

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): \_\_\_\_\_



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 - Page 2

**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**

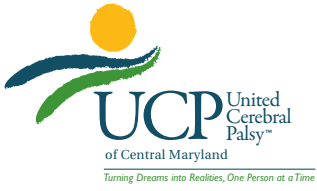
Has your child previously attended any other program? \_\_\_\_\_

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:



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

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

**RELEASE OF INFORMATION**

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

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

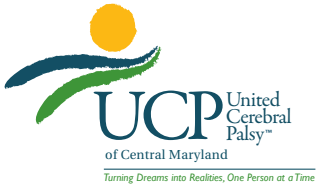
to release information and records pertaining to my child to:

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)



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

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

**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)