



THE PARISH SCHOOL

Application

Date: _____ Applying For: School Admissions Year: _____ - _____
 Summer Camp Year: _____

Information Provided By: _____

Child's Name: _____
First Middle Last Name Called

Address: _____ City: _____ State: _____ Zip Code: _____

Birth Date: _____ Age: _____ Gender: _____

Parent 1: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____
(if different)

Contact Numbers: Home: _____ Work: _____ Cell#: _____

Email Address: _____

Occupation: _____ Employer: _____

Education: _____

Parent 2: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____
(if different)

Contact Numbers: Home: _____ Work: _____ Cell#: _____

Email Address: _____

Occupation: _____ Employer: _____

Education: _____

Marital Status of Parents: married divorced separated widowed remarried

Who has legal custody of this child? _____

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Child's Name: _____



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Is this child adopted? _____ At what age? _____ Is he/she aware of this? _____

Please list the occupants of your child's home:

| Household 1 | | | Household 2 | | |
|-------------|-------|--------------|-------------|-------|--------------|
| Name | Age | Relationship | Name | Age | Relationship |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Is any language other than English spoken in the home? _____ Which? _____

Does your child understand the language? _____ Does your child speak the language? _____

Who referred you to The Parish School? _____

FAMILY HISTORY

Is there a family history of speech, language, or learning difficulties? _____

If yes, please complete the following to briefly describe the difficulty:

Biological Father's Family History (include father's history, his brothers and sisters, nieces, nephews)

Difficulties in Speech/Language Development:

Medical Conditions:

Difficulties in School:

Biological Mother's Family History (include mother's history, her brothers and sisters, nieces, nephews)

Difficulties in Speech/Language Development:

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Medical Conditions:

Difficulties in School:

Sibling's History

Difficulties in Speech/Language Development:

Medical Conditions:

Difficulties in School:

DEVELOPMENT

Pre- and Post-Natal/Infant

Which pregnancy was this (include miscarriages, stillborn, children who have died)? _____

What was your general state of health during the pregnancy? _____

Were any substances used (medications, tobacco, alcohol, other)? If yes, please list:

Gestational Age at Birth: _____

Check all that apply to delivery:

- Cesarean
- Very long labor
- Anesthesia
- Very short labor
- Inducement
- Use of instruments

Were there any immediate problems with your baby after delivery (breathing, injury, jaundice)? If so, please describe.

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Weight: _____ Length: _____

Was your baby nursed or bottle fed? _____ How long? _____

Any feeding difficulties? How long? _____

Any sleeping difficulties? How long? _____

Did your child do any thumb sucking? _____ For how long? _____

Did your child use a pacifier? _____ For how long? _____

Early Childhood

Language/Social Communication Milestones (age of onset)

Smiles at another _____ Babbling _____ Maintains eye gaze _____

Imitation _____ Two- or three-word phrase _____ Uses gestures (i.e. points) _____

Uses complete sentences _____

Please describe any areas of concern (articulation, socialization, receptive language, expressive language, echolalia—"parrots" what is said)

Gross Motor Milestones (age of mastery if applicable)

Sat independently _____ Walked independently _____ Ran smoothly _____

Jump with 2 feet _____ Climb play equipment _____ Skip with coordination _____

Ride a bike: Three-wheeler _____ Training wheeler _____ Two-wheeler _____

Fine Motor Milestones (age of mastery if applicable)

Used writing utensils _____ Toilet Trained Day _____ Night _____

Used eating utensils _____ Fasten Clothing _____ Tie Shoes _____

Is he/she left-handed or right-handed? _____ Does he/she change from hand to hand? _____

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Child's Name: _____



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Please describe any areas of concern (i.e., fine or gross motor, balance)

SOCIAL/EMOTIONAL/BEHAVIORAL HISTORY

Does your child exhibit any distinctive behavioral characteristics? If yes, please describe.

