UCP United Cerebral Palsy of Central Maryland
Turning Dreams into Realities, One Person at a Time

UCP DELREY SCHOOL
3610 COMMERCE DRIVE
SUITES 804-807
BALTIMORE, MD 21227-1640

PHONE 410-314-5000
FAX 410-314-5015
WWW.DELREYSCHOOL.ORG

Application

There are two ways to complete this application: **1.** Complete the fields online and print out; **2.** Print out the form and complete by hand (please print). After the application is completed, please sign the Release of Information and the Record Dissemination Permit. Mail or fax the completed and signed application to UCP Delrey School using the contact information above. Call 410-314-5000 if you have any questions.

Child's Name: _____ Date: _____
First Middle Last

Child's SSN#: _____ Date of Birth: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

PARENT INFORMATION

Mother's Name: _____ (If Guardian, please indicate.) ☐

Address: _____ Zip: _____

Telephone: (Home) _____ (Cell) _____

Email: _____

Employment Address: _____ Telephone: _____

Father's Name: _____ (If Guardian, please indicate.) ☐

Address: _____ Zip: _____

Telephone: (Home) _____ (Cell) _____

Email: _____

Employment Address: _____ Telephone: _____

EMERGENCY CONTACT (if parent/guardian is unavailable)

Name: _____

Address: _____ Zip: _____

Relationship: _____ Telephone: _____

Email: _____ Cell: _____

Reason for referral to UCP Delrey School:

Referred by (person or agency): _____

(Address of person or agency): _____

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MEDICAL INFORMATION *(The following information is considered confidential.)*

Diagnosis: Primary _____ Secondary _____

Current Medications: _____

Does your child have seizures? _____ Does your child have allergies? _____

Physician(s), Health Facility providing medical care: (List additional physicians or health facilities on separate sheet.)

Name: _____ Telephone: _____

Address: _____ Last Seen: _____

Name: _____ Telephone: _____

Address: _____ Last Seen: _____

Dental care is provided by:

Dentist: _____ Telephone: _____

Address: _____ Last Seen: _____

HISTORY INFORMATION

Has your child previously attended any other program? _____

If yes, state names of facilities, address, and length of attendance:

Has your child previously received, or is he/she currently receiving therapies? ☐ Yes ☐ No

If yes, state which therapies and where:

Describe your child's condition and what you believe is his/her greatest need:

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RELEASE OF INFORMATION

Child's Name:_____ DOB:_____

I,_____ , _____
(Parent/Guardian's Name) (Relationship to child)

hereby authorize (names and addresses of hospitals or doctors):

to release information and records pertaining to my child to:

UCP Delrey School
3610 Commerce Drive - Suites 804-807
Baltimore, Maryland 21227-1640
410-314-5000

_____
(Parent/Guardian's Signature)

_____
(Parent/Guardian's Address)

_____
(Date)

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RECORD DISSEMINATION PERMIT

Child's Name:_____ DOB:_____

I,_____ , _____
(Parent/Guardian's Name) (Relationship to child)

hereby permit the offices of UCP Delrey School to send reports of my child (see above) to the following doctors at the addresses shown:

_____
(Parent/Guardian's Signature)

_____
(Parent/Guardian's Address)

_____
(Date)