

Enrollment Form: JTC's Distance Education for Parents of Young Children (0-5 years old) with Hearing Loss  
 Instantly fill this form online at [pals.jtc.org](http://pals.jtc.org) or print this form, fill it out and mail it to the address at the bottom.

<b>Parent 1 Information</b>		You are the: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other:	
First Name :		Middle Name:	Last Name:
Sex <input type="checkbox"/> F <input type="checkbox"/> M	Family Name:		Email:
Occupation:		US Military Service? <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Marines <input type="checkbox"/> Navy	
Primary Language:		Secondary Language:	

<b>Parent 2 Information</b>		Significant other is the: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____	
First Name:		Middle Name:	Last Name:
Occupation:		US Military Service? <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Marines <input type="checkbox"/> Navy	

<b>Mailing Address Information</b>		Preferred Contact Method: <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Mail	
Address 1:			
Address 2:		City:	State
Postal Code:		Country:	
Home Phone:		Mobile Phone:	Work Phone:
Preferred Contact Name: <input type="checkbox"/> Parent(s) First Name(s) <input type="checkbox"/> Parent(s) First & Last Name(s) <input type="checkbox"/> Parent(s) Last Name(s)			
Other Preferred Contact Name(s) <i>if not listed previously</i> :			

<b>Distance Education Course Information</b>			
Lesson Options: <input type="checkbox"/> Online - instant access <input type="checkbox"/> Regular Mail - <i>may take up to 3 weeks</i>		Lesson Materials: <input type="checkbox"/> English <input type="checkbox"/> Spanish	

<b>Child Information</b>			
First Name:		Middle Name:	Last Name:
Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth: (mm/dd/yyyy)		Prematurity? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how many weeks?
Was your baby healthy at birth? <input type="checkbox"/> No <input type="checkbox"/> Yes		History of childhood hearing loss in the family? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Recent hearing test or evaluations: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please mail, fax, or email a copy to JTC.</i>			
Medical, developmental, or other special needs:			
Age at diagnosis:	Year:	Month:	Cause, if known:
Amount of hearing loss:			
<b>Right:</b> <input type="checkbox"/> None <input type="checkbox"/> 26-40 dB mild <input type="checkbox"/> 41-55 dB moderate <input type="checkbox"/> 56-70 dB moderately-severe <input type="checkbox"/> 71-90 dB severe <input type="checkbox"/> 91+ dB profound			
<b>Left:</b> <input type="checkbox"/> None <input type="checkbox"/> 26-40 dB mild <input type="checkbox"/> 41-55 dB moderate <input type="checkbox"/> 56-70 dB moderately-severe <input type="checkbox"/> 71-90 dB severe <input type="checkbox"/> 91+ dB profound			
Devices your child is now using:		Age child started using device consistently: <b>Year:</b> <b>Month:</b>	
Cochlear Implant Model/Type:		<b>Side:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	
Hearing Aid Model/type:		<b>Side:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> BAHA <input type="checkbox"/> Body <input type="checkbox"/> Bone Conduction <input type="checkbox"/> Other	
If no listening device, why? <input type="checkbox"/> Not able to pay <input type="checkbox"/> Not available <input type="checkbox"/> Not obtained yet <input type="checkbox"/> Not recommended <input type="checkbox"/> Not wanted <input type="checkbox"/> Other:			
Current Services: <input type="checkbox"/> Early Intervention/Preschool <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical/Occupational Therapy			
Other Services:			

**Developmental Checklist (check all that apply):**

- Motor:  Holds head up  Reaches for objects  Sits by self  Crawls  Walks independently
- Development:  Picks up/eats finger food  Uses spoon  Helps dress self  Plays with toys  Enjoys simple games
- Listening:  Notices sounds  Reacts to voice  Enjoys noisy toys  Imitates sounds  Responds to spoken language
- Communication:  Understands gestures  Uses single words  Answers simple questions  Looks at pictures and books  Uses short sentences
- Family Uses:  Spoken Language  Sign Language of Country (ASL, BSL, etc)  Cued Speech  Total Communication  Other:
- Current concerns about your child:

**Other Children's Information**

First Name	Middle Name	Last Name	Sex	Date of birth mm/dd/yyyy
			<input type="checkbox"/> F <input type="checkbox"/> M	
			<input type="checkbox"/> F <input type="checkbox"/> M	
			<input type="checkbox"/> F <input type="checkbox"/> M	
			<input type="checkbox"/> F <input type="checkbox"/> M	

**Release Information**

I give permission for John Tracy Clinic to use:

- Pictures of me and my minor child(ren)  Portions of my written comments (with initials or first names only)
- in the publication and promotion of educational materials without limitation or reservation.

Sign:

Date:

**Optional Parent 1 Information**

*JTC is committed to respecting your privacy. Answers to the questions below will ONLY be used for collecting data and requesting funding.*

Marital Status:  Single  Married  Separated/Divorced  Other:

Race:  White  Black, African American

American Indian or Alaska Native (Specify name of enrolled or principal tribe): \_\_\_\_\_

Hispanic (Specify, for example, Columbian, Cuban, Mexican, Puerto Rican and so on): \_\_\_\_\_

Asian Indian  Japanese  Chinese  Korean  Filipino  Vietnamese

Other Asian (Specify, for example, Cambodian, Hmong, Laotian, Pakistani, Thai, and so on): \_\_\_\_\_

Native Hawaiian  Samoan  Guamanian or Chamorro

Other Pacific Islander (Specify, for example, Fijian, Tongan and so on): \_\_\_\_\_

Other Race (Specify): \_\_\_\_\_

Education:  No formal schooling  1 - 8 years  9 - 11 years  High School graduate  
 13-15 years (some college)  16 years (college/university graduate)  16+ years (graduate school)

Employment Status:  Student  Part-time  Full time  Unemployed

Number of adults in household: \_\_\_\_\_ Number of children under 18 years old in household: \_\_\_\_\_ Number of languages used in home: \_\_\_\_\_

Housing:  Own  Rent  Shared  No permanent address  Homeless

Does your family receive government financial assistance?  Food  Housing  Transportation  Other  None

Do you have health insurance or receive medical financial help?  Yes, for adults only  Yes, for children only  Yes, for whole family  None

Do you use the Internet?  No  Yes Do you have a computer?  No  Yes

How did you hear about JTC?  Suggestion from parent/friend  Internet search  Referral from professional: