Beach House Arts Application:

Date of Application	Date of Campus Tour if applicable	Person Completing application
		(ex: Guardian)

Name of person filling out application: _____

Is the client their own legal guardian? Y or N

If YES who do we have permission to speak to? _____

Who does client live with? _____

Does client have VIATrans ID? Y or N ID#_____

Client First name: _____ Client Last name:_____

Client Address:_____

Client/Guardian Home Phone: _____ Client/Guardian Cell Phone: _____

Client Email address:_____

Client Sex: M or F Client Date of Birth: _____

Primary Disability Diagnosis: _____

Emergency Contact Name and Phone number:

Government Assistance (circle all that apply) : SSI SSDI Medicaid Medicare THML CLASS

If applicant has THML or CLASS, list name and number of service provider:_____

Functional Skills

Communication: Verbal Non-verbal

Can she/he walk: Y or N

Does client require adaptive equipment? (walker, wheelchair, crutches etc.) Y or N

How much assistance does client need with the following?

Toileting: None Minimal Total Adult Diapers Other

Female Menstruation Assistance: None Minimal Total Adult Diapers Other

Feeding: None Minimal Total Adult Diapers Other

Dressing: None Minimal Total Adult Diapers Other

Please describe what assistance is needed minimal to the above questions:

Mental Health Condition:

☐ Depression ☐ Schizophrenia ☐ Bipolar ☐ Anxiety ☐ Alzheimer's
☐ Phobia ☐ OCD ☐ None ☐ Other

Please explain and checked Mental Health responses:

Behaviors: Has applicant utilized a Behavioral Contract? Y or N

Behaviors:

Behaviors (please check all that apply) *

☐ Tantrums	☐ Scratches	☐ Steals	☐ Hyperactive	☐ Fantasizes
☐ Screams	☐ Pulls Hair	☐ Withdrawn	☐ Runs Away	☐ Bites
☐ Kicks	☐ Moody	☐ Pinches	☐ Hits	☐ Head Bangs
☐ Self-Abusive	☐ Aggressive	☐ Spits	☐ Slaps	☐ Destructive
☐ Talks to self	☐ Uses Bad Language	☐ Other		

Explain all Behaviors Checked:

Are there things that bother him/her? (Loud noises, change of routine, large crowds, etc.)

How would you describe his/her day-to-day behavior? (Quiet, hyperactive, social, aggressive)

Please include any other vital information about him/her that would be helpful to us

Personal Information:

Reading: Can Not Simple Words Independently If independently what level?

Writing: Can Not Simple Words Independently If independently what level?

Check any/all of the extracurricular activities that he/she enjoys doing: *

☐ Board Game ☐ Drama ☐ Crafts ☐ Fitness ☐ Art
☐ Cooking ☐ Sports ☐ Music ☐ Reading ☐ Video Games
☐ Computer ☐ Other

Medication Information

1. RX Name:	1. Dosage	1. Time	1. Reason for Medication:

2. RX Name:	2. Dosage	2. Time	2. Reason for Medication:

3. RX Name	3. Dosage	3. Time	3.Reason for Medication

4. RX Name	4. Dosage	4 Time	4 Reason for Medication

5. RX Name	5. Dosage	5. Time	5. Reason for Medication

Medication Example:

RX Name	Dosage	Time	Reason for Medication
Lamictal 25mg tablets	50mg	7am & 7pm	Epilepsy

In non-emergency situations BHA staff may give client medical treatment as needed including: Minor wound care with Bandaids, etc (Yes__) (No__), Tylenol (Yes__) (No__), ICE (Yes__) No__), Benadryl Cream (Yes__) (No__), Benadryl pills or capsules (Yes__) (No__), Tums (Yes__) (No__)

Does he or she have Seizers? Y or N

If Yes: Please provide a care plan.

Does he or she have any dietary restrictions? Y or N

Does he/she have any allergies to food, animals, medication, etc.? ***Example: Food allergy – Diary products (all). Reaction - Will break out in hives, rash, etc.*** **Y or N**

11. CONDITIONS

Artificial Limb * ○ Yes ○ No	Asthma/Bronchitis * ○ Yes ○ No	Cerebral Palsy * ○ Yes ○ No
Chewing/Swallowing * ○ Yes ○ No	Diarrhea * ○ Yes ○ No	Ear Aches * ○ Yes ○ No
Hearing Impairment * ○ Yes ○ No	Heart Condition * ○ Yes ○ No	Hepatitis * ○ Yes ○ No
Limb Pain * ○ Yes ○ No	Skin Rashes * ○ Yes ○ No	ADD/ADHD * ○ Yes ○ No
Behavior * ○ Yes ○ No	Dyslexia * ○ Yes ○ No	Emotional Problems * ○ Yes ○ No
Learning Disabled * ○ Yes ○ No	Blind * ○ Yes ○ No	Contact Lenses * ○ Yes ○ No
Glasses * ○ Yes ○ No	Visual Disorders * ○ Yes ○ No	Visually Impaired * ○ Yes ○ No
Has Shunt * ○ Yes ○ No	Other * ○ Yes ○ No	

Explain all checked conditions which are yes

What is his/her favorite activity, games, or hobby?

What is his/her favorite thing to talk about?

What are his/her favorite foods?

When is he/she most cooperative?

When is he/she least cooperative?

What frightens him/her?

What calms him/her?

What personal goals would you like to have him/her work on?

Student's Name (Print)	Student's Signature	Date
Parent/Guardian's Name (Print)	Parent/Guardian's Signature	Date
Staff Member's Name	Staff Member's Signature	Date