

Admissions Application

Coldwater Canyon Prep School

PLEASE RETURN THIS PAGE AND THE APPLICATION TO:

The Help Group
Admissions Office
13130 Burbank Blvd.
Sherman Oaks, CA 91401

Please check each box to make sure all of the following are included. (If not applicable, please mark N/A)

- Completed Coldwater Canyon Prep Application
- Recent photo of your child
- The two most recent **annual IEPs**, and all subsequent addenda
- A copy of the referral letter from your school district (LAUSD only)
- Report cards for the past two academic years
- Transcripts (for students in 7th through 12th grades)

Documentation as to the nature of your child's needs including but not limited to:

- Educational Evaluations
- Psychological Evaluations
- Department of Mental Health 3632 Evaluation
- Speech and Language Evaluations
- Occupational Therapy Evaluations
- Other Evaluations (please list) _____

AUTHORIZATION AND AGREEMENT

“I authorize investigation of all statements contained in this Application for Admission to the educational program as may be necessary in arriving at an admission decision. In the event of admission, I agree that false or misleading information, given in the application of my child, or in any interviews, may result in rescission of any admission. I understand also that continued admission to the educational program requires the student to abide by all rules and regulations of the educational institution.”

Parent/Legal Guardian

Parent/Legal Guardian

DATE OF APPLICATION: _____

I. STUDENT INFORMATION

STUDENT'S LAST NAME FIRST MIDDLE DATE OF BIRTH

AGE: _____ MALE [] [] FEMALE

STUDENT'S PLACE OF BIRTH STATE COUNTRY

CURRENT SCHOOL OF ATTENDANCE GRADE LEVEL

CURRENT RESIDENCE:

[] PARENT'S HOME [] RELATIVE/GUARDIAN [] OTHER _____
PLEASE SPECIFY

STREET ADDRESS CITY STATE/ ZIP HOME PHONE (____)

SOCIAL SECURITY # MEDI-CAL or INSURANCE POLICY NUMBER

MOTHER'S NAME FATHER'S NAME

STREET ADDRESS (if different than student's) STREET ADDRESS (if different than student's)

CITY STATE ZIP CITY STATE ZIP

HOME PHONE PAGER/CELL HOME PHONE PAGER/CELL (____)

E-MAIL ADDRESS: E-MAIL ADDRESS:

PREFERRED METHOD OF CONTACT:

PHONE [] E-MAIL [] EITHER []
(Circle: Home Cell Work)

MOTHER'S WORK INFORMATION

FATHER'S WORK INFORMATION

NAME OF BUSINESS

NAME OF BUSINESS

JOB TITLE/POSITION

JOB TITLE/POSITION

STREET ADDRESS

STREET ADDRESS

CITY STATE ZIP

CITY STATE ZIP

()
WORK PHONE NUMBER EXTENSION

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WORK PHONE NUMBER EXTENSION

II. FAMILY HISTORY

FAMILY MEMBERS / SIBLINGS:

NAME: AGE: RELATIONSHIP:

NAME: AGE: RELATIONSHIP:

NAME: AGE: RELATIONSHIP:

OTHER HOUSEHOLD MEMBERS:

NAME: AGE: RELATIONSHIP:

NAME: AGE: RELATIONSHIP:

NAME: AGE: RELATIONSHIP:

Is your child adopted? [] YES [] NO If "Yes," at what age?

Primary language: Languages spoken in the home:

(If parents are separated or divorced):

Date of separation or divorce: Child's age at time of divorce:

Current custody arrangement:

III. MEDICAL HISTORY

Does the applicant have any chronic or serious health problems? [] YES [] NO

If yes, please describe: _____

Does the applicant have any health restrictions or limitations? [] YES [] NO

If yes, please describe: _____

Does the applicant have any allergies? [] YES [] NO

If yes, please describe: _____

Is there a history of the applicant taking medications? [] YES [] NO

If yes, please list:

<u>CURRENT MEDS</u>	<u>DATES</u>	<u>DOSAGE/TIMES</u>	<u>PRESCRIBING DR.</u>	<u>PURPOSE</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

<u>PAST MEDS</u>	<u>DATES*</u>	<u>DOSAGE/TIMES</u>	<u>PRESCRIBING DR.</u>	<u>PURPOSE</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*** please indicate month/year of initiation and month/year of discontinuation (ex: 03/99-06/02)**

Has your child been hospitalized for any reason? [] YES [] NO (if yes, please explain below)

