

## Application Form 2017-2018

Dear Parents,

The Lebanese Autism Society- LAS created a new admission system for the school year 2017-2018, for the following projects:

- **Classes for Children with Autism- French Section** ( Collège Sacré Coeur Gemmayzé): candidates who can benefit from academic and social integration in a regular French-speaking school.
- **Classes for Children with Autism- English Section** (Adduha school): candidates who can benefit from an academic and social integration in a regular English-speaking school.
- **Center for Autism Intervention and Research- LASCAIR:** candidates in need of a specialized structure; 3 sections are available; early intervention, specialized classes and prevocational/vocational classes.

The applications can be downloaded online or collected from the headquarters of the Lebanese Autism Society- LAS, Collège Sacré Coeur Gemmayzé, Beirut, Lebanon.

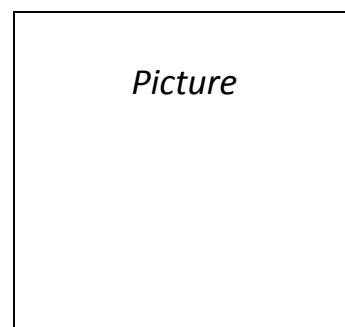
- Medical reports:
  - Child psychiatrist/child neurologist report stating the diagnosis of the child
  - Medical test reports
  - Chromosomal and genetic report
  - Copy of the immunization and vaccination card
  - Any other relevant medical report
- Therapist reports: (dated less than 6 months)
  - Speech Therapist report
  - Psychomotor Therapist report
  - Special Educator report
  - Psychological report
- Educational reports:
  - Report from the current school, nursery or center the child is attending to
- Official papers:
  - 2 passport sized photos
  - Copy of the Identity card or إخراج قيد

### **Admission procedure:**

- An admission committee will study each application and decide upon the action plan
- Incomplete application will be disregarded
- Each application will be considered as a confidential document and only shared by members of the admission committee

Application # : \_\_\_\_\_

Date : \_\_\_\_\_



Child's Name :	Date of birth :
Father's Name :	Mother's name :
Address :	Phone number :
E-mail :	Referred by :
Language the child uses or understands:	Interested in: <input type="checkbox"/> Classes for Children with Autism- <i>French Section</i> <input type="checkbox"/> Classes for Children with Autism- <i>English Section</i> <input type="checkbox"/> Center for Autism Intervention and Research- LASCAIR
Diagnosis of the child and doctors' name and specialization	

**Table 2 to be filled by LAS Administration**

Action	Date	Details	Follow up
1 <sup>st</sup> contact			
Fill in the case history			
Date of Observation			
Assessment needed			
Date of Assessments			
Closure of the application			

Child's information	
Child's name	

Date of Birth	
Place of Birth	
Nationality	
Current address	
Home Phone number	
<b>Father's information</b>	
Father's name	
Date of Birth	
Nationality	
Profession	
Educational background	
Mobile number	
Work phone number	
E-mail	
<b>Mother's information</b>	
Mother's name	
Date of Birth	
Nationality	
Educational Background	
Profession	
Mobile number	
E-mail	
<b>Brothers' and sisters' information</b>	
Name and date of birth of siblings ( brothers and sisters)	
<b>Family Dynamics</b>	
Consanguinity	Yes      Relation:

	No	
Family members living with the child		
Caregiver of the child		
Language spoken at home Language spoken to the child		
Parents' relationship( married, divorced, separated etc..)		
Current medical Status of the child		
	Yes	No
Epilepsy		
Allergy		
Other medical conditions		
Medication		Name of Drug : Purpose : Quantity : Onset:
Comments :		
Socio-economical status		
	1.000.000 -2.000.000	2.000.000 -3.000.000
	3.500.000 -4.500.000	5.000.000 -6.000.000
	6.500.000 -7.500.000	More than 8.000.000
Salaries per month (Net)		
Ministry of Social affairs card number		
Medical Insurance		
Company		Expiration date

Family History			
Type	Yes	No	Relationship with the child
Mental retardation			
			Details

Speech delay				
Motor delay				
Physical Handicap				
Mental Handicap				
Genetic Disorder				
Down Syndrome				
Epilepsy				
Other				
Comments				

Child's development			
<b>Child's conception</b>			
	Yes	No	Details
Natural Pregnancy			Type :
Medical problems during pregnancy (Disease/hypertension/etc....)			Type : Pregnancy month : Time : Hospitalization :
Hospitalization during pregnancy			Reason : Pregnancy month : Time :
Administration of drugs during pregnancy			Reason : Type : Quantity : Pregnancy month : Time:
Any psychological trauma to be mentioned Divorce/ death/accident/ disease in the family /war			Type : Pregnancy month : Time :
Change in the family dynamics Move/ trip/ etc...			Type : Pregnancy month : Time :
Other information			
Child's development			
<b>Child's birth</b>			
	Yes	No	Details
Pregnancy ended at term			Pregnancy month :

Natural delivery			Type of delivery :
Score Apgar 8/10			Score :
Any medical intervention after delivery to the child			Reason : Type : Time :
Any medical intervention after delivery to the mother			Reason : Type : Time :
Hospitalization of the mother :			Reason : Time :
Other information:			
<b>Motor Development</b>			
Type	Age	Comments	
Head Holding			
Sitting position			
Standing position			
Walking			
Teeth			
Hand Preference/use (right or left)			
Other information:			
<b>Language development</b>			
Type	Age	Comments	
Cooing			
Babbling			
Pointing			
First words			
First sentences			
Other information:			
<b>Social Development</b>			
Type	Age	Comments	
Smiling			
Eye contact			
Respond to name calling			
Play			
Other Information:			

<b>Food</b>	
Food Habit	

Other information:

**Toilet training**

Clean during the day		
Clean at night		

Other information:

**Self-help skills**

Dressing/ Undressing	
Brushing teeth	
Washing face/ body/ Bath	
Food alimentation	
Toilet	

Other information

**First Pathological signs noticed by parents (Signs/Symptoms on-set etc..)**

**Medical History**

**Diseases**

Type	Age	Duration	Hospitalization duration	Treatment	Comments

**Accidents**

Type	Age	Duration	Hospitalization duration	Treatment	Comments
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**Medications**

Type	Age	Reason	Duration	Off-set	Comments

Other information concerning the medical history of the child:

**Medical tests( report should be attached to the application)**

Type	Yes	No	Details
EEG			
IRM			
Eye exam			
Chromosomal/ genetic exam			
Audiogram or PEA			
Pediatrician report			
Neurologic report			
Psychiatric report			

Other exams or reports

**Schooling**

Type	Name	Address	Phone number	Time/	Reason for stopping
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				Duration	intervention

Other information

**Therapies**

Therapies	Therapist Name	Therapist number	Beginning of therapy	Duration /modality	Reason for stopping intervention

Other information

**Assessments done**

Type	Yes	No	Details
School Assessment			
Speech Assessment			
Psychomotor Assessment			
Psychological Assessment			
Educational Assessment			

Other Assessments: