

# NOR-WEST REGIONAL SPECIAL SERVICES

## Participant Application

**Mailing Address:**  
P. O. Box 420  
Crugers, NY 10521  
Fax: (914) 737-4838

**Office Location:**  
293-D Furnace Dock Rd.  
Cortlandt Manor, NY 10520  
(914) 737-4797

### INSTRUCTIONS:

1. Parents/guardian should complete sections 1-4; Physician should complete Section 5.
2. When all sections are complete, mail entire application to the **mailing address** above.
3. Please call the Nor-West office to arrange an intake assessment. This 30 minute meeting gives us an opportunity to meet the participant and you a chance to learn more about Nor-West's programs and services. Please bring a recent copy of the Individualized Education Plan if applicable.

### 1. Participant Information:

Participant's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
City: \_\_\_\_\_ NY Zip Code: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Who referred you to Nor-West? \_\_\_\_\_

Disability Classification: (Circle all which apply)

- |                               |                                     |
|-------------------------------|-------------------------------------|
| 1. Mental retardation         | 6. Pervasive developmental disorder |
| 2. Learning disability        | 7. Seizure disorder                 |
| 3. Attention deficit disorder | 8. Neurological impairment          |
| 4. Cerebral Palsy             | 9. Currently unclassified           |
| 5. Autism                     | 10. Other: _____                    |

Level of self-care: (Enter appropriate number)

- |                      |                              |
|----------------------|------------------------------|
| Eating _____         | 1- Completely independent    |
| Dressing _____       | 2- Needs supervision         |
| Toileting _____      | 3- Needs physical assistance |
| Bus entry/exit _____ | 4- Total dependence on staff |

Does participant utilize: Wheelchair: \_\_\_\_\_ Crutches: \_\_\_\_\_ Braces: \_\_\_\_\_ Hearing Aid: \_\_\_\_\_  
Sign Language: \_\_\_\_\_ Other: \_\_\_\_\_

Seizure History: (Circle all that apply)

1. No seizure history.
2. No seizures in last three years.
3. Currently has seizures with no warning.
4. Currently has seizures; warning signs: \_\_\_\_\_
5. Seizures well-controlled with medication.

Behavioral Issues: (Circle all which apply)

- |                                 |                         |
|---------------------------------|-------------------------|
| 1. No issues                    | 6. Extreme mood changes |
| 2. Physically assaultive        | 7. Verbally abusive     |
| 3. Self-injurious               | 8. Temper tantrums      |
| 4. Biting                       | 9. Hyperactivity        |
| 5. Actively resists supervision | 10. Sexual misbehavior  |

Comments regarding above behaviors: \_\_\_\_\_  
\_\_\_\_\_

OMRDD requires Nor-West to obtain the following information (please circle):

ETHNICITY/	1. White	3. Hispanic	5. Amer. Indian/Alaskan
RACE:	2. Black	4. Asian or Pacific Islander	6. Other
LANGUAGE:	1. English	3. Other Spoken	5. Other Symbolic
	2. Spanish	4. Sign	6. No language
EDUCATION:	1. None	4. Grade (specify 1-8) ( )	7. College
	2. Ungraded	5. High School	8. Unknown
	3. Preschool	6. Vocational	

**2. Family Information:**

Father's Name: \_\_\_\_\_  
Day Tel. # \_\_\_\_\_ Evening # \_\_\_\_\_ Beeper # \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
Day Tel. # \_\_\_\_\_ Evening # \_\_\_\_\_ Beeper # \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Guardian/Spouse: \_\_\_\_\_  
Day Tel. # \_\_\_\_\_ Evening # \_\_\_\_\_ Beeper # \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

If parent/guardian is unreachable in case of emergency, please list an alternative contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Day Tel. # \_\_\_\_\_ Evening # \_\_\_\_\_ Beeper # \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Youth Participant Section: School: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Is school placement: \_\_\_ Mainstreamed \_\_\_ Resource room \_\_\_ Self-contained

Adult Participant Section: Work location: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Is work setting: \_\_\_ Competitive employment \_\_\_ Workshop \_\_\_ Day training

Briefly describe the participant's present living situation. Include level of parental involvement, siblings, peer friendships, etc. If participant lives in a group residence, IRA, or supportive apartment, describe their level of independence.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Medical Authorization:**

This application has been completed and the information herein is accurate to the best of my knowledge. The applicant has permission to take part of all Nor-West activities, except as noted by me or by the examining physician.

