GOOD WILL-HINCKLEY
Educating Youth. Changing Lives.

Campus Living Program | College Step-Up | Roundel Residential | LC Bates Museum | Glenn Stratton Learning Center

Glenn Stratton Learning Center

Please send the referral packet to the address below or email to abelanger@gwh.org I will share information with my education and clinical team and respond to you promptly. Thank you for your interest in GSLC.

School Year 2020-2021 **Date of Referral: _____**

Student's Full Name: _____D.O.B.: _____
Grade Placement : ____
Parent's/Guardian's Name:_____
Address: _____
Current Parent Phone Number _____
Parents have been informed of this placement option. _____YES / _____NO
Parents support this placement. _____YES / _____NO

PRIMARY REASON FOR REFERRAL:

Describe why an alternate placement is needed at this time:

When does student need placement?

Is there a current Day Treatment IEP?

What intervention strategies and positive behavior supports were not successful to address the problems (administrative and instructional):

STUDENT BACKGROUND INFORMATION:
School Performance:

_____Low Achievement	_____Retained in grade(s):
_____Over-age for grade	_____Inconsistent or no effort
_____Poor Attendance	_____No extracurricular

Has attended ___ Schools in ___ years. (# of school changes since kindergarten.)

Referral for Day Treatment in the past?
_____ No / _____ Unknown / _____ Yes: date (___/___/___)
Reason for referral: _____
Outcome of referral:_____

BEHAVIOR:
History of behavior problem: _____ No / _____ Yes, since grade _____.

Please check the types of behavior that apply:

___discrimination
___disrespect
___Intimidation
___defiance
___fighting
___Possession of weapon
___profanity or vulgarity
___class disruption
___bullying
___extortion
___Possession of controlled substance
___assault
___bus behavior
___insubordination
___inappropriate attire
___harassment
___stealing
___cheating
___verbal/written threats
___sexual harassment
___leaving campus
___Tobacco violations
___other (_____)

BEHAVIOR (cont.):
Suspensions this school year: _____ Detentions this school year: _____
Attendance this school year: _____ Expulsion this school year: _____

If Expulsion is there a current plan in place? _____ (if yes, please attach)

Past involvement with courts: _____No / _____Yes, when: (___/___/___)
Current involvement with courts: _____No / _____Yes, when: (___/___/___)
General Health:_____

MENTAL / PHYSICAL HEALTH:
Medical Issues:_____
Medical health diagnosis:_____
Toileting issues: _____No / _____Yes: describe:_____

Other:
_____Student has received mental health services.
_____Records attached
_____Records have been requested

Inpatient?_____No / _____Yes, when: (___/___/___)
Outpatient: _____No / _____Yes, when: (___/___/___)

SOCIO-ECONOMIC:

_____Free/reduced lunch
_____Family moves frequently
_____Low educational expectations
_____Student is expecting a child
_____Family disruption
_____Not living with natural parents
_____Student is a parent

Other issues that may impact student's behavior and/or academic progress:

Days absent this year: _____ Days absent last year: _____

Student received the following services prior to referral:

_____academic support
_____crisis counseling
_____referral to outside agency
_____credit recovery
_____Occupational therapy
_____bullying intervention
_____social skills development groups
_____guidance
_____truancy court
_____family counseling
_____special education evaluation
_____medical evaluation
_____Speech/Language
_____Other:_____

Currently on probation: _____No / _____Yes:

PO Contact Info:_____
_____
_____

What are the expected measureable outcomes of this placement?

_____ These goals have been shared with the student and his/her family.

How will the student's response to this placement be evaluated?
(Ex. Improved grades/ discipline record

DATE OF IEP MEETING CONFIRMING OUT OF DISTRICT PLACEMENT:

Administrator Requesting Placement: _____
District:_____

Please list names and contact information of someone who is knowledgeable of the student's current functioning:
_____
_____
_____

Please attach the following documents:
- Current IEP
- Latest Evaluations
- Current Transcripts
- Last Written Notice
- Restraint/Seclusion reports
- Release of Information for GSLC
- Anything else that may support placement decisions

Director of Special Education, GSLC:_____
____N/A ____ Approved ____Rejected*

*Reason for rejection:_____
_____
_____
_____
_____

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Glenn Stratton Learning Center Enrollment Application

GOOD WILL-HINCKLEY

Student Information

Last Name	First Name	Middle Name	Age	Sex M/F	Date of Birth

Nickname	Height	Weight	Eye Color	Social Security Number

Adopted Yes/No	At what age?	Place of Birth	Hometown	US Citizen Yes No

Name and address of last school attended

Current Grade	Last day attended school

Maine Care Number (if applicable)

Name of Medical Insurance

Group Number	Policy Number

Please provide the student's current address if not living with parent or guardian

Name	Relationship	Telephone

Address	City	State	Zip

Student's Housing Information:

PLEASE CIRCLE THE APPROPRIATE RESPONSE

Housing Source: rent, own, subsidized, shelter, other	**STUDENT'S MARITAL STATUS**
Housing Type: apartment, trailer, house, other	Single
Heat Source: wood, oil, electric, none, other	Married
Water Source: town/city, well, none, other	

Custody Information

Are parents separated or divorced? Yes ☐ No ☐

If YES, who has:

Legal Custody	
Physical Custody	
Sole Custody	

IMPORTANT
****Please submit all documents related to the custody of the student with this application.****

Current Family or Guardian Information

Father's Name		Occupation	Level of Education
Home Street Address	Town	State	Zip Code
Home Telephone	Cell Phone	Work Phone	Email

Mother's Name		Occupation	Level of Education
Home Street Address	Town	State	Zip Code
Home Telephone	Cell Phone	Work Phone	Email

Other Family or Guardian Information

Name/Relation to child		Occupation	Level of Education
Home Street Address	Town	State	Zip Code
Home Telephone	Cell Phone	Work Phone	Email

Name/Relation to child		Occupation	Level of Education
Home Street Address	Town	State	Zip Code
Home Telephone	Cell Phone	Work Phone	Email

Sibling Information

Please list all siblings and others who live with your child

Name	Age	Gender	Relationship	Biological / Adopted

Professional Consultations

Please list Psychiatrists, Psychologists, Educational Consultants, etc. that have worked with your child.

