



INITIAL INQUIRY FORM

STUDENT INFORMATION

Last Name _____		First Name _____		<input type="checkbox"/>	<input type="checkbox"/>	Date of Birth _____	Age _____
				M	F		
Grade: _____	_____	How did you hear about UCP? _____					

PRIMARY CONTACT/PARENT/LEGAL GUARDIAN

Last Name _____		First Name _____		<input type="checkbox"/>	<input type="checkbox"/>
				M	F
Relationship to Child _____		E-Mail Address _____ @ _____			
Address _____		City _____	State _____	Zip _____	
Home Phone _____		Business Phone _____		Cell Phone _____	
Name of Employer _____		Position _____		Address _____	

If applicable, where does your child currently attend school? What kind of services do they receive?

PROGRAM LOCATION PREFERENCE

Location Preference:

- | | | |
|------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> EO/Bailes | <input type="checkbox"/> Holloway/Downtown Orlando | <input type="checkbox"/> Pine Hills |
| <input type="checkbox"/> Seminole | <input type="checkbox"/> West Orange | <input type="checkbox"/> TLA |
| | <input type="checkbox"/> Osceola | |

THERAPY SERVICES

Please check requested therapy services:

- | | | |
|---|---|---|
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Speech Therapy |
|---|---|---|

Funding Source:

- | | |
|---|---|
| <input type="checkbox"/> Private Pay | <input type="checkbox"/> Commercial Insurance _____ |
| <input type="checkbox"/> CMS | <input type="checkbox"/> Medicaid/ Medicaid HMO _____ |
| <input type="checkbox"/> Charter School (County: _____) | |
| <input type="checkbox"/> Other: _____ | |

HEALTH AND SAFETY INFORMATION

List any limitations or prohibited activities for your child?

Does your child have an Individual Family Support Plan (IFSP) or Individual Education Plan (IEP)?

Yes No

Does your child require the use of any adaptive equipment? Yes No

If yes, please explain.

Does your child have or had medical issues including allergies? Yes No

If yes, please specify.

Does your child have any behavior issues? Yes No If yes, please specify. (Behavior Therapy)

Does your child have or had seizures? Yes No Date of Last seizure. _____

Type of seizure _____ Frequency _____

List any medications presently being taken:

Med _____	For _____	Dosage _____	Time _____
Med _____	For _____	Dosage _____	Time _____

For the majority of the day, can your child successfully function with an adult ratio of:

1 adult to 3 children: Yes No If no, please provide additional information:

1 adult to 5-6 children: Yes No If no, please provide additional information:

For the majority of the day, can your child successfully function in a group size of:

9 children Yes No If no, please provide additional information:

12 – 16 children Yes No If no, please provide additional information:

Is over the age of three, is your child potty trained/able to toilet themselves?

Yes Under Age 3 No If no, please provide additional information:

If Middle School age or older, is your child working on a standard or Special Diploma?

Standard Diploma Special Diploma Not Applicable
