EXCEPTIONAL OPPORTUNITES, INC.
ICF/ID ADMISSION FORM

DATE OF APPLICATION _____

PERSONAL INFORMATION

INDIVIDUAL'S NAME _____

INDIVIDUAL'S SOCIAL SECURITY # _____

MEDICAID # _____ MEDICARE # _____

MANAGED CARE ORGANIZATION: _____

SEX _____ BIRTHDATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER(S) _____

CELL PHONE NUMBER(S) _____

EMAIL ADDRESS (optional) _____

CONTACT INSTRUCTIONS _____

FATHER'S BIRTHDATE _____ OCCUPATION _____

VETERAN YES _____ NO _____ DATES SERVED _____
IF YES, WHICH BRANCH OF THE SERVICE? _____

WORK TELEPHONE # _____ EDUCATION _____

MOTHER'S BIRTHDATE _____ OCCUPATION _____

VETERAN YES _____ NO _____ DATES SERVED _____
IF YES, WHICH BRANCH OF THE SERVICE? _____

WORK TELEPHONE # _____ EDUCATION _____

WHO SHOULD BE CONTACTED IN CASE OF EMERGENCY IF YOU ARE NOT AVAILABLE:

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE/CELL NUMBER(S) _____

RELIGIOUS AFFILIATION: _____

MINISTER/PRIEST _____

TELEPHONE NUMBER # _____

BURIAL FUND YES _____ NO _____

MORTICIAN _____ PHONE # _____

FUNERAL HOME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HEALTH INSURANCE YES _____ NO _____

PROVIDER _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PROVIDER NUMBER(S) _____

LIFE INSURANCE YES _____ NO _____

PROVIDER _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PROVIDER NUMBER(S) _____

DIAGNOSES

PLEASE LIST ANY MEDICAL DIAGNOSES:

_____

_____

_____

_____

MEDICAL HISTORY

PHYSICIAN _____ TELEPHONE NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

LAST PHYSICAL EXAMINATION _____

DENTIST _____ _____ TELEPHONE NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

LAST DENTAL EXAMINATION _____

OPTOMETRIST _____ TELEPHONE NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

LAST VISION EXAMINATION _____

IMMUNIZATIONS (Dates):

DPT SERIES _____ _____ _____

POLIO _____ _____ _____

MMR (MEASLES, MUMPS, RUBELLA) _____

TETANUS _____ **HEP B** _____

TB _____ **PNEUMONIA** _____

CHICKEN POX _____ **OTHER** _____

cont:

ALLERGIES _____

CHILDHOOD DISEASES INDIVIDUAL HAS HAD AND YEAR _____

_____

_____

SEIZURE HISTORY

DOES THE INDIVIDUAL HAVE SEIZURES? YES _____ NO _____

IF YES, PLEASE DESCRIBE:

_____

_____

_____

MEDICATIONS

MEDICATIONS:	DOSAGE:	TIME TAKEN:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADDITIONAL MEDICAL INFORMATION

THIS AREA IS FOR ANY PHYSICIANS OR OTHER SPECIALISTS THE INDIVIDUAL HAS SEEN OR SEES.

SPECIALIST ____ TELEPHONE NUMBER ___________________

ADDRESS ____

CITY ____ STATE ______________ ZIP CODE _____________

LAST EVALUATION ____

SPECIALIST ____ TELEPHONE NUMBER ___________________

ADDRESS ____

CITY ____ STATE ______________ ZIP CODE _____________

LAST EVALUATION ____

SPECIALIST ____ TELEPHONE NUMBER ___________________

ADDRESS ____

CITY ____ STATE ______________ ZIP CODE _____________

LAST EVALUATION ____

SPECIALIST ____ TELEPHONE NUMBER ___________________

ADDRESS ____

CITY ____ STATE ______________ ZIP CODE _____________

LAST EVALUATION ____

SPECIALIST ____ TELEPHONE NUMBER ___________________

ADDRESS ____

CITY ____ STATE ______________ ZIP CODE _____________

LAST EVALUATION ____

NUTRITIONAL INFORMATION

SPECIAL DIET? _____

_____

FOOD ALLERGIES _____

FOOD LIKES _____

FOOD DISLIKES _____

EATING SKILLS _____

_____

ADAPTIVE EATING EQUIPMENT _____

_____

_____

MISCELLANEOUS INFORMATION

TOILETING SCHEDULE _____

_____

DRESSING SKILLS _____

_____

AMBULATORY STATUS (SPECIAL EQUIPMENT NEEDED?) _____

COMMUNICATION SKILLS _____

_____

BEHAVIOR DIFFICULTIES (EX. AGGRESSION, SELF-INJURIOUS BEHAVIOR, ETC.)

_____

_____

ACTIVITIES THE INDIVIDUAL ENJOYS OR DISLIKES _____

_____

SLEEPING HABITS _____

EDUCATIONAL INFORMATION

EDUCATIONAL SERVICES RECEIVED AND DATES OF SERVICE:

_____

_____

_____

OTHER SERVICES: Examples: early intervention services, in-home services, respite care, previous work or residential services.

LIST SERVICE PROVIDER AND DATES OF SERVICE:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL INFORMATION THAT WOULD BE HELPFUL IN CARING FOR THE INDIVIDUAL:

SIGNATURE(S) OF PARENT(S)/GUARDIAN(S):

_____

_____