EARLY CHILDHOOD / EARLY GRADES APPLICATION FOR ADMISSIONS

Mailing Address: 517 Soraparu Street, Suite 104 New Orleans, LA 70130 info@raphaelacademy.org 504-524-5955	Date: ____________________ School Year Applying For: ____________ Grade applying For: ______________ Date Received: ________________ Fee Received: _________________ **Please attach a photo**

GENERAL STUDENT INFORMATION

Child's Name: ____
First Middle Last

Date of Birth: ______________ Age: ____________ Gender: ____________

Residential Address: ____
City Zip Code

Mailing Address: ____
City Zip Code

Telephone: ________________ Alternate Telephone: ________________

Current Nursery/School Program: ______________________________
Name of School / Program Address Grades Attended

Previous Nursery/School Program: _____________________________
Name of School / Program Address Grades Attended

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian's Name: __________________________________
Relationship to Child

Address: ____
(IF DIFFERENT FROM CHILD'S) City State Zip Code

Home Phone: ____________________ Mobile Phone: ____________________

Work/Alternate Phone: ____________________ Email: ____________________________________

Occupation: ________________________ Location of Work: ________________________________

Parent/Guardian's Name: ____

Relationship to Child

Address: ____

(IF DIFFERENT FROM CHILD'S) City State Zip Code

Home Phone: ________________________________Mobile Phone: _________________________

Work/Alternate Phone: _________________________ Email: _____________________________

Occupation: ___________________________ Location of Work: ____________________________

Grandparent's Name:____

Address:____

Email:____ Phone:_______________________

Grandparent's Name:____

Address:____

Email:____ Phone:_______________________

APPLICANT INFORMATION

Height: __________ Weight: _________ Hair Color: ______________ Eye Color: _______

Religious Affiliation: _________________ Primary language spoken at home: ______________

Person(s) to be contacted in case of emergency:

____

Name Relationship

____

Address Phone #

Thank you for answering the following questions to the best of your knowledge. This information, which will be kept strictly confidential, will help us to understand your child.

I. PREGNANCY

(a) Do you know of any hereditary or congenital diseases in the family on either side? Note any of the following conditions: genetic syndromes, autism, epilepsy, mental or nervous diseases, malformations, deafness or other serious diseases?

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(b) Describe any bleeding (during pregnancy), premature labor, infections, accidents or medical complications.

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II. BIRTH

(a) Length of Pregnancy ________________________ (**b**) Duration of Labor ______________________

(c) Describe Birth, easy or difficult, instruments used, anesthesia, c-section, etc.

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(d) Describe the neonatal course (e.g. neonatal ICU, care, treatment for jaundice, antibiotics, spinal tap, oxygen, etc.)

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____
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(e) Did the baby require special treatment to assist breathing injections, oxygen, etc.)?

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(f) Birth weight: __________ lbs. _____________ oz.

(g) Any other comments on your child's birth.

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III. INFANCY

(a) How was your baby fed during the first year of life? Describe any complications.

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(b) Did the infant show affection in the usual way? Was he/she quiet or restless? Was he/she a "happy" baby?

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(c) Were there any disturbances of digestion, recurrent vomiting, or colic?

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____

(d) Was there any unusual sleep pattern? ____

IV. DEVELOPMENTAL MILESTONES:

(a) At what age was your child exhibiting the following behaviors:

- First smile ____________
- Reaching out for things ____________
- Teething ____________
- Sitting unaided ____________
- Walking unaided ____________
- Crawling ____________
- First word said ____________ What was it? __________
- Speaking in sentences ____________
- Any other comments relating to infancy

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(b) Were there any periods of regression, loss of speech, etc.?______________________________

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(c) Did your child have tics, repetitive movement patterns, fixations or self-stimulatory behavior?

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(d) When and why did you become concerned that your child was not developing normally? What did you do about it?

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(e) What is your child's diagnosis? When was it first made? Has it changed over the years?

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V. CHILDHOOD TO PRESENT

(a) Communication

1. Describe your child's ability to speak, and/or other means of communication.

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____

2. What other means are used (sign, gesture, assistive device)?

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(b) Behavior

1. Has your child received special behavioral treatment or therapy, such as wrap-around services, or ABA (Applied Behavioral Analysis)? ☐ Yes ☐ No

If so, did you find ABA helpful? Give details______________________________________

____

Where were the services received: (Name/Address) ______________________________

____

____

May we contact them? ☐ Yes ☐ No

Dates of service (approximate):____

____

2. Describe any self-stimulatory behaviors and/or aggressive behaviors, such as rocking, head-banging, and/or verbal or physical aggression, etc.

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3. Describe any behavior issues, e.g. running away, hiding objects, bad habits, obsessions and/or compulsions, destructiveness, self-abusive, aggression (verbally/physically, etc.)?

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4. When do these behaviors usually occur? (what conditions/situations)?

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____

5. What do you do to discipline your child?

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6. How does she/he react to discipline?

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7. Does your child have a "behavior intervention plan?" If so, are you willing to work with the school staff to review and modify if necessary?

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8. Describe your child's self care and toileting habits (teeth brushing, washing, toilet trained, etc.)

