receive special help at school now, or has he/she in the past? yes (sí) no (no)

¿Actualmente, recibe su niño ayuda especial en la escuela, o él/ella ha recibido en el pasado?

Check all that apply. (You may need to ask your child's teacher to help you if you're not sure.)

Marque todas las que apliquen. (Tal vez usted necesite pedir ayuda al maestro de su niño si no está seguro)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Tutoring
<i>Tutoría</i> | <input type="checkbox"/> Speech
<i>Habla</i> | <input type="checkbox"/> Dyslexia class
<i>Clase de Dislexia</i> | <input type="checkbox"/> ESL
<i>Inglés Como Segundo Lenguaje</i> |
| <input type="checkbox"/> Title 1
<i>Título 1</i> | <input type="checkbox"/> Resource
<i>Recursos</i> | <input type="checkbox"/> 504 plan
<i>Plan 504</i> | <input type="checkbox"/> Inclusion
<i>Inclusión</i> |
| <input type="checkbox"/> Reading Recovery
<i>Recuperación de Lectura</i> | <input type="checkbox"/> Content Mastery
<i>Dominio de la Materia</i> | <input type="checkbox"/> Occupational Therapy
<i>Terapia Ocupacional</i> | <input type="checkbox"/> Other _____
<i>Otro</i> |

7) Have you ever been to a school meeting for this child to receive special help

(special education, 504, dyslexia)? *¿Ha tenido usted alguna vez una junta escolar para que este niño reciba ayuda especial (educación especial, plan 504, dislexia)?* yes (sí) no (no)

IN ORDER FOR YOUR APPLICATION TO BE COMPLETE, YOU MUST PROVIDE ALL PREVIOUS TEST SCORES, SUCH AS ACHIEVEMENT TESTS, TAAS/SDAA/TAKS AND SPECIAL EDUCATION REFERRALS.

(If you don't already have a copy of the test scores, ask your school principal to help you get a copy.) PARA QUE SU SOLICITUD ESTE COMPLETA, USTED DEBE PROPORCIONAR TODAS LAS CALIFICACIONES DE LAS PRUEBAS ANTERIORES, TALES COMO, TAAS/SDAA/TAKS Y REFERIDOS DE EDUCACION ESPECIAL. (Si aún usted no tiene copia de las calificaciones de las pruebas, pídale al director de la escuela que le ayude a obtener una copia.)

8) Is there a plan for this child to be tested by the school or another private agency? yes (sí) no (no)

¿Hay algún plan para que este niño sea evaluado por la escuela o por otra agencia privada?

Name: _____

Nombre

Date of Birth: _____

Fecha de Nacimiento

9) Does your child have a history of delays in development? yes (*sí*) no (*no*)

¿Tiene su niño un historial de retraso en el desarrollo?

If yes, please describe:

Si la respuesta es sí, por favor, descríbala

10) Has your child seen a doctor about attention or behavior problems? yes (*sí*) no (*no*)

¿Ha visto su niño a un médico por problemas de atención o de comportamiento?

11) Has your child ever taken medicine to help with attention or behavior? yes (*sí*) no (*no*)

¿Ha tomado su niño alguna vez medicamento para ayudarle con el problema de atención o del comportamiento?

12) If yes, what medicine(s)?

Si la respuesta es sí, ¿Qué medicamento(s)?:

If yes, when did your child first start taking medication for attention or behavior?

Si la respuesta es sí, ¿Cuándo comenzó su niño a tomar medicamento para el problema de atención o de comportamiento?

Month (*Mes*): _____ Year (*Año*) _____

Name: _____
Nombre

Date of Birth: _____
Fecha de Nacimiento

13) Does your child have any medical diagnoses? yes (*sí*) no (*no*)
¿Tiene su niño algún diagnóstico médico?

