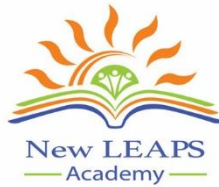


Last Name: _____ First Name: _____



APPLICATION FORM

Date: _____

Child's Name: _____ **Grade:** _____ **Matrix:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Age: _____ **Date of Birth:** _____ **Place of Birth:** _____ **Sex:** M ___ F ___

Referred by: _____ **Adopted:** Yes ___ No ___ **Yes, at what age:** _____

Father's Name: _____ **Age:** ___ **Email address:** _____

Occupation: _____ **Last grade in school:** ___ **Employer:** _____

Mother's Name: _____ **Age:** ___ **Email address:** _____

Occupation: _____ **Last grade in school:** ___ **Employer:** _____

Step Parent: _____ **Age:** ___ **Email address:** _____

Occupation: _____ **Last grade in school:** ___ **Employer:** _____

Child lives with: _____ **Family Income:** _____

Other children in home and ages: _____

Scholarship: McKay ___ PLSA ___ **Step up for Students** ___ **Other** _____

IEP ___ **Transfer from** _____ **New Student** ___ **Self Pay** _____

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Last Name: _____ First Name: _____

1. Present Needs:

A. What type of needs does this child have? Give as many details as you can.

B. What do you think are the causes? Is there a specific diagnosis?

C. Other earlier noticeable struggles: (list and give age at time)

2. Which best describes your child?

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Last Name: _____ First Name: _____

Verbalization: Talkative _____ Average _____ Non-Verbal _____
Attention Span: Short _____ Average _____ Above Average _____
Speed of Response to Questions: Fast _____ Average _____ Slow _____
Necessity to Repeat Directions: Rarely _____ Sometimes _____ Usually _____
Frequently _____ Always _____
Dresses Self: Rarely _____ Sometimes _____ Usually _____ Always _____
Ties shoes _____ Trouble buttoning and/or unbuttoning clothes _____

3. Health History

A. List in order of occurrence all illnesses, operations, injuries and health issues, e.g., allergies, asthma, frequent colds, etc. Give age and/or date when possible.

B. Present Health. Describe in detail.

C. List any physical limitations: vision, hearing, speech, etc.

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D. List any significant illness of the parents or other adult household members. Other children's health?

E. Is your child on medication? Yes ___ No ___ If yes, Type _____

Prescribed by whom: _____ Dosage: _____

Date first prescribed: _____
Month Year

F. Name of Pediatrician and date of last examination.

4. Emotional Adjustment

A. How would you describe your child? For example, is he/she:

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Sensitive _____ **Shy and Timid** _____ **Boastful** _____

Rebellious _____ **Aggressive** _____ **Affectionate** _____

Stubborn _____ **Distant** _____

Give details or examples to make clear what you feel are important immediately.

B. What are your child's strengths, as you see them?

C. What are your child's weaknesses, as you see them?

5. Additional Comments: (Check or comment on any that might be present in your child)

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Last Name: _____ First Name: _____

- a. **Hyperactive**
- b. **Withdrawn or appears often to be daydreaming**
- c. **Easily distracted by extraneous stimuli**
- d. **Forms different associations than usual, making responses sound illogical or irrelevant**
- e. **Sensitive to changes – responds with erratic behavior when faced with change**
- f. **Has difficulty in remembering and following sequences**
- g. **Has emotional problems that stem from years of misunderstanding, frustration and failure**

6. Education: Pre-school _____ Primary _____

Elementary _____ Junior High _____

A. Psychological Evaluations: Date _____ By Whom _____

Date _____ By Whom _____

B. Learning Deficiencies:

Grades repeated _____ Reading level _____

Describe the above or any other special assistance needed:

C. Adjustment in school. Has there been any change in adjustment? Have there been any obstacles in entering school, any fear or refusal to attend school, inability to make friends, difficulties participating in play? Discipline concerns, etc.? Special likes and/or dislikes?

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Last Name: _____ First Name: _____

7. List the professional person(s) or agencies with who you have discussed your child.

8. Developmental Information

A. Mother's labor with this child? Normal _____ Prolonged _____ Induced _____

B. Child was: Full term _____ Premature _____ Late _____

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Last Name: _____ First Name: _____

C. Birth was: Natural ____ Caesarian ____ Instrument ____

D. Condition first two weeks? Normal ____ Jaundice ____ Convulsions ____

Any other difficulty or abnormality? _____

Breast fed ____ Bottle fed ____ Present eating habits _____

E. Age when the following were attempted:

Held head up ____ Rolled over ____ Sat alone ____ Pulled self-up ____

Crawled ____ Stood alone ____ Walked assisted ____ Walked alone ____

Made sound ____ Babbled ____ Used words ____

F. Handedness of Child (left or right) ____ Mother ____ Father ____

G. Child's general disposition? _____

H. Any unusual fears? _____

I. Present deficiencies noted whom? _____ When? _____

J. Further comments:

This form is to be filled out by both parents and will constitute application for admission to New L.E.A.P.S. Academy of Wesley Chapel, FL. The information provided will be used to evaluate your child, his/hers potential and special needs and to be used to set goals. This information is entirely confidential, and will not be released to anyone other than school staff and personnel, unless requested by you.

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Last Name: _____ First Name: _____

A pre-admission interview will be scheduled once this application has been completed, returned and reviewed by our staff.

A Non-Refundable application fee of \$50.00 will be charged at the time of the interview.

A Non-Refundable registration fee of: \$200.00 will be charged at the time of the acceptance and enrollment.

Date: _____ **Parent/Guardian Signatures** _____

For internal purpose only:

Date application received _____

By: _____

Appointment date and time set: _____

Contact info: _____