I understand that every attempt will be made to contact me in case of an emergency. In the event that I cannot be contacted, I give my consent to emergency x-rays, medical treatments, surgery, or dental care for \_\_\_\_\_

I understand that Nor-West **does not** provide medical insurance for participants.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian Signature)

**4. Photo/Video Release:** Please check one:

\_\_\_\_\_ I hereby grant permission to Nor-West Regional Special Services to use my son/daughter's likeness, picture, voice, words, or name in either television, radio, film, video, newspapers, magazines, brochures, flyers, and other media, in any form, for the express purpose of advertising, fund-raising, or communication the programs and services of Nor-West.

\_\_\_\_\_ I **do not** consent to the above photo release.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian Signature)

**Nor-West Regional Special Services**

**5. Medical Form:** Please have your physician complete and sign.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

**I Medical History:**

**A. Immunizations:** If one or more of the required immunizations is contraindicated, Please indicate the reason on the reverse.

**DPT** (1<sup>st</sup>) \_\_\_/\_\_\_/\_\_\_ (2<sup>nd</sup>) \_\_\_/\_\_\_/\_\_\_ (3<sup>rd</sup>) \_\_\_/\_\_\_/\_\_\_ (Bstr) \_\_\_/\_\_\_/\_\_\_.

**Oral Polio** (1<sup>st</sup>) \_\_\_/\_\_\_/\_\_\_ (2<sup>nd</sup>) \_\_\_/\_\_\_/\_\_\_ (3<sup>rd</sup>) \_\_\_/\_\_\_/\_\_\_ (Bstr) \_\_\_/\_\_\_/\_\_\_.

**Hib** (1<sup>st</sup>) \_\_\_/\_\_\_/\_\_\_ (2<sup>nd</sup>) \_\_\_/\_\_\_/\_\_\_ (3<sup>rd</sup>) \_\_\_/\_\_\_/\_\_\_ (4th) \_\_\_/\_\_\_/\_\_\_.

**Hepatitis B** (1<sup>st</sup>) \_\_\_/\_\_\_/\_\_\_ (2<sup>nd</sup>) \_\_\_/\_\_\_/\_\_\_ (3<sup>rd</sup>) \_\_\_/\_\_\_/\_\_\_ (4th) \_\_\_/\_\_\_/\_\_\_.

**MMR** (1<sup>st</sup>) \_\_\_/\_\_\_/\_\_\_ (2<sup>nd</sup>) \_\_\_/\_\_\_/\_\_\_.

Other (List Type) \_\_\_\_\_ / /  
Other (List Type) \_\_\_\_\_ / /

**B. Test Results:**

Tuberculin: \_\_\_\_\_ Urine: \_\_\_\_\_ HCT: \_\_\_\_\_

Other tests: \_\_\_\_\_

**C. Indicate history/dates of the following (if applicable):**

Measles: \_\_\_\_\_ Mumps: \_\_\_\_\_ Chicken Pox: \_\_\_\_\_ Hepatitis: \_\_\_\_\_

Allergies: \_\_\_\_\_ Seizures: \_\_\_\_\_

**D. Medication:** Nor-West medical personnel are authorized to administer the following:

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone

**II. Physical Examination:**

Primary Diagnosis: \_\_\_\_\_ Secondary Diagnosis: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Heart: \_\_\_\_\_ Resting Pulse \_\_\_\_\_

Please indicate the absence of disease or medical issue by writing "WNL" (Within Normal Limits):

Lungs: \_\_\_\_\_ Abdomen: \_\_\_\_\_ Extremities: \_\_\_\_\_ Vision: \_\_\_\_\_ Hearing \_\_\_\_\_

Skeletal: \_\_\_\_\_ Nose: \_\_\_\_\_ Throat: \_\_\_\_\_ Lymph Nodes: \_\_\_\_\_ Thyroid: \_\_\_\_\_

Skin: \_\_\_\_\_ Speech: \_\_\_\_\_ Ambulation: \_\_\_\_\_ Balance: \_\_\_\_\_

Restrictions on physical activity: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone

**PLEASE USE THE REVERSE SIDE TO CLARIFY OR ELABORATE MEDICAL ISSUES**

