

Dear Family or Referral,

Thank you for your interest in the educational programs at the South Carolina School for the Deaf and the Blind (SCSDB). We are proud of our programs and welcome the opportunity to participate in your child's education. To be enrolled at our school, students must meet our eligibility criteria. This process usually takes from four to six weeks after we receive the application. You can help with this process by collecting this information and sending it to us.

To begin, please send the **completed** application packet, which includes the following:

1. _____ Student Application.
2. _____ Student Service History form (attached)
3. _____ Social History Information form (attached)
4. _____ Parent/Guardian Authorization form (attached)
5. _____ Parent/Guardian Authorization for Release of Information form (attached)
6. _____ General Medical Examination Form completed by a physician (attached) with a prescription from the doctor for evaluations and services
7. _____ A copy of your child's registered birth certificate
8. _____ A copy of your child's SC Immunization Record (DHEC Form 1148) or a special exemption form
9. _____ Tuberculin (TB) test results
10. _____ A copy of your child's social security card
11. _____ A copy of your child's health insurance card or Medicaid card
12. _____ A copy of your child's custody papers if the child is not living with the natural parent or grandparent, or if there is a legal custody directive
13. _____ A recent photograph of your child

Then, you can send or we can request:

1. _____ Vision or Eye Exam report from an optometrist or ophthalmologist. (This exam must be done within the past 3 years if the child is over 6 years or within the past 12 months year if the child is under age 6.)
2. _____ Hearing Exam report from an audiologist (same time frame as above.)
3. _____ Other important medical information we need to know.
4. _____ Information about social services the child has received.

And finally, you can send or we can request:

1. _____ A copy of the most recent Individualized Education Plan (IEP), IEP progress reports, Extended School Year (ESY) and re-evaluation data, Functional Behavior Assessment, Special Education Placement Form and Transition Plan.
2. _____ Copies of school transcripts and grades.
3. _____ Copies of standardized test scores.
4. _____ Copies of any other testing done (hearing, vision, psychological, educational, physical or occupational therapy.
5. _____ LEP assessment (Limited English Proficiency Survey)

When all of the above information is received:

- the Admissions Team will hold a **File Review** meeting
- your child will come to SCSDB for more **evaluations**. If you live more than two hours from campus, you are invited to stay on campus the night before the evaluation.
- the Admissions Team will hold the **Eligibility Meeting**. The local school district is invited to this meeting. The family is not required to attend this meeting. If eligibility is established, the school principals then decide if your child is accepted based on the school's ability to provide a program to meet his/her educational needs.

You will receive a call from the Admissions Coordinator or the Principal. If eligible and accepted, your child will then be scheduled for the **Placement/IEP** meeting. The parent or legal guardian is required to attend this meeting to help write the initial IEP.

At the Placement/IEP meeting, you will meet the teachers and principal and learn more about our dormitory and bus system. You can return home being assured that your child is receiving the best educational services possible. Believing that "it takes a village to raise a child," we are here to help you.

If you have any questions during the application process, we encourage you to contact us.

Monday - Friday, 8:00 a.m. - 4:00 p.m.
864 577-7579 Joan Dudgeon
888-447-2732 (toll free)
864-577-7552 or 864-577-7559 or 864-577-7690 (fax numbers)

Mailing Address:
Admissions
SC School for the Deaf and the Blind
355 Cedar Springs Road
Spartanburg, SC 29302

We look forward to serving you,

Sincerely,

Loreta Dylgjeri
Admissions Coordinator

Marlane Babb
Admissions Administrative Assistant

SCSDB Student Application

Today's Date:

| | | | | | | |
|---|---------------|----------------|---------------------------|-------------------------------|--|--|
| Child's Name: | | Date of Birth: | Social Security Number: | | Disability: Hearing or Vision Other: | |
| Address: | | Age: | Grade: | Gender: | Home County: | |
| Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> African-American <input type="checkbox"/> African Amer/Amer Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Hawaiian-Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> White/Asian <input type="checkbox"/> White/African American <input type="checkbox"/> White/American Indian <input type="checkbox"/> Other _____ | | | | | | |
| Email Address: | | | | | | |
| Mother / Guardian's Name: | | | Father / Guardian's Name: | | | |
| Parents are: Married Separated Divorced Deceased Single | | | | | | |
| Child lives with: | Phone: (home) | Phone: (work) | Phone:(cell) | Who has custody of the child? | | |
| Emergency / Alternative Contact Person's Name: | Relation: | Phone: (home) | Phone: (work) | Phone: (cell) | | |

Check other related conditions affecting your child's education or health:

- | | | |
|----------------------------------|---------------------------|----------------------|
| _____ mental retardation | _____ speech / language | _____ learning |
| _____ orthopedic problems | _____ chronic health | _____ emotional |
| _____ ADD / ADHD / Hyperactivity | _____ behavioral | _____ cerebral palsy |
| _____ neurological | _____ epilepsy / seizures | _____ other _____ |

How did you learn about SCSDB? Please explain:

Why do you want your child to attend SCSDB? Please explain:

Will your child be a _____ residential student or a _____ day* student. *Some restrictions apply.
 * lives within 35 miles of SCSDB

Signature of parent / guardian/custodian _____

All applicants receive equal consideration with regard to race, creed, color, sex and national origin.

SCSDB Student Service History

| School Programs: Schools attended in the past 5 years | Address: | Phone Number: | Attendance Dates: |
|---|-----------------|----------------------|--------------------------|
| | | | |
| | | | |
| | | | |
| Doctors: Family doctors, vision / hearing doctors, surgeries, hospitals | Address: | Phone Number: | Date of Service: |
| | | | |
| | | | |
| | | | |
| Service Agencies: Family, medical, therapeutic services | Address: | Phone Number: | Date of Service: |
| | | | |
| | | | |
| | | | |

Demographic Information

Today's Date:

Relation to Child:

Child's Name:

Date of Birth:

| Family Information: | | | |
|--|--|--|---|
| List persons living in the home: | Age: | Gender: | Relationship: |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| Communication Information: | | | |
| What is the first language in the home? English Sign Language Spanish Other | | | |
| How does the child communicate? Talking Sign Language Gestures | | | |
| Does the child follow directions? Yes No | | Does the child enjoy communication? Yes No | |
| With whom is the child comfortable? Family Friends Adults Children Large Groups Small Groups My child is not social | | | |
| Does the child use assistive communication devices? Communication Board Computer Other: | | | |
| Other important communication information: | | | |
| Academic History: | | | |
| Was the child in the Early Intervention Program? Yes No | | | |
| Contact Person: | | | |
| Current School and Address: | | Grade: | Type of School Placement: Resource Self-contained Itinerant Regular Class |
| What is the child's attitude about school? Good Fair Poor | Is anyone (teachers, doctors, relatives) concerned about a learning problem in the child? Yes No | Does the child ever miss a lot of school? Yes No Over 10, 20, 30 days? Yes No | |
| What are the child's strengths? | | | |

| Behavior Information: | | | |
|--|--------------------------------|---|---------------------------|
| The child plays best with children who are: Same Age Older Younger | | | |
| The child's favorite hobbies, toys are: | | | |
| The child's routine household duties or chores are: | | | |
| The behaviors that requires me to discipline the child are: | | | |
| The best way I can discipline the child is: | | | |
| Generally, who is responsible for disciplining the child? Mother Father Other | | | |
| Has the child received counseling or mental health services? Yes No Contact Name / Address/Phone: | | | |
| Has the child been referred to the Department of Juvenile Justice? Yes No Explain: | | | |
| To the best of your knowledge, has the child been exposed to any form of abuse? | | | |
| Sexual | Verbal | Physical | Other |
| Has the child ever been suspended from school? Yes No Explain: | | | |
| Does the child have special transportation needs? | | | |
| Wheelchair | Car seat | Medication | Harness Other: |
| Behavior Checklist: | | Please check all that apply to your child: | |
| Shares easily | Is self-confident | Holds grudges | |
| Has leadership ability | Daydreams often | Complains | |
| Is considerate of others | Self stimulates or sucks thumb | Engages in unusual sexual activity | |
| Does not sleep well | Is suspicious of people | Is affectionate | |
| Does not eat well | Has many mood changes | Has nightmares | |
| Is a show-off | Is very lazy | Is creative | |
| Is easily discouraged | Is nervous | Wets the bed | |
| Is depressed | Hurts self | Is very shy | |
| Walks while sleeping | Hurts animals | Is very stubborn | |
| Has temper tantrums daily | Hurts other people | Is very disobedient | |
| Is truthful | Has strong hates | Swears / curses | |
| Is a bully | Has strong fears | Is very sensitive | |
| Is overactive | Follows directions well | Steals | |
| Controls temper | Is overly dependant for age | Has a short attention span | |
| Is very jealous | Is generally happy | Is destructive | |
| Other behaviors that concern you: | | | |