Name	Professional	Location	Dates of Service
Describe type of service rendered and why consultation was needed:			

Name	Professional	Location	Dates of Service
Describe type of service rendered and why consultation was needed:			

Name	Professional	Location	Dates of Service
Describe type of service rendered and why consultation was needed:			

Out-of-Home Placements

Please list hospitals, treatment centers, wilderness programs, etc. that have worked with your child.

Name	Program	Location	Dates of Service
Describe type of service rendered and why placement was needed:			

Name	Program	Location	Dates of Service
Describe type of service rendered and why placement was needed:			

Goals and Expectations

What are your goals and expectations for your child's emotional wellbeing?
What are your expectations of your child academically?

Student's Personal History

In your words, what are your child's strengths, positive qualities, accomplishments, and interests?
In your words, what are your child's difficulties and when did they first become apparent?
Has your child experienced any traumatic events (divorce, illness, death, separation, etc.)? Yes No Please describe:
Has your child experienced many significant life changes such as numerous moves and or school changes? Yes No Please describe:
What behavioral and/or mood issues are you concerned about? How long has the behavior or mood change existed?
How does your child express feelings of anger, sadness, frustration, and disappointment? (Inwardly, outwardly, harmful to self/others, etc.)
Describe your child's relationships with siblings, peers and animals
Is the student married? Yes _____ No _____

To the best of your knowledge, has your child experienced or engaged in any of the following?

Fire setting? Yes No Please describe:
Violent behavior? Yes No Please describe:
Sexual abuse? Yes No Please describe:
Arrests, incarcerations, or juvenile probation? If so, is student on probation? Yes No Please describe:
Cruelty to animals? Yes No Please describe:
Suicide attempts or threats? Yes No Please describe:
Self-abusive behavior or self-mutilation? Yes No Please describe:
Unusual thoughts? Yes No Please describe:
Fears and anxieties? Yes No Please describe:
Bed wetting? Yes No Please describe:
Depression? Yes No Please describe:
Obsessive-compulsive behavior? Yes No Please describe:

Physical abuse? Yes No Please describe:
Sexual activity? Yes No Please describe:
Eating disorder? Yes No Please describe:
Drug and alcohol or tobacco use? Describe frequency and any significant events: Yes No
Is there a history of mental illness in the child's family? Yes No Please describe:
Running away? Yes No Please describe:
Is there a history of substance abuse in the child's family? Yes No Please describe:
Please describe things you feel your family does well.

Student's Medical History

Please identify and describe any health problems.	
When was your child's last physical? Name, address and phone of physician:	When was your child's last dental exam? Name, address and phone of dentist:
Are there any current dental problems?	
When was your child's last eye exam? Name, address and phone of eye doctor:	
Does your child wear glasses or contacts? Yes No Indicate which and reason for needing them.	

Is your child currently taking any medications? Yes No
If Yes, Please list below:

Medication	Dose	Frequency	Reason

Please explain your child's response to the medication:

Please describe any medication concerns you have for your child:

Student's Medical History –Continued

Have any of your child's relatives had any of the following diseases? If yes, identify the relative.

	Yes	No	Relative
Tuberculosis			
Bleeding Disorder			
Cardiovascular Disease			
Asthma			
Cancer			
Epilepsy or Convulsion			
Diabetes			
Kidney Disease			
High Blood pressure			
Muscle Disorder			
Other Illnesses			

Please indicate by entering his or her age if your child has had any of the following diseases or illnesses:

	Age			Age			Age
Anemia (low red blood count)			Epilepsy			Pneumonia, Bronchitis	
Arthritis			Frequent Colds			Polio	
Bladder or Kidney Infection			German Measles (three days)			Red Measles (ten days)	
Bone Condition			Hearing Disorder			Rheumatic Fever	
Chicken Pox			Heart Disorder			Scarlet Fever	
Constipation or Diarrhea			Hepatitis A			Scoliosis	
Convulsions or Seizures			Hepatitis B High Blood Pressure			Tuberculosis	
Diabetes			Meningitis, Encephalitis			Ulcers	
Ear infection			Mumps			Sexually transmitted infection	
Eczema, Dermatitis			Muscle Weakness			Others:	

Developmental information:

At what age did the applicant:	Walk:	Talk:	Toilet train:	Puberty Onset:

Please answer the following questions regarding the applicant's birth mother:

Pregnancy Duration:	Full Term	Premature	Birth weight:
Was this a normal and uncomplicated pregnancy? Yes		No	Unknown
Describe any complications with the pregnancy or delivery:			
Explain if there was a history of drugs, alcohol, tobacco or mental health issues during pregnancy.			

I represent that the above information is correct to the best of my knowledge and belief. Both parents'/guardians' signatures are required.

_____ _____

Signature Date

_____ _____

Signature Date