



FREDERICK CAMPUS

101 Clarke Place

P.O Box 250

Frederick, MD 21705-0250

301.360.2000

301.360.2001 TTY

301.360.1400 FAX



*Frederick Campus
Established 1868*

*Columbia Campus
Established 1973*



Dear Parent(s):

Thank you for your interest in the Maryland School for the Deaf. We offer a wide range of programs that meet the specific needs of each individual student. Enclosed you will find a copy of our Parent/Student Handbook. The handbook offers you a comprehensive view of our entire program.

Also, in the handbook, you will find our Admissions Policy on pages 13 – 20. Allow me to briefly list what you need to do to make the admission procedure run smoothly.

- Fill out the following forms and send them to us at the address on the left side of this letter or fax them to us at 301-360-1403. Once we received the below forms, we will contact you to set up a date for your child's admissions evaluation. Please bring the originals to the admissions evaluation appointment. The forms we need are:
 - Application for Admission
 - Pertinent Data
 - Permission for Release and Transmittal of Educational Information for each school/program that your child has attended
 - Permission for Release and Transmittal of Medical and/or Psychological Information
 - Intake/Case History
 - Receipt of Parental Rights Document

- Provide us with copies of the following records:
 - Child's Birth Certificate
 - Two Copies of Proof of Residency (See page 14 in Handbook)
 - Copy of the official Petition for Guardianship and Court Order of Guardianship, if applicable
 - Educational records from the past 3 years
 - Report Cards or Transcripts
 - Educational Assessments / Tests
 - Records from any hospital or treatment program, if applicable

If you have any questions, please do not hesitate to contact my secretary, Ms. Kate Baker at 301-360-2030 Voice/TTY or at bakerka@msd.edu or myself at 301-360-2031 TTY or at theresa.napoli@msd.edu.

We look forward to hearing from you real soon.

Sincerely,

Theresa A. Napoli

Director of Admissions/Director of Student Support Services - Frederick Campus

Required Documents and Forms to be completed for Consideration for Admission

Dear Parents/Guardians of Prospective Students

In order to help move along your son or daughter's application, we thought it would be helpful to list the information enclosed.

There are three types of documents that you need to provide:

- 1) Copy of your child's Birth Certificate.
- 2) At least two (preferably more) documents as proof of residency in Maryland.
- 3) If applicable, copies of the petition AND court order for legal guardianship.

Please refer to the enclosed pages from the MSD Parent/Student Handbook for more information on #2) and #3).

There six forms enclosed which need to be filled in and returned by you:

- 1) Application for Admission*
- 2) Release Form for Educational Records. * Please make certain to list the last three educational placements and their addresses.
- 3) Release Form for Medical Information. * Please list all medical centers and physicians that have treated your child, being sure to include their addresses.
- 4) Pertinent Data
- 5) Case History
- 6) Receipt of Procedural Safeguards-Parental Rights Document (enclosed).

*Critical to begin the evaluation process

Please keep the enclosed information from the MSD Parent/Student Handbook and Procedural Safeguard-Parental Rights. Document and send all other requested documents and completed forms to the Admissions Office as quickly as you can. This is especially important for the release of information forms as we must send them out and get responses back prior to the tentative evaluation date.

Thank You.

MARYLAND SCHOOL FOR THE DEAF

101 Clarke Place
Post Office Box 250
Frederick, MD 21705

Student Number: _____
(office use only)

APPLICATION FOR ADMISSION

1. Child's full legal name _____
Race _____ Sex _____
2. Child's present address _____
_____ County _____
3. By what name is the child called at home? _____
4. Date of Birth _____ Verified by _____
5. Place of Birth _____
6. Since what date has child lived in Maryland? _____
7. Describe hearing problem _____
8. Cause _____ At Age _____
9. Previous education: _____

10. Where has the child been tested or treated at a hearing and speech clinic or hospital?

11. Name and address of family physician _____

12. Name of health and medical insurance co., if any _____
_____ Policy number _____
13. Full name of parents or legal guardian _____
14. Address _____

Relationship _____
15. Home Telephone _____ Email _____
How can parents /guardians be reached in an emergency: _____
16. **Child's family: (List all children in order according to age)**

Name	Relations hip	Birth date	Marital Status	Education
	Father			
	Mother			

I VERIFY THE ABOVE INFORMATION TO BE CORRECT TO THE BEST OF MY KNOWLEDGE AND I AM REQUESTING MY CHILD BE CONSIDERED FOR ADMISSION TO THE MARYLAND SCHOOL FOR THE DEAF.

SIGNATURE OF PARENT OR GUARDIAN

DATE

**SIGNED PERMISSION FOR THE EXCHANGE OF
EDUCATIONAL AND MEDICAL INFORMATION:**



STUDENT NAME: _____ DOB: _____

By my signature below, I authorize permission for Maryland School for the Deaf to exchange private pertinent information regarding the above named student:

Signature: _____ Date: _____

Relationship to student: _____

I understand that granting permission is voluntary and that I may revoke this permission in writing at any time. This authorization will expire one year from today's date. I grant permission for communication with the following institution:

(Name of school/program/clinic)

(Full address of school/program/clinic)

(Contact Person, number and/or email address)

FREDERICK
CAMPUS
101 Clarke Place
P.O. Box 250
Frederick, MD 21705-
0250

301.360.2000 V
240.575.2966 VP
301.360.1400 FAX

✧
COLUMBIA CAMPUS
8169 Old Montgomery
Road
P.O. Box 894
Columbia, MD 21044-
0894

410.480.4500 V
410.696.2966 VP
410.480.4506 FAX

✧
*Frederick Campus
Established 1868*

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Established 1973*

✧
The Maryland School for the Deaf does not discriminate on the basis of age; ancestry; color; creed; marital status; mental or physical disability; national origin; race; religious affiliation, belief, or opinion; sex or sexual orientation in matters affecting programs, activities, or employment practices.

THE FOLLOWING EDUCATIONAL AND MEDICAL FILES ARE BEING REQUESTED FOR PURPOSE OF UPDATING EDUCATIONAL PLACEMENT /PARENT REQUEST/OTHER _____:

- Audiograms and Communication assessments, including speech-language, speech reading, ASL, assistive technology, etc.
- Individualized Educational Programs (IEPs) and/or Individualized Family Service Plans (IFSPs)
- Psychological and/or Psychiatric Evaluations/Assessments
- Educational Evaluations/Assessments, Transcripts, Report Cards/Progress reports
- Test Scores (Achievement Tests, District Wide Tests, Maryland State Assessments)
- Behavior Assessments and Reports, including Functional Behavioral Assessments (FBA) and Behavioral Intervention Plans (BIP)
- Physical/Immunization record
- Occupational Therapy (OT) Evaluations/Assessments and Physical Therapy (PT) Evaluations/Assessments

PLEASE SEND ALL FILES TO EITHER:

Ms. Theresa Napoli, MSD Admissions, Frederick Campus
101 Clarke Place, P.O. Box 250
Frederick, MD 21705-0250
301-360-2030 (V) or 240-575-2958 (VP)
theresa.napoli@msd.edu
301-360-1403 (fax)

-Or-

Dr. Jennifer Mertes, MSD Admissions, Columbia Campus
8169 Old Montgomery Road, P.O. Box 894
Columbia, MD 21044-0894
410-480-4570 (V) or 410-696-7441 (VP)
jennifer.mertes@msd.edu
410-480-4596 (fax)



INTAKE CASE HISTORY

I. Identifying Information

Today's Date: _____

Student's Name: _____

Age: _____ Last Birth date _____/_____/____ First Middle Gender: Male / Female

Home Address: _____

Street Address

City

County

State

Zip Code

Home Phone: (____) _____ V/TTY Cell phone: (____) _____.