| Medical Information: | | | | |
|--|--|--|--|--|
| Did the mother have any problems during pregnancy? Mumps Measles Diabetes High Blood Pressure Anemia Heart Medication Kidney Disease Other: | | | | |
| Were there any unusual problems during the child's birth? Yes No Explain: | | | | |
| Was the child premature? Yes No Birth Weight: | | | | |
| Did the child have any difficulties? Allergies Bleeding Vomiting Convulsion Brain Injury Feeding Problems Other: | | | | |
| Has the child had any serious illness, accidents, head injuries? Yes No Explain: | | | | |
| Has the child had a high fever (104 or above)? Yes No Explain duration: | | | | |
| Does the child get sick often? Yes No Explain: | | | | |
| What is the child's present health? Good Fair Poor Very Poor | | | | |
| Do you have any concerns about the child's health? Yes No Explain: | | | | |
| Has the child been hospitalized? Yes No Explain: | | | | |
| At what age was the child diagnosed with a sensory impairment? | | | | |
| Other important information: | | | | |
| Specify activities you do not want your child to participate in. | | | | |

**South Carolina School for the Deaf and the Blind
Parent/Legal Guardian Authorization Form**

Note: Signature is required two times below

(1) Permission for Emergency Medical Treatment

I give permission to the South Carolina School for the Deaf and the Blind, through its authorized representatives, to give or seek temporary medical and / or dental treatment for my child until I am notified. In case of an emergency, the school has my permission to seek medical and /or dental treatment, to order injections, anesthesia, or surgery for my child. I give permission for my child to be transported off-campus for visits to other medical disciplinarians as necessary.

Name of Student: _____ Medicaid # _____

Private Health Insurance Provider: _____ Policy # _____

If group policy, give your date of employment and the policyholder:

(1) Signature of Parent / Legal Guardian Date

(2) Financial Responsibility

I understand that I am responsible and financially liable for the medical and / or dental care of my child who is a student at the South Carolina School for the Deaf and the Blind. If applicable, I authorize the South Carolina School for the Deaf and the Blind to release any medical information necessary to process Medicaid and / or other insurance claims on behalf of my child.

(2) Signature of Parent / Legal Guardian

Date

South Carolina School for the Deaf and the Blind
Parent/Legal Guardian Authorization for Release of Information

Student's Name: _____ Date of Birth: _____

Written reports and records are needed to consider a student for admission to the South Carolina School for the Deaf and the Blind. Physicians, schools and other professionals or agencies who have worked with the above named child will be contacted for information.

My signature authorizes the release and use of information about my child to the South Carolina School for the Deaf and the Blind.

I am the: (check one)

Parent _____

Legal Guardian _____

Surrogate Parent _____

Signature of Parent / Legal Guardian / Surrogate

Date

**South Carolina School for the Deaf and the Blind
General Medical Examination Form - Completed by a Family Physician**

Name of Student: _____ Date of Birth: _____
Age: _____ Gender: _____ Race: _____ Phone Number: _____

| Physical Exam: | | | |
|--------------------------------------|---------------|---------------------------------|------------------|
| | Normal | Description of Findings | |
| Head / Neck | | | |
| Ears | | | |
| Eyes | | Vision | R 20/ L 20/ |
| Nose / Throat | | | |
| Mouth / Teeth | | | |
| Chest / Breasts | | | |
| Heart | | BP: | Pulse: |
| Lungs | | | |
| Abdomen | | | |
| Liver / Spleen | | | |
| Back / Spine | | | |
| Hips / Extremities | | | |
| Neurological | | | |
| Skin/ Nodes | | | |
| Physical Limitations | | | |
| Height and Weight | | Height: | Weight: |
| Other | | | |
| Medical Tests | Date | Results | |
| Urinalysis | | | |
| Hemoglobin | | | |
| TB Skin Test* | | *Mandatory | |
| Other | | | |
| Medical History: | | | |
| Seizures | | Explain: | |
| Surgeries | | List on the back of this sheet: | |
| Allergies (medicines, food, insects) | | List on the back of this sheet: | |
| Current medications | | List on the back of this sheet: | |
| Chicken Pox | | Date: | |

Physician's Statement

I have examined this child and found him / her to be free of contagious and infectious disease.
(If not, I will explain on the back of this form.)

(Please include orders to evaluate & treat this student as necessary for OT, PT and Speech-Language.)

Physician Printed Name (or Stamp)

Physician's Signature

Phone Number

Date