If yes, check all that apply. *Si la respuesta es sí, marque todas las que aplican.*

- | | | |
|--|---|---|
| <input type="checkbox"/> ADHD/ADD
<i>ADHD/ADD</i> | <input type="checkbox"/> Enuresis
<i>Enuresis</i> | <input type="checkbox"/> Sickle Cell Anemia
<i>Anemia Perniciosa</i> |
| <input type="checkbox"/> Allergies
<i>Alergias</i> | <input type="checkbox"/> Fetal Alcohol Syndrome
<i>Síndrome de Alcohol fetal</i> | <input type="checkbox"/> Sickle Cell Trait
<i>Características de Anemia</i> |
| <input type="checkbox"/> Angelman Syndrome
<i>Síndrome de Angelman</i> | <input type="checkbox"/> Fragile X
<i>X frágil</i> | <input type="checkbox"/> Spina Bifida
<i>Espina Bifida</i> |
| <input type="checkbox"/> Anxiety Disorder
<i>Trastorno de Ansiedad</i> | <input type="checkbox"/> Galactosemia
<i>Galactosemia</i> | <input type="checkbox"/> Static Encephalopathy
<i>Encefalopatía Estática</i> |
| <input type="checkbox"/> Asperger's Syndrome
<i>Síndrome de Asperger</i> | <input type="checkbox"/> History of Cancer
<i>Historial de Cáncer</i> | <input type="checkbox"/> Suicidal Tendencies
<i>Tendencias Suicidas</i> |
| <input type="checkbox"/> Asthma
<i>Asma</i> | <input type="checkbox"/> History of Meningitis
<i>Historial de Meningitis</i> | <input type="checkbox"/> Thyroid Disorder
<i>Trastorno de la Tiroides</i> |
| <input type="checkbox"/> Attachment Disorder
<i>Trastorno de Apego</i> | <input type="checkbox"/> History of Near Drowning
<i>Historial de haber estado a punto de ahogarse.</i> | <input type="checkbox"/> Tic Disorder
<i>Trastornos de Movimientos Involuntarios</i> |
| <input type="checkbox"/> Autism
<i>Autismo</i> | <input type="checkbox"/> History of Stroke
<i>Historial de Embolia</i> | <input type="checkbox"/> Tourette Syndrome
<i>Síndrome de Tourette</i> |
| <input type="checkbox"/> Bipolar Disorder
<i>Trastorno Bipolar</i> | <input type="checkbox"/> HIV
<i>VII</i> | <input type="checkbox"/> Traumatic Brain Injury
<i>Lesión Cerebral Traumática</i> |
| <input type="checkbox"/> Cerebral Palsy
<i>Parálisis Cerebral</i> | <input type="checkbox"/> Irritable Bowel Syndrome
<i>Síndrome de Colon Irritable</i> | <input type="checkbox"/> Tuberous Sclerosis
<i>Esclerosis Tuberosa</i> |
| <input type="checkbox"/> Cleft Palate/Cleft Lip
<i>Paladar Hendido/Labio Leporino</i> | <input type="checkbox"/> Klinefelter's Syndrome
<i>Síndrome de Klinefelter</i> | <input type="checkbox"/> Turner's Syndrome
<i>Síndrome de Turner</i> |
| <input type="checkbox"/> Conduct Disorder
<i>Trastorno de Conducta</i> | <input type="checkbox"/> Muscular Dystrophy
<i>Distrofia Muscular</i> | <input type="checkbox"/> William's Syndrome
<i>Síndrome de Williams</i> |
| <input type="checkbox"/> Crohn's Disease
<i>Enfermedad de Crohn</i> | <input type="checkbox"/> Neurofibromatosis
<i>Neurofibromatosis</i> | |
| <input type="checkbox"/> Depression
<i>Depresión</i> | <input type="checkbox"/> Obsessive Compulsive Disorder
<i>Trastorno Compulsivo Obsesivo</i> | |
| <input type="checkbox"/> Developmental Delay
<i>Retraso en el Desarrollo</i> | <input type="checkbox"/> Oppositional Defiant Disorder
<i>Trastorno de Oposición Desafiante</i> | |
| <input type="checkbox"/> Diabetes
<i>Diabetes</i> | <input type="checkbox"/> Pervasive Developmental Disorder
<i>Autismo y Trastorno Generalizado del Desarrollo</i> | |
| <input type="checkbox"/> Dwarfism
<i>Enanismo</i> | <input type="checkbox"/> Phenylketonuria
<i>Fenilcetonuria</i> | |
| <input type="checkbox"/> Encopresis
<i>Encopresis</i> | <input type="checkbox"/> Seizure Disorder
<i>Trastornos Convulsivos</i> | |