



RAPHAEL ACADEMY

KINDERGARTEN/EARLY GRADES APPLICATION FOR ADMISSIONS

<p>Mailing Address: 517 Soraparu Street, Suite 104 New Orleans, LA 70130</p> <p>info@raphaelacademy.org 504-524-5955</p>	<p>Date: _____</p> <p>School Year Applying For: _____</p> <p>Grade applying For: _____</p> <p>Date Received: _____</p> <p>Fee Received: _____</p> <p>**Please attach a photo**</p>
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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/Gaurdian'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: _____

Grandparents Name: _____ Phone: _____

Address: _____ Email: _____

Grandparents Name: _____ Phone: _____

Address: _____ Email: _____

Home Phone: _____ Mobile Phone: _____

Work/Alternate Phone: _____ Email: _____

Occupation: _____ Location of Work: _____

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? _____

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

II. BIRTH

(a) Length of Pregnancy _____ (b) Duration of Labor _____

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

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

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

(f) Birth weight: _____ lbs. _____ oz.

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

III. INFANCY

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

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

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

(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 _____

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

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

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

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

V. CHILDHOOD TO PRESENT

(a) Communication

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

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

(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? ___Y ___N

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. _____

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

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

5. What do you do to discipline your child?

6. How does she/he react to discipline? _____

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?

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

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

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

(c) Eating Habits

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

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. _____

(D) Sleeping Habits

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

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

(E) Medical-Diagnosis/treatment

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

2. Describe any falls or accidents and at what age _____

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

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.?

Have they been effective?

6. Admission or outpatient attendance at hospital:

(a) Date(s) of Admission _____

(b) Reason(s) for admission or attendance _____

(F) Social

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

Strengths and Needs

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

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

4. Does your child have a current IEP? ____ Y ____ N **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 | 14. Nightmares |
| 2. Wetting during the day | 15. Temper Tantrums |
| 3. Thumb sucking | 16. Contrary or stubborn |
| 4. Stammering or stuttering | 17. Disobedient |
| 5. High strung or easily upset | 18. Lying |
| 6. Too restless | 19. Selfish in sharing |
| 7. Shy | 20. Jealous of brothers & sisters |
| 8. Sad or sulky | 21. Fighting with other children |
| 9. Feelings easily hurt | 22. Purposely destroys things |
| 10. Wanting too much attention | 23. Feeding |
| 11. Wanting too much comfort/
support from parent | 24. Toilet issues |
| 12. Daydreaming | 25. Any other problems? Or comments: |
| 13. Sleep issues | |

Elaborate further if needed:

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. _____

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?

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

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

Day? _____

Evening? _____

(G) EDUCATION

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

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

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

Why? _____

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

e. How does your child relate to going to school/education? _____

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

g. What does your child like best/least about school? _____

11. 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.

Please provide their Name and address

Approximate period of attendance _____

Advice given to you, and your comments _____

12. Has your child undergone any psychological or intelligence tests? yes no
If yes, please attach a copy of all evaluations.

13. Has your child had any private tutoring? yes no

When? For what _____

14. Is your child registered with the local human services/ social services/ or MH/IDD agency to receive services? _____ If YES, please provide the following information:

* Name of Supports Coordinator/Case Manager/Social Worker

* Name of Agency _____

* Contact Info: Address _____

* Phone _____ Email _____

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

VII. Parent Involvement

1. 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 _____

HOW DID YOU LEARN ABOUT RAPHAEL ACADEMY?

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.

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

Raphael Academy does not discriminate on the basis of race, age, color, creed, gender, sexual orientation, national origin, ethnic origin, or disability