

ABILITY KC MARY SHAW BRANTON THERAPEUTIC PRESCHOOL

Enrollment Information



CHILD'S INFORMATION

First Name: _____ Last Name: _____

Date of Birth (Day, Month, Year): _____ Age: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County of Residence: _____

Parent/Guardian Name: _____

Phone: (_____) _____ Alt Phone: (_____) _____

Parent/Guardian Name: _____

Phone: (_____) _____ Alt Phone: (_____) _____

I am interested in the following service(s) for my child:

Preschool:

+3 years old

1-2 years old

Home Based Education
(1-2 years old)

Therapy Services:

Applied Behavior Analysis (ABA)

Aquatic Therapy

Assistive Communication
Technology

Occupational Therapy

Physical Therapy

Speech Therapy

INSURANCE INFORMATION

What best describes your current insurance?

Private Insurance _____ Medicaid _____ Other: _____

Name of Cardholder: _____ Cardholder DOB: _____

Member ID #: _____ Group #: _____ Customer Service Phone: _____

If you have Medicaid, please list the type of plan: _____ Medicaid ID #: _____

YOUR CHILD'S HEALTH INFORMATION

Does your child have any special needs? Yes No *If yes, please list their diagnosis:*

Please list any allergies or medical concerns you have about your child:

Please list your child's special medical needs or medications:

Pediatrician's Name: _____ Phone Number: (_____) _____

Has your child been seen by this pediatrician in the past 12 months? Yes No

**For questions about enrollment or to submit a completed enrollment form,
please contact Kerri Perks at kerri.perks@abilitykc.org**

YOUR CHILD'S HEALTH INFORMATION (continued)

Does your child receive therapy? Yes No

Therapist's Name: _____ Phone Number: (_____) _____

Please describe any past or current therapies your child has participated in:

Has your child ever used assistive communication technology? Yes No

Do you think your child would benefit from the use of assistive communication technology? Yes No

If yes, please describe your child's current communication skills:

Do you have any feeding or swallowing concerns for your child? Yes No

If yes, please describe your concerns:

Do you have any sensory or behavioral concerns? Yes No

If yes, please describe your concerns:

Do you have any fine or gross motor concerns for your child? Yes No

If yes, please describe your concerns or any mobility aids needed, i.e. wheelchair, walker, braces, etc.):

Please list any other information you would like us to know about your child's health:

YOUR CHILD'S EDUCATION EXPERIENCE

Your school district: _____

Is your child receiving therapy services in your school district? Yes No

If yes, please describe the services they are receiving: _____

My child has an: IEP IFSP NA

Please describe your child's educational experience in other preschool or child care settings and their typical interactions with other children:

How did you hear about Ability KC?

Ability KC Employee	Friend	Kansas City	Social Media (Facebook,
Children's Mercy	Head Start	Regional Center	Instagram, Twitter, YouTube)
Hospital	Infant/Toddler	Pediatrician	Web Search
First Steps	Services (Kansas)	School District	Other _____

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