

Admissions Application

The Help Group

“Because Every Child Deserves a Great Future”

APPLICATION TO:

- Village Glen School *
- Village Glen, Beacon Program
- Sunrise School
- Bridgeport School

** Village Glen School has a campus both in Sherman Oaks and Culver City.*

CAMPUS: Sherman Oaks Culver City

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

DATE OF APPLICATION: _____

I. STUDENT INFORMATION

STUDENT'S LAST NAME FIRST MIDDLE DATE OF BIRTH

STREET ADDRESS CITY STATE/ ZIP HOME PHONE (____)

CURRENT RESIDENCE:

PARENT'S HOME RELATIVE/GUARDIAN OTHER _____
PLEASE SPECIFY

AGE: _____ MALE FEMALE

STUDENT'S PLACE OF BIRTH STATE COUNTRY

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

STUDENT'S SOCIAL SECURITY #

MEDI-CAL or INSURANCE POLICY NUMBER

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
ZIP

CITY STATE

WORK PHONE NUMBER EXTENSION

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>MEDICATION*</u>	<u>DOSAGE/TIMES</u>	<u>PRESCRIBING DR.</u>	<u>PURPOSE</u>
_____*	_____	_____	
_____*	_____	_____	
_____*	_____	_____	

***Please indicate month/year of initiation and month/year of discontinuation**

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

- Nonpublic
- Public School
- Private

Current Type of Program

- Full-Inclusion Classroom
- Full-Inclusion Classroom with resource pull-out (specify subject for pull-out)
- Special Day Class
- Special Day Class with some mainstreaming (specify mainstreamed subjects)

Please check any current educational concerns:

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty with reading <input type="checkbox"/> Difficulty with spelling <input type="checkbox"/> Difficulty with school attendance <input type="checkbox"/> Difficulty with abstract concepts | <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty with handwriting <input type="checkbox"/> Difficulty with arithmetic <input type="checkbox"/> Difficulty maintaining attention <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.

For each question identified below, place an X in the box to the right that appropriately describes your child.	Often	Sometimes	Rarely	Never
1. My child prefers to do things with others rather than on his / her own.				
2. My child prefers to do things the same way over and over again.				
3. My child has been involved in fights at school.				
4. My child has been suspended from school.				
5. My child often notices small sounds when others do not.				
6. In a social group, my child can easily keep track of several different people's conversations.				
7. My child has made inappropriate sexual statements.				
8. My child has engaged in inappropriate sexual activities on one or more occasions.				
9. My child finds social situations easy.				
10. When my child talks, it isn't always easy for others to get a word in edgewise.				
11. My child finds it hard to make new friends.				
12. It upsets my child if the daily routine is disturbed.				
13. My child finds it easy to "read between the lines" when someone is talking to me.				
14. New situations make my child anxious.				

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

VII. 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?

VIII. 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

IX. 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