

THE KING'S ACADEMY

1015 S. Ebenezer Road Florence, SC 2501



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Application for Educational Therapy 2010-2011

Name of Student _____ Date _____

Birth date _____ Age _____ Grade _____ Sex _____ Teacher _____

Father _____ Occupation _____ Work Phone _____

Email _____ Cell Phone _____

Mother _____ Occupation _____ Work Phone _____

Email _____ Cell Phone _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Referred by _____

FAMILY HISTORY

Child is living with:

natural father stepfather natural mother step mother

legal guardian other: _____

Child is: adopted foster

Since the child's birth there has been:

Reaction of child:

death in the family

separation

divorce

remarriage of mother

remarriage of father

other major trauma

Other children in the family:

| Name | Age | Grade | Present School |
|-------|-------|-------|----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Is there a history of learning difficulties in your family? Yes No

If yes, please explain _____

Briefly describe your child's relationship with you, your spouse, and other members of the family: _____

Name of the church your family attends _____

MEDICAL/DEVELOPMENT HISTORY

Child was: full term premature

State any complications that occurred during pregnancy (e.g., toxemia, diabetes, etc.)

State any complications that your child had immediately after birth (e.g. difficulty breathing, blue color, etc.) _____

Check where applicable:

| | |
|---|--------------------|
| <input type="checkbox"/> recent physical exam | date/results _____ |
| <input type="checkbox"/> recent eye exam | date/results _____ |
| <input type="checkbox"/> recent hearing exam | date/results _____ |
| <input type="checkbox"/> recent speech evaluation | date/results _____ |

Check any problems in infancy or childhood with:

| | | | |
|-----------------------------------|-------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> colic | <input type="checkbox"/> talking | <input type="checkbox"/> crawling | <input type="checkbox"/> walking/running |
| <input type="checkbox"/> sleeping | <input type="checkbox"/> bedwetting | <input type="checkbox"/> eating | <input type="checkbox"/> general slow development |

Child: (check where applicable)

| | | |
|---|--|---|
| <input type="checkbox"/> needs glasses | <input type="checkbox"/> wears glasses | <input type="checkbox"/> has/had frequent ear infection |
| <input type="checkbox"/> has allergies/asthma | <input type="checkbox"/> has/had high fevers | <input type="checkbox"/> has/had hearing difficulties |
| <input type="checkbox"/> had seizures, convulsions, or staring spells | <input type="checkbox"/> experienced injury/accident to head | |

Explain items checked:

EDUCATIONAL HISTORY

=====
List all schools previously attended (preschool to present):

| School | Grades | Reason for Change |
|--------|--------|-------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Child writes with:

right hand left hand uses both hands mirror writer

Check where applicable and provide pertinent information:

repeated grade(s); if so, grade(s) repeated

received tutoring; if so, subjects(s)

enrolled in a special class; if so, what kind

receives/received physical/occupational therapy

receives/received speech therapy or language therapy

State child's best and worst subject: Best _____ Worst _____

Child has been tested before: Yes No

If yes, give date and location of testing:

Child has been diagnosed as:

ADD ADHD Learning Disabled Other: _____

Is your child currently on medication? Type: _____ When taken: _____