1. Reason: _____

Age: _____ DX: _____

Duration: _____

2. Reason: _____

Age: _____ DX: _____

Duration: _____

IV. SCHOOL HISTORY

NAME OF CURRENT SCHOOL	GRADE	CURRENT TEACHER'S NAME	
STREET ADDRESS	CITY	STATE	ZIP
()			
PHONE NUMBER	DATE STARTED	ENDING DATE	

Reason for seeking a new school placement: _____

Current Type of School	Current Type of Program
<input type="checkbox"/> Nonpublic	<input type="checkbox"/> Full-Inclusion Classroom
<input type="checkbox"/> Public School	<input type="checkbox"/> Full-Inclusion Classroom with resource pull-out (specify subject for pull-out)
<input type="checkbox"/> Private	<input type="checkbox"/> Special Day Class
	<input type="checkbox"/> Special Day Class with some mainstreaming (specify mainstreamed subjects)

Please check any current educational concerns:

<input type="checkbox"/> Difficulty with reading	<input type="checkbox"/> Difficulty with handwriting
<input type="checkbox"/> Difficulty with spelling	<input type="checkbox"/> Difficulty with arithmetic
<input type="checkbox"/> Difficulty with school attendance	<input type="checkbox"/> Difficulty maintaining attention
<input type="checkbox"/> Difficulty with abstract concepts	<input type="checkbox"/> Difficulty with organization (forgets homework, misses assignments)

Other (specify): _____

Please list all schools in which your child was placed prior to his/her current school. Also indicate if it was a special education program and the reason for discontinuation.

<u>Name of School</u>	<u>Grade(s)</u>	<u>Reg. Ed.</u>	<u>Special Ed.</u>	<u>Reason for Discontinuation</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever applied to any other Help Group school? Yes No
 If yes, which school, and what was the outcome? _____

V. HISTORY OF INTERVENTIONS

A. Diagnosis

Does your child currently have a diagnosis (if so, what)? _____

Who diagnosed your child? _____ (_____) _____
Name Agency Phone Number

Date of diagnosis: _____

What prompted you to seek an evaluation? _____

B. Please reply only if your child has received services in any of the following areas:

1. Speech and Language _____ (_____) _____
Name of Service Provider Phone Number

When was your child last assessed for these services? _____

What are the goals of this intervention?

2. Counseling _____ (_____) _____
Name of Service Provider Phone Number

When was your child last assessed for these services? _____

What are the goals of this intervention? _____

3. Occupational Therapy _____ (_____) _____
Name of Service Provider Phone Number

When was your child last assessed for these services? _____

What are the goals of this intervention? _____

4. Educational Therapy or Tutoring _____ (_____) _____
Name of Service Provider Phone Number

When was your child last assessed for these services? _____

What are the goals of this intervention? _____

Please provide any assessments completed by the professionals above or any other assessments you may have.

VI. ADDITIONAL INFORMATION

Describe your child's strengths.

What are your child's favorite activities?

Is your child involved in any extracurricular activities? [] YES [] NO (if yes please list)

Please describe your child's social relationships at home and at school.

Please describe any behavioral or attentional problems that have been brought to your attention by the school staff.

Is there any additional information that you feel would be helpful in evaluating your child?

Si necesita ayuda en español, por favor llame al 818.779.5207.

VII. IEP INFORMATION AND FUNDING SOURCE

Please enclose a copy of your child's **two most recent annual IEPs, and all subsequent addenda**. If your child does not have a current IEP, please state where you are in the IEP process. Do you currently have:

Valid I.E.P. with Non Public School designation YES NO

I.E.P. meeting with district to receive NPS funding YES NO

If IEP meeting set, please indicate date: _____

Mediation Agreement YES NO

If Mediation Agreement meeting set, please indicate date: _____

Fair Hearing YES NO

If Fair Hearing meeting set, please indicate date: _____

Will fund privately YES NO

ASSISTED/REPRESENTED BY: SELF ADVOCATE ATTORNEY
Name: _____

SEEKING PLACEMENT FOR: ASAP FALL SPRING SUMMER

VIII. REFERRAL SOURCE

Please provide the following information regarding the person or organization that referred you to The Help Group.

1. _____
NAME

2. _____
NAME

TYPE OF REFERRAL

TYPE OF REFERRAL

AGENCY

AGENCY

STREET ADDRESS

STREET ADDRESS

CITY STATE ZIP

CITY STATE ZIP

PHONE NUMBER

PHONE NUMBER