Does your child play well with siblings? _____

Does your child prefer to play alone? _____

Does your child prefer to play with older younger or same age peers? (Please check one)

Is your child aware of his/her difficulties? _____

What are your child's favorite activities? _____

What methods of discipline are used? _____

What are your child's reactions to discipline? _____

Who is usually responsible for discipline? _____

Please check all that apply to your child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Happy | <input type="checkbox"/> Sensitive to change in routine |
| <input type="checkbox"/> Sensitive to loud noises | <input type="checkbox"/> Daydreams | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Sensitive to certain clothing/textures |
| <input type="checkbox"/> Unusual Fears | <input type="checkbox"/> Dislikes being touched | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Resistant to change | <input type="checkbox"/> Affectionate | <input type="checkbox"/> Repetitive Behaviors (i.e. flapping) |
| <input type="checkbox"/> Food Aversions | <input type="checkbox"/> Head Banging | <input type="checkbox"/> Biting/Hair Pulling |
| <input type="checkbox"/> Other: _____ | | |

EDUCATIONAL HISTORY

Name of current school placement and grade/class: _____

In your child's classroom, what is the number of: Teachers _____ Students _____

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Has he/she repeated any grades? If so, which? _____

With what area(s) has your child had particular difficulty?

With what area(s) does your child excel?

Has your child had special help through the school? If so, describe.

How does your child feel about school? _____

Do you think your child's teacher likes him/her? _____

Does the teacher describe your child with any of the following comments? (please check all that apply)

- Cannot follow directions
- Seems to be daydreaming
- Cannot sit still
- Picks on other children
- Is aggressive
- Is sneaky
- Learns best using multi-sensory approach
- Learns best auditorily
- Learns best visually
- Has a difficult time expressing his/her thoughts
- Doesn't seem to comprehend what's said
- Cannot complete tasks

Other Schools Attended

Please list all schools (include preschools) your child has attended, including dates and reasons for withdrawal.

| Name of School | Grades | Dates Attended | Reason for Withdrawal |
|----------------|--------|----------------|-----------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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MEDICAL HISTORY

Child's Physician: _____ Telephone #: _____

Does your child have allergies? If yes, what types?

Please list any illnesses/injuries your child has had that led to hospitalization or extensive care (i.e. prolonged fever, concussions, broken bones, seizures, surgeries, etc.):

Does your child have any long-term medical conditions for which he/she is now being or has been treated?

Does your child take any medication regularly? If so, what medication and for what condition?

Has your child had frequent colds or ear problems? If yes, please list about how many and the treatment provided. (Were P.E. tubes inserted? When?)

Has your child had a vision test? If so, where and when? What were the results?

Has your child had a hearing test? If so, where and when? What were the results?

Has your child had a neurological examination? If so, where and when? What were the results?

Has your child had a psychological examination? If so, where and when? What were the results?

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Has your child had a recent medical examination? If so, where and when? What were the results?

Other Professionals

List other professionals (speech/language pathologists, psychologists, psychiatrists, neurologists, tutors, educational diagnosticians, etc.) your child has **seen in the past or is currently seeing**:

| Name | Telephone Number | Dates Under Care in The Past | Current Appointment (Days & Times) | Reason for Seeing |
|------|------------------|------------------------------|------------------------------------|-------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please use this area for any additional comments or concerns:

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Authorization for Request/Release of Information

I hereby authorize The Parish School and The Carruth Center to **REQUEST/RELEASE** information which may be helpful in providing services for my child (full name),

Below are the persons, agencies and schools that The Parish School may contact:

| Name | Address | Telephone |
|------|---------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |

I understand any information obtained is strictly confidential and privileged.

Parents or Legal Guardians:

Signature: _____ Signature: _____

Date: _____ Date: _____

*A copy of this instrument is as valid as the original.
The Parish School does not discriminate on the basis of a child's race, gender, creed or religious beliefs.*