



Little Light House

CENTRAL MISSISSIPPI

A Christian Developmental Center for Children with Special Needs

PO Box 13662, Jackson, Mississippi 39236
(p) 601.956.6131 (f) 601.956-6143 www.LLHMS.org

Application for Children's Services Waiting List

The Little Light House, Inc. is a non-profit Christian Developmental Center for children with disabilities, age birth through six years of age. The Little Light House does not discriminate on the basis of religion, sex, race, color, national or ethnic origin, or medical diagnosis (unless it affects the child's ability to attend on a regular basis) in the administration of its educational policies, admissions policies, and other school administered programs. Some behavioral conditions may be evaluated on an individual basis. The Little Light House assures that all children's records will be maintained as confidential.

**Please attach a photo
(snapshot) of child**

Date: _____

Name of child: _____
First Middle Last

Date of birth: _____

Male ___ Female ___ Current age: _____

Weight _____ Height _____

Address of residence: _____
Street Address City State Zip

Parent/Guardian Information

Father: _____
First Middle Last

Home Phone: _____

Email Address: _____

Work Phone: _____

Mailing Address: _____
Street

Legal Guardian: Yes / No
Please circle one

City State Zip

Mother: _____
First Middle Last

Home Phone: _____

Email Address: _____

Work Phone: _____

Mailing Address: _____
Street

Legal Guardian: Yes / No
Please circle one

City State Zip

I understand that it is my responsibility to contact The Little Light House, Inc., in writing of change concerning any component that could deter communications between The Little Light House, myself, and said child. **This includes but is not limited to a change of telephone number, name, and/or address.** *Should I fail to do this, I understand that my child could be withdrawn from the waiting list, due to the inability of The Little Light House to contact me.* I will do my part to ensure that The Little Light House is able to communicate with me at all times.
Initial here.

Mission Statement

"To glorify God by improving the quality of life for children with special needs, their families and communities."

Current Services

Please explain why your child is in need of special education and therapy services: _____

Have you pursued services through First Steps? _____ Yes _____ No

Have you pursued services through public schools? _____ Yes _____ No

Are you aware of alternative programs for your child? _____ Yes _____ No

Are you considering alternative programs until your child can be enrolled in The Little Light House? _____ Yes _____ No

What services (speech, physical, occupational therapy &/or special classes) is your child presently receiving?

1. Agency/School _____ Services _____
For how long? _____ Primary emphasis _____

2. Agency/School _____ Services _____
For how long? _____ Primary emphasis _____

3. Agency/School _____ Services _____
For how long? _____ Primary emphasis _____

Who referred you to The Little Light House? _____

Child Information

What is your child's diagnosis? _____

What is/are your child's impairment(s) or delay(s) at this time? _____

Please list the types of toys your child enjoys: (i.e. music, switch toys, See 'N Say, etc.) _____

Please list the types of food your child eats and its consistency (tube feedings, baby food, pureed, chopped, finger foods, table foods): _____

Does your child drink from a *please circle* (bottle, cup with a lid, cup without lid, nurses)

Does your child eat finger foods independently? _____ Yes _____ No

Does your child use a spoon independently? _____ Yes _____ No

How does your child let you know what he/she wants? (i.e. crying, pointing) _____

What is your child's primary means of mobility? _____
Please list any special equipment used with your child: _____

Please list any special precautions that may need to be taken with your child: _____

Please list all medications and methods of administration: _____

Please list **all** surgeries your child has had (i.e. tubes in ears, orthopedic, shunt, feeding tube, etc.): _____

Please check applicable medical appliances and/or treatments.

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Tracheotomy | <input type="checkbox"/> Ostomy |
| <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Shunt |
| <input type="checkbox"/> Prosthesis (please describe) _____ | |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Other (please describe) _____ | |

Is there anything else that you would like The Little Light House to know about your child? _____

Waiting List Testing Authorization

The undersigned being the parent/legal guardian of _____
Does hereby authorize qualified staff of The Little Light House, Inc. to administer psycho-educational, developmental, speech and language, and other types of diagnostic testing, as necessary for educational planning and placement purposes. It is understood that the said results will be considered confidential and will be released to other agencies only by the signed authorization of the parents or legal guardian of the child.

Parent/Legal Guardian Signature

Date