Tel.: 0721 355896
0720632423
Email: info@rainbowtherapies.co.ke
Physical Address: 2.5D Main Kitisuru
Road Nairobi, Kenya

FORM A: APPLICATION INFORMATION

(Please complete and return to the school before assessment)

1. Learner Details

Name and Surname: ____

Date Of Birth: ________________________ Age (years/months):________

Home Language: ______________________ Sex:__________________

Address (Home): ____

____

____

Address (Postal): ____

____

____

2. Parents/Guardian Details

Father's Name: ____

Date Of Birth: ____

Marital Status: ____

Address (Home): ____

____

____

Address (Postal): ____

____

____

Tel (Home):____

Tel (Work):____

Tel (Mobile):____

Email:____

Employer:________________________Occupation:__________________

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Mother's Name: ____

Date Of Birth: ____

Marital Status: ____

Address (Home): ____

____

____

Address (Postal): ____

____

____

Tel (Home): ____

Tel (Work): ____

Tel (Mobile): ____

Email:____

Employer: ________________________Occupation:____________________

3. Alternate Emergency Contact Person

Name: ____

Relationship to learner: ____

Tel (Home): ____

Tel (Work): ____

Tel (Mobile): ____

Email:____

4. Private Health Insurance Details

Main Member: ____

Private Health Insurance Scheme: ____

Private Health Insurance Number: ____

Doctor:____

Tel (Work):____

Tel (Mobile):____

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5. Family History

Parents (any history of inherited disorders e.g. asthma, heart problems, learning difficulties etc):

____

____

Learner concerned (any inherited disorders e.g. asthma, heart problems, learning difficulties etc):

____

____

Siblings (any inherited disorders e.g. asthma, heart problems, learning difficulties etc):

____

____

Extended family (any inherited disorders e.g. asthma, heart problems, learning difficulties etc):

____

6. Obstetrical History

Did you have difficulty falling pregnant? ________________________________

____

Did you have miscarriages before falling pregnant? ___________________________

____

How old were you when you fell pregnant? ______________________________

What was the age of the father at the beginning of pregnancy? ____________________

Was your pregnancy planned? ______________________________________

What was your/mother's general state of health during pregnancy e.g. viral infections, illness, German Measles, stress, excessive morning sickness, haemorrhage?

____

____

Were any prescription drugs taken during your pregnancy?

____

____

Where there any blood type complications during your pregnancy?

____

____

How many weeks did your pregnancy last? ________________________________

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____

What was the duration of your labour? ____

____

Did you have a normal or caesarean birth (if caesarean state reasons)?

____

____

7. Neonatal Period

What was the birth weight of your baby? ____

Were there any complications during the birth of your baby?

____

____

Did you breast feed or bottle feed your baby?

____

____

Did your baby have any feeding problems?

____

____

Were there any difficulties introducing solids?

____

8. Milestones (Please indicate approximate age of):

First smile: ____

Held head up first time: ____

Sat unaided: ____

Stood unaided: ____

Crawled: ____

Walked unaided: ____

Began babbling: ____

First words: ____

Sentences: ____

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Understanding and response to commands: ____

9. Medical History

Has your child had any significant illnesses?

____

____

Has your child ever been in hospital (if yes please give a brief description)?

____

____

Has your child experienced any recurrent illnesses (e.g. ear/nose/throat infections)?

____

____

Does your child have a history of seizures, convulsions or epilepsy?

____

____

Is your child on any medication at present (if yes, supply reason, name and dosage)?

____

____

Has your child had any long-term treatment or therapy e.g. occupational, speech, psychological, physical, remedial?

____

____

What immunisations has your child had?

____

____

Does your child have any allergies?

____

____

Does your child have any coordination difficulties?

____

Does your child have any visual and/or auditory problems? (has hearing and vision been tested?)

____

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10. Family Relations

Describe the relationships your child has with your immediate family members:

____

____

Describe any behavioural or emotional difficulties your child may have:

____

____

If both parents are working what are your child's day care arrangements:

____

11. Emotional and Social Development

How would you describe your child's personality?

____

____

How would you describe your child's relationships with his/her friends and siblings:

____

____

Please indicate (tick) if your child has difficulties with any of the following:

Sleeplessness		Tactile Defensive		Auditory Defensive	
Oral Sensitivity		Self Stimulatory Behaviours		Easily Frightened	
Nail Biting		Tantrums		Restrictive Routines	
Tic		Phobia		Need for Attention	
Over Dependency		Behaviour Difficulties		Any other:	

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12. School History

Has your child ever attended a playgroup/crèche/nursery/primary school? If yes please give name and a brief description:

____

____

Were there any particular problems experienced at any of the above-mentioned playgroup, crèche, nursery or primary schools?

____

____

What do you think are your child's main areas of difficulty?

____

____

What do you think your child's areas of strength are?

____

____

13. Has your child had any previous assessments (if yes please describe and supply reports where possible):

____

____

____

14. Any additional information

____

____

____

15. What are your goals for your child?

____

____

____