Email: _____ Video phone: _____

Student's Social Security Number: _____/_____/_____

Medical Assistance: Yes / No Medical Assistance Number: _____

Other Health Insurance: _____ Member # _____

Parent's Name: _____ Birth date: _____/_____/_____

Occupation: _____ Work phone: (____) _____

Highest Educational Degree Completed: _____

Parent's Name: _____ Birth date: _____/_____/_____

Occupation: _____ Work phone: (____) _____

Highest Educational Degree Completed: _____

Student's Legal Guardian: _____

Resident of Maryland: Yes / No

Sibling's Name: _____ Age Gender Hearing Status _____

Others living in the home: _____

The Maryland School for the Deaf does not discriminate on the basis of race, color, sex, age, national origin, religion, or disability in matters affecting program, activities or employment practices. Inquiries regarding sex and race are made for reporting purposes only and the results of these inquiries are not used in making any admissions decisions. Answering these questions is voluntary.

Race Code (as defined by MD State Dept of Education): Hispanic or Latin origin? Yes/No

Please circle at least one of the following:

- 1) American Indian/Alaska Native
 - A person having origins in any of the original or Alaska Native peoples of North America and South America (including Central America) and who maintains cultural identification through tribal affiliation or community recognition
- 2) Asian
 - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including for example, Cambodia, China, India, Japan, Korea, the Philippine Islands, Malaysia, Pakistan, Thailand and Vietnam
- 3) Black or African American
 - A person having origins in any of the black racial groups in Africa
- 4) Native Hawaiian or Other Pacific Islander
 - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- 5) White
 - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

II. Developmental History

A. Pre/Post Birth:

Prenatal complications - please identify any factors that may have affected the child during pregnancy (i.e., bleeding; medications; injury; sickness; in-utero substance exposure; etc.):

Length of pregnancy: _____ Full term _____ Premature _____

Birth weight: _____ Birth height: _____ Health of child at birth: _____

Hospital where child was born: _____

Postnatal complications (jaundice; breathing problems; NICU stay; extended hospital stay; artificial ventilator), if any: _____

B. Developmental Milestones (when did your child. . . ?):

Crawl _____ Stand alone _____ Walk alone _____ Begin babbling/talking _____

Begin using sign language _____ Accomplish toilet-training _____

Any parental concerns regarding your child's development? _____

III. Medical History

Are your child's inoculations (shots) up to date? ___Yes ___No

(Immunizations must be up-to-date before students can begin attending classes. Please provide a copy of the immunization records).

Date of most recent physical examination: _____

(A copy of your child's current physical is required for participation in certain school activities).

Is your child currently taking any prescription medications? ___Yes ___No

If yes, please list:

Please provide us with the name, address, and phone number of your child's physician.

Has your child ever had surgeries or been hospitalized? ___Yes ___No If yes, please explain:

Is there a family history of medical or emotional/behavioral concerns?

Motor Coordination:

Handedness (Right or Left) _____

Dresses independently: ___Yes ___No

Can your child: Button ___Yes ___No

Snap ___Yes ___No

Zip ___Yes ___No

Tie own shoes ___Yes ___No

Eat independently ___Yes ___No

Participate in Sports: ___ Yes ___No (describe any restrictions or limitations) _____

Nutrition:

Does your child have a medical condition that requires a special diet? ___Yes ___No

If yes, please explain:

List any food allergies: _____

List any ethnic or religious food restrictions: _____

Does your child currently receive any of the following services?

