ILLINOIS CENTER FOR REHABILITATION & EDUCATION – ROOSEVELT
1950 West Roosevelt Road ~ Chicago, Illinois 60608
Telephone 312 433-3125 FAX 312 433-3254

ADMISSION APPLICATION

_____ **Day Program** _____ **Residential Program**

STUDENT INFORMATION

Student Name (Last, First, Middle Initial)		Sex (circle) M F
Street	Date of Birth	Birthplace
City, State, Zip Code	Ethnicity	Social Security Number
Email Address	Cellular Telephone	
Primary Diagnosis		
Secondary Diagnosis		
Vision: Does student wear glasses? ❑ Yes ❑ No	Hearing: Does student wears aids? ❑ Yes ❑ No	Language spoken at home
Allergies ❑ Yes ❑ No List:	Seizures ❑ Yes ❑ No	

PRIMARY PARENT INFORMATION ❑ Student is Own Guardian

Name	Date of Birth	Birthplace
Address	Telephone	Cell Telephone
City, State, Zip Code	Ethnicity	Fax Telelphone Number
Relationship to Students:	Email Address	

PARENT/GUARDIAN INFORMATION

Name	Date of Birth	Birithplace
Address	Telephone	Cell Telephone
City, State, Zip Code	Ethnicity	Fax Telephone Number
Relationship to Student	Email Address	

SCHOOL INFORMATION

Name of District / District Number	Email Address	
High School	Contact Person	School Telephone
Address	Contact phone number	Email
City	State	Zip Code
Student has an IEP or Section 504 Plan? ❑ Yes ❑ No	Indicate IEP Date:	Evaluation Date:
Ensure that IEP or Section 504 Plan states that the school is responsible for transportation.		

Student Name: _____

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ENTITLEMENTS

O Student Receives S.S.I	O Student is S.S.I. Payee. O Student is NOT S.S.I. Payee.
Name of Payee:	Address of Payee:

O Private Medical Insurance

Insurance Company Name:		Address:
Telephone Number:		
Policy Number:	Group Number:	Identification Number:
Policy Holder Name:		Employer Address:
Employer:		

Or

O Medicaid

Case Name:	Case Number	Recipient Number

Or

O Medicare

Medicare Number:	O Part A O Part B O Parts A & B

PRIMARY HEALTH CARE PROVIDER / PHYSICIAN INFORMATION

Name	Date of Last Physical	
Office Name	Telephone Number	
Address	Fax Number	
City	State	Zip Code
Email Address		

ADDITIONAL MEDICAL CARE PROVIDER / PHYSICIAN INFORMATION

Name	Date of Last Physical	
Office Name	Telephone Number	
Address	Fax Number	
City	State	Zip Code
Email Address		

Student Name: _____

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MEDICATIONS AND TREATMENTS

Please list all medications and medical treatments the student is currently receiving	
Name	Dosage / Frequency/ Doctor

ADDITIONAL CONTACT INFORMATION

Name	Address:	Relationship	Telephone Number
Name	Address:	Relationship	Telephone Number

Comment Section:

Signature: _____Date: _____

Print Name of signature: _____

Student Name: _____