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9. How many hours per day does your child watch TV, movies, or play computer/video games? Specify

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10. Are you willing to work with staff to make adjustments to media exposure, if necessary?

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(c) Eating Habits

1. Describe eating habits (use of utensils, how your child relates to food/meal times)

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2. What does your child usually eat for:

Breakfast ____

Lunch ____

Supper____

Additional Comments: ____

Snacks ____

How many snacks a day? ____

3. Is your child on a special diet? What is the reason for the special diet? Please be specific.

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(d) Sleeping Habits

1**.** Describe sleeping habits (bedtime, how long, how deeply).

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2. What does your child do if he/she awakens in the night (cry, make noise(s), wander, etc.)?

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(e) Medical-Diagnosis/treatment

1. What illnesses or childhood diseases has your child had, and at what age?

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2. Describe any falls or accidents and age at which they occurred.

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3. Has your child had any seizures? If so, describe type, duration, and frequency. Did they recur at particular times?

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4. List all **current** medications and purposes (seizures, anxiety, behavior, etc.), dosages and when started (approximately).

Drug	Dosage	Purpose	Date Started

List all **previous** medications and purposes (seizures, anxiety, behavior, etc.), dosages and when started and stopped (approximately).

Drug	Dosage	Why was it discontinued?	Date Started/Stopped

5. Has your child been prescribed or given any unconventional treatments—special diets, supplements, vitamins, homeopathy, etc.?

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Have they been effective?

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6. Admission or outpatient attendance at hospital:

(a) Date(s) of Admission

____

____

(b) Reason(s) for admission or attendance

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____

(f) Social

1. How would you describe your child as a person?

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____

____

Strengths and Needs

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____

____

2. What does your child like to do? (hobbies/interests)

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____

____

3. What kinds of things scare or worry your child?

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____

4, Does your child have a current IEP? ☐ Yes ☐ No **If yes, please attach the most recent copy.**

5. Put a circle around any of the following areas of concern regarding your child.

1. Bedwetting
2. Wetting during the day
3. Thumb sucking
4. Stammering or stuttering
5. High strung or easily upset
6. Too restless
14. Nightmares
15. Temper Tantrums
16. Contrary or stubborn
17. Disobedient
18. Lying
19. Selfish in sharing

7. Shy
8. Sad or sulky
9. Feelings easily hurt
10. Wanting too much attention
11. Wanting too much comfort/ support from parent
12. Daydreaming
13. Sleep issues
20. Jealous of brothers & sisters
21. Fighting with other children
22. Purposely destroys things
23. Feeding
24. Toilet issues
25. Any other problems? 0r comments:

Elaborate further if needed:

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____

6. How many other members of the family live in the same house as the child (siblings, grandparents, aunts/uncles, etc.) and what is each member's relationships to the child? Please include the ages of any siblings.____

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7. How does your child get along with mother, father, and other children/family members? Does your child show normal affection? How does child relate to peers?

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____

8. Are there any family social/economic issues, such as problems with housing, employment, food, etc. (describe)?

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9. Who looks after the child most of the time?______________________________

Day? ____

Evening?____

(g) Education

1. Why are you considering a change of school for your child at this time?

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2. What is the current ratio of staff/child at your child's current/previous school/daycare?

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3. What was your child's support level (independent? Part-time aid? Full-time aid?)

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____

Why? ____

____

4. Does your child presently receive related services? List types and frequency (e.g. Speech – 1x/week 30 min.) ____

____

____

5. How does your child relate to going to school/education? ____________________

____

6. Does your child enjoy singing, dancing, rhyming and storytelling?

____

____

7. What does your child like best/least about school? _________________________

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8. Is your child currently or has your child recently been under the supervision of a psychologist, psychiatrist, counselor, or other mental health professional? If so, please state reason.

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____

Please provide their name and address:

____

____

Approximate period of attendance ______________________________________

Advice given to you, and your comments ________________________________

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____

9. Has your child undergone any psychological or intelligence tests? ☐ Yes ☐ No
If yes, please attach a copy of all evaluations.

10. Has your child had any private tutoring? ☐ Yes ☐ No

When? For what? ____

____

11. Is your child registered with the local human services/ social services/ or MH/IDD agency to receive services? ☐ Yes ☐ No

If YES, please provide the following information:

* Name of Supports Coordinator/Case Manager/Social Worker
  ____
* Name of Agency ____
* Address____
* Phone ____________________ Emai l______________________________

12. If your child is accepted, would you continue, or plan any other programs after or during school hours? If so, please explain/describe.

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VII. Parent Involvement

(a) How would you like to, or imagine you would, be involved in your child's education (e.g. parent teacher evenings, parent workshops, parent groups, volunteering for events, etc.) Specify:

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HOW DID YOU LEARN ABOUT RAPHAEL ACADEMY?

____

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Do you have remarks you wish to add? Please feel free to use additional sheets for more information on any of the previous questions, or for any information you feel important that was not asked for.

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Please return application via mail to:
Raphael Academy
517 Soraparu Street, Suite 104
New Orleans, LA 70130

or by hand to:
500 Soraparu Street
New Orleans, LA 70130

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