Service	Yes	No	Where/Who?	How often?
Speech-Language therapy				
Aural (re)habilitation/ Auditory Training				
PT (Physical Therapy)				
OT (Occupational Therapy)				
Educational services				
IEP/IFSP (Individualized Educational Programs/Individualized Family Service Plans)				
Other				

Please indicate if your child has experienced any of these conditions:

Illness or Medical Concern	Yes / No	Age of Onset / Diagnosis	Explain (Use back of paper, if necessary)
Attention deficit disorder (ADHD)			
Allergies			
Anemia			
Asthma			
Chicken pox			
Colic (as a baby)			
Concussion			
Diabetes			
Dizziness			
Ear infections			
Encephalitis			
Fainting			
Head injury			
Heart problems			
High fevers			
Measles			
Meningitis			
Migraines / headaches			
Pneumonia			
Seizures			
Serious injuries or surgeries			
Tuberculosis			
Ushers Syndrome / Retinitis Pigmentosa			
Vision problems / corrective glasses			

IV. Hearing Status

Child's age when hearing loss first suspected: _____

Child's age when hearing loss confirmed by professional? _____

Cause of child's hearing loss: _____

Is anyone in the family or extended family Deaf or Hard of Hearing? (If yes, please list)

Child's hearing levels: (Right ear) _____ (Left ear) _____

Date of most recent audiological exam: _____

Name of audiologist: _____

Name of center/agency where test was completed: _____

Does your child own a hearing aid? ___ Yes ___ No (if Yes, please fill out questions below)

Right Ear (Make/Model) _____ Left Ear (Make/Model) _____
 At what age did your child begin using hearing aids? _____
 Does your child currently use hearing aids at: Home ___ Yes ___ No
 School ___ Yes ___ No

Does your child have a cochlear implant (CI) ___ Yes (if Yes, please fill out questions below)
 ___ No (if No, continue to next section)

If yes, when was the surgery done, which hospital, and is the child currently receiving therapy? _____

Does your child wear the CI consistently? ___ Yes ___ No (If no, explain when the CI is used) _____

Were there any complications during the CI surgery? ___ Yes ___ No (If yes, please explain) _____

Does your child have a CI in the Right Ear? ___ Yes ___ No Left Ear? ___ Yes ___ No

If monaural (one ear), does your child use a hearing aid with their CI? ___ Yes ___ No

CI brand: Advanced Bionics _____ Med El _____ Cochlear _____

V. Communication

How do you and your child communicate at **home**? (Check all that apply)

___ ASL ___ Sign and speech together at the same time ___ Cued Speech ___ Oral/Aural
 ___ Gestures ___ Finger spelling ___ Signed English (PSE, SEE) ___ Homemade signs
 ___ Other (describe) _____

How successful is your child's communication at home? _____

What is your child's preferred method of communication in the **classroom**?

___ ASL ___ Sign and speech together at the same time ___ Cued Speech ___ Oral/Aural
 ___ Other (describe) _____

How successful is your child's communication at school? _____

Is your child's speech easily understood by family members? ___ Yes ___ No

Can people unfamiliar with the child understand your child's speech? ___ Yes ___ No

What do you feel is your child's best mode of communication? _____

What are your concerns, if any, do you have about your child's communication skills?

VI. Educational History**A. Parent-Infant Program/Early Intervention Services/Family Education:**

Schools attended	Address	Dates	Age	Program
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A. Pre-School / Family Education:

Schools attended	Address	Dates	Age	Program
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B. Elementary:

Schools attended	Address	Dates	Age	Program
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C. Middle:

Schools attended	Address	Dates	Age	Program
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D. High School:

Schools attended	Address	Dates	Age	Program
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Has your child ever been suspended or expelled from school? ___Yes ___No (If yes, please explain) _____

VII. Miscellaneous

What characteristics best describe your child?

What are your child's learning strengths?

What concerns, if any, do you have for your child's learning?

What concerns, if any, do you have regarding your child's behavior and/or social-emotional development?

What are your child's favorite hobbies or activities?

Why are you interested in having your child attend the Maryland School for the Deaf?

Name of person(s) completing this case history: _____

Signature(s): _____

Relationship to Student: _____