|  |  |  |
| --- | --- | --- |
| Student name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of birth: \_\_\_\_\_\_\_\_\_\_\_ | |
| County of residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |
| Managed Care Organization (MCO): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |

**DOCUMENTS TO BE SUBMITTED WITH APPLICATION**

|  |  |
| --- | --- |
|  | Consent to Exchange Information Form |
|  | Immunization Record |
|  | Cognitive (IQ) Evaluation (within past 3 years) **\*report required\*** |
|  | Academic Achievement Evaluation (within past 3 years) **\*report required\*** |
|  | Autism Spectrum Disorder (ASD) Evaluation (if applicable) **\*report required\*** |
|  | Current Individualized Education Plan (IEP) or 504 Plan (if applicable) **current copy required\*** |
|  | Speech/Language Evaluation (if applicable) |
|  | Neurological Evaluation (if applicable) |
|  | Discharge Summaries from Psychiatric Hospitalizations (if applicable) |
|  | Discharge Summaries from prior residential placements (if applicable) |
|  | DSS reports (if applicable) |
|  | Juvenile Court Records (if applicable) |

**MANAGED CARE ORGANIZATION (MCO) SIGNATURE OF REVIEW**

MCO submitting referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of submission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MCO Representative Signature of Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Care Coordinator (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Wright School Application for Admission**

|  |  |
| --- | --- |
| Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Height: \_\_\_\_\_\_\_\_\_\_\_\_  Weight: \_\_\_\_\_\_\_\_\_\_\_\_  Gender Identity:  Female  Male  Other (Specify if desired): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Prefer not to answer  County of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent/Guardian Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Race:  Black or African-American  White  American Indian or Alaskan Native  Asian  Native Hawaiian and Pacific Islander  Hispanic or Latino or Spanish Origin  Not Hispanic or Latino or Spanish Origin  Prefer not to answer |

Parent/Guardian Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| Phone #(s): | Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Parent/Guardian(s) Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family members currently living in home with child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Strengths:** |
| **Interests:** |
| **Triggers:** |
| **Academic Skill Deficits:** |
| **Troubling Behaviors:** |
| **Diagnoses:** |
| **Medications:** |

|  |  |
| --- | --- |
| **Behavioral Strategies/Mental Health Interventions** | **Effectiveness (Describe)** |
|  |  |
|  |  |
|  |  |
|  |  |

**Cognitive (IQ) test:**

|  |  |
| --- | --- |
| Name of test: | Date administered: |

|  |
| --- |
| Results: |

**Answer “YES/NO” for each:**  **If you answered “YES,” describe:**

|  |  |
| --- | --- |
| Allergies:  Yes No |  |
| Runaway attempts:  Yes No |  |
| Fire setting:  Yes No |  |
| Problematic sexualized behaviors:  Yes No |  |
| Special medical needs:  Yes No |  |
| Bedwetting:  Yes No |  |
| History of trauma:  Yes No |  |
| Autism:  Evaluated: Yes No  Diagnosed: Yes No  Suspected: Yes No | \*If evaluated for Autism, the complete evaluation report must be provided with referral\* |
| Covid Vaccinations Status:  Initial : Yes No  Second: Yes No  Most Current Booster:  Yes No  Not vaccinated | \*If vaccinated for covid, please attach vaccination card. |

|  |  |
| --- | --- |
| Current community school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Grade: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Ever been retained:  Yes  No What grade: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

|  |  |  |
| --- | --- | --- |
| Eligible for Special Education services: | Yes | No |

If yes, area(s) of eligibility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, current IEP Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| School Supports and Strategies | Effectiveness (Describe) |
|  |  |
|  |  |
|  |  |
|  |  |

Contact Information:

|  |  |  |
| --- | --- | --- |
| Mental Health Professional | Name |  |
| Agency |  |
| Address |  |
| Work Phone |  |
| Email |  |
| DSS Worker (if applicable) | Name |  |
| Agency |  |
| Address |  |
| Work Phone |  |
| Email |  |
| Guardian Ad Litem (if applicable) | Name |  |
| Agency |  |
| Address |  |
| Work Phone |  |
| Email |  |