TEXAS WOMAN'S UNIVERSITY

Department of Communication Sciences & Disorders
P O Box 425737
Denton, TX 76204-5737
Phone: 940-898-2285 Fax: 940-898-2276

APPLICATION FOR CHAMP CAMP 2018

Thank you for your interest in our Summer Intensive camp for Childhood Apraxia and Motor Planning (CHAMP). This information will assist in planning for the best camp experience. Please return this completed form to the above address by April 23, 2018 and include a copy of your child's most recent speech and language evaluation and objectives. A non-refundable $50.00 deposit is required with your application that will be applied to the cost of the camp.

If your child has not attended TWU before or he/she has made significant progress since we last saw him/her, we would like for you to upload a 5-10 minute video of your child communicating at home or of a speech therapy session, to give us an idea of his current communication skills. Upload the video to your Google drive and share it with Laura Moorer (lmoorer@twu.edu). If you do not have a Google account, upload the video on a private YouTube channel and share it with Laura using her email.
Please answer the questions as fully and accurately as possible. Many parents have found the child's baby book helpful in remembering particular dates. If you are not sure of a particular date, please write the date that you think is correct and put a question mark after it. Your family physician may also be able to provide you with some information.

All of the following information is for the confidential use of the Speech-Language and Hearing Clinic staff only.

Date: _____

Person completing this form: _____ _____
Name Relationship to child

I. REFERRAL

Who referred you to this camp? _____

Professional title and/or relationship to the child: _____

What are your concerns in the areas of hearing, speech and/or language for your child? _____

_____

_____

_____

II. IDENTIFICATION

Child's name _____ Age: _____ Date of birth: _____ Sex: ____

Address: _____ Phone: _____
Street

_____
City State Zip

Mother's name: _____ Age: _____

Address: _____ Home phone: _____
Street

_____
City State Zip

E-mail address: _____

Mother's occupation: _____ Work phone: _____

Father's name: _____ Age: _____

Address: (if different than mother's) _____
Street

_____
City State Zip

Father's occupation: _____ Work phone: _____

Highest grade completed by mother: _____ by father: _____

Are parents divorced? _____ If so, who has custody of the child? _____

If child isn't living with either biological or adoptive parent, who has legal guardianship?

_____ Relationship to child: _____

Address: _____
Street City State Zip

Cell Phone: _____ Home Phone: _____

List Siblings	Age	Male/Female	Do they live in the home?
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐

Does anyone in the family have speech or hearing problems? ☐ Yes ☐ No If yes, indicate relationship to child and explain the type of problem: _____

_____

III. PRENATAL AND BIRTH HISTORY

During this pregnancy, did mother experience any unusual illness, condition or accident, such as German Measles, false labor, RH incompatibility, etc? ☐ Yes ☐ No If yes, describe

_____

Length of pregnancy: _____ Duration of labor: _____ Birth weight: _____

Condition at birth: ☐ Normal delivery ☐ Caesarean ☐ Breech birth

Anesthetics: ☐ Yes ☐ No Forceps: ☐ Yes ☐ No Was infant blue ☐ Yes ☐ No

Jaundiced: ☐ Yes ☐ No Other unusual conditions? (If any, describe below)

_____

_____

Conditions immediately following birth:

Did infant have: ☐ Feeding problems ☐ Scars or bruises ☐ Seizures

☐ Swallowing or sucking difficulties Was birth weight regained quickly? ☐ Yes ☐ No

☐ Other (please explain) _____

_____

IV. DEVELOPMENT

When did your child:

First hold head up alone? _____

First crawl? _____

Sit alone without support? _____

Pull himself/ herself to a standing position? _____

Walk unaided? _____

Gain bowel control? _____ Bladder control? _____

Does your child prefer right or left hand? _____

Does your child fall or lose balance easily? ☐ Yes ☐ No

(If Yes, please explain): _____

Does your child have (check all that apply): ☐ Fear of heights?

☐ Show fear if moved unexpectedly? ☐ Difficulty climbing up or downstairs?

Are there activities that involve fast movements and spinning that your child finds difficult? Please explain: _____

_____

Can your child ride a bike? ☐ Yes ☐ No

Does your child seem awkward or uncoordinated? ☐ Yes ☐ No

Does you child have difficulty chewing or swallowing now? ☐ Yes ☐ No

Describe any developmental difficulties: _____

Describe any academic difficulties: (reading, math, writing, spelling) _____

_____

Additional Comments: _____

_____

V. MEDICAL

Check disease(s) your child has had, giving age and degree of severity:

Disease	Age	Mild, average or severe	Disease	Age	Mild, average or severe
Allergies	_____	_____	Kidney disease	_____	_____
Asthma	_____	_____	Measles	_____	_____
Bronchitis	_____	_____	Meningitis	_____	_____
Chicken pox	_____	_____	Mumps	_____	_____
Colds (frequent)	_____	_____	Ear infections	_____	_____
Hay fever	_____	_____	Pneumonia	_____	_____
Headaches (frequent)	_____	_____	Scarlet fever	_____	_____
Heart disease	_____	_____	Seizures	_____	_____
Influenza	_____	_____	Tonsillitis	_____	_____

Other illnesses not noted above: _____

Has your child ever had a fever of 103 degrees or more lasting more than 24 hours ☐ Yes ☐ No

or has there been changes in behavior following an illness? ☐ Yes ☐ No

If yes, please describe: _____

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, when and for what reason?

_____

_____

Is your child up to date with all immunizations? ☐ Yes ☐ No If no, please explain?

_____

Has your child had a vision screening or test? ☐ Yes ☐ No Date? _____

Does your child wear glasses? ☐ Yes ☐ No

Is your child in good health at this time? ☐ Yes ☐ No State any physical challenges:

_____

Does your child sleep well? Yes ☐ ☐ No Does your child eat well? ☐ Yes ☐ No

If no, describe_____

_____

VI. EDUCATION HISTORY

At what age did your child first start school? _____ Were any grades repeated? ☐ Yes ☐ No

If yes, which grades? _____ Current Teacher: _____

School attending now:_____

Please name any subjects giving your child particular difficulty: _____

_____

What are your child's usual grades?
☐ Excellent ☐ Above average ☐ Average ☐ Below average ☐ Failing

What is your child's attitude toward:

School? _____

His/her homework? _____

VII. SOCIAL

How does your child get along with other children? _____

What activities and games does your child enjoy? _____

Does your child tend to play alone or with other children? _____

What are the ages of his/her playmates? _____

Is your child teased about his/her speech problem by others? ☐ Yes ☐ No

If "yes", please explain: _____

What is your child's reaction to his/her speech problem? _____

By whom and how is your child disciplined? _____

Is your child difficult to discipline? ☐ Yes ☐ No Explain: _____

_____

Please check the boxes which identify your child's behaviors:

☐ Excitability	☐ Temper Displays	☐ Shyness
☐ Mouth breathing	☐ Day Dreaming	☐ Thumb Sucking
☐ Sensitivity	☐ Easily Discouraged	☐ Prefers younger children
☐ Prefers older children		

Are there any other behaviors you are concerned about? _____

VIII. HEARING HISTORY

If you suspect that your child has a hearing problem, when, how and by whom was the hearing problem first noticed? _____

_____

Has your child had a hearing examination prior to this time? ☐ Yes ☐ No If yes, when?

_____ Where? _____

Are there any indications of your child not hearing plainly? ☐ Yes ☐ No

Does your child wear a hearing aid? ☐ Yes ☐ No

IX. SPEECH AND LANGUAGE HISTORY

During your child's first 6 months, did he/she coo and babble? ☐ Yes ☐ No

During the first year did he/she make many sounds other than crying? ☐ Yes ☐ No

Other than crying, would you say your child was:

☐ a silent baby? ☐ a vocally average baby? ☐ a very noisy baby?

At what age did your child first say meaningful words? _____

What were they? _____

Did your child: ☐ say one or two words and then go for a long time before saying other words?

or ☐ continuously add words once he/she started to talk?

At what age did your child begin to use words to name people and objects? _____

At what age did your child have a name for everything? _____

At what age did your child combine words into small sentences like, “want drink” or “me out?”

_____

At what age did your child combine short sentences? _____

Does your child understand what you say as well as you think he/she should? ☐ Yes ☐ No

If not, explain: _____

_____

Please describe your child’s current communication abilities? _____

_____

_____

At this time does your child talk

☐ a great deal? ☐ an average amount? ☐ very little?

Does your child’s talking consist mainly of:

☐ complete sentences? ☐ phrases? ☐ one or two words? ☐ sounds?

How well can your child be understood by brothers, sisters, playmates?

☐ good ☐ sometimes ☐ not at all

Comments: _____

By adults other than family members?

☐ good ☐ sometimes ☐ not at all

Comments: _____

Has your child ever communicated better than they do now? ☐ Yes ☐ No

If “yes”, please explain:

_____

At what age did your child start receiving speech therapy? _____

At what age did your child receive a diagnosis of CAS or suspected CAS? _____

Please describe the setting, frequency and type of therapy your child has had to this point?

Setting (home-based, clinic, school-based, hospital etc) _____

Frequency (30 mins 2X/Wk, 20 mins 1X/Wk, 60 mins 2X/Month) _____

Type (expressive language, articulation, phonology, treatment for CAS) _____

How would you rate your child's progress in therapy up to this point? (Excellent rapid progress, Good, Steady but slow progress, Minimal progress made)

_____

What types of techniques, strategies and cuing does your child respond the best to? _____

_____

_____

What types of activities are highly motivating to your child? _____

_____

IX. OTHER INFORMATION

Has your child had a neurological examination prior to this time? ☐ Yes ☐ No If yes, when?

_____ Where? _____

Has your child had a psychological examination prior to this time? ☐ Yes ☐ No If yes, when?

_____ Where? _____

Has your child had an educational examination prior to this time? ☐ Yes ☐ No If yes, when?

_____ Where? _____

Has your child had a recent medical examination? ☐ Yes ☐ No If yes, when? _____

_____ and by whom? _____

If your child has had any of the above examinations, it will be helpful to the clinic if you will contact the person who examined your child and ask them to send a copy of their findings to the address at top of first page or fax it to 940-898-2276

If there is any additional information which you feel will help us to understand your child better, please describe:

_____

_____

_____

Please include a copy of your child's most recent speech and language evaluation and objectives with this paper work. If your child has not been previously seen at the TWU Speech-Language and Hearing clinic or has made significant progress since he/she was seen, please forward a short video clip (5-10 mins) of your child communicating at home or talking with his/her speech therapist. See page 1 for instructions for uploading a video.

Does your child need a current evaluation to differentially diagnose Childhood Apraxia of Speech?
☐ Yes ☐ No
If interested in having a full evaluation at the TWU Clinic, please provide the best contact information and we will call to set up an appointment.

Name _____ Phone # _____

Please complete the additional authorization forms that are attached below. Once we have received this packet in our office, it will be evaluated and we will let you know by May 1st regarding attending CHAMP camp.

_____ _____
Signature Date

Thank you for your interest in our Speech-Language-Hearing Program at Texas Woman's University. If you have any questions, please call (940) 898-2266. You may mail this completed packet to the address below, or you may fax it to 940-898-2276, or email it to lmoorer@twu.edu.

Mail to:
Texas Woman's University
Speech & Hearing Clinic
P.O. Box 425737
Denton, Texas 76204
Attn: Laura Moorer

TEXAS WOMAN'S UNIVERSITY
Department of Communication Sciences & Disorders
P.O. Box 425737, Denton, TX 76204-5737
Phone: (940) 898-2285 | Fax: (940) 898-2276 | TTY: (940) 898-2019

Disclosure Form

Patient Name (Please print)	Date of Birth	File#
_____	_____	_____

Please read and initial in the space provided.

_____I understand that, by federal law, Texas Woman's University may not use or disclose my health information, except as provided in the University's Notice of Privacy Practices, without my authorization. My signature on this disclosure form indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release Texas Woman's University and its employees from any and all liability that may arise from the release of information as I have directed.

_____ I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to the person or institution named above. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

_____ I understand that copies of the Speech, Language, and Hearing Clinics HIPAA Privacy Practices are available to me in the clinic office.

_____ I understand that once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

This disclosure expires automatically upon

(Specify date, event, or one year from date of signature)

_____ I understand that I may refuse to sign this disclosure form. I also understand that the institution or individuals named above cannot deny treatment if I refuse to sign this disclosure form.

I have read and understand the information in this authorization form.

Signature of Patient or Legal Representative:

Please print name: _____ Date: _____

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AUTHORIZATION FOR CONFIDENTIALITY

I authorize that the evaluation and/or treatment procedures and information regarding the same may need to be e-mailed back and forth between Texas Woman's University and the parent/guardians and between the supervisors and students. I authorize that this procedure may be used to further the understanding between clinical personnel and parent/guardian. Should I choose not to authorize this communication, students and supervisors will communicate via an in-house secured network communication accessible only to personnel of the clinic, but will not use e-mail to communicate with me.

_____initial

I realize that the evaluation and/or treatment procedures might be observed in the room where the T.V. monitors are located or in the observation room by other parents/ guardians. Confidentiality will be maintained to the best extent possible. I understand that privacy will be observed as much as possible. Please respect the privacy of others while in the observation room.

_____initial

Due to patient and student education privacy laws, written permission is required for you to take photographs of our clinic sessions. Audio or video recordings of our clients or students are not permitted, except when made for student education purposes by clinic personnel.

_____initial

I understand that I may revoke my permission at any time by communicating in writing with the clinical coordinator.

_____ _____
Date Parent/Guardian Signature

_____
Client's Name

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AUTHORIZATION FOR RECORDING AND USE OF EVALUATION/TREATMENT PROCEDURES

I hereby authorize that the evaluation/treatment procedures of _____
Clients' Name
may be recorded, videotaped, photographed, and/or audio taped at the Department of Communication Sciences and Disorders at Texas Woman's University.

Yes ☐ No ☐ _____ Initial

I authorize that the recorded evaluation/treatment procedure may be used for educational and/or research purposes both within and outside the University.

Yes ☐ No ☐ _____ Initial

I authorize that the recorded evaluation/treatment procedure may be used for advertising purposes both within and outside the University.

Yes ☐ No ☐ _____ Initial

I authorize that the evaluation/treatment procedures may be observed and discussed by students in disciplines related to the Department of Communication Sciences and Disorders for academic purposes.

Yes ☐ No ☐ _____ Initial

Furthermore, I authorize that the evaluation/treatment data may be used for research purposes as approved by the appropriate University authorities.

Yes ☐ No ☐ _____ Initial

_____ _____
Date Client or Parent/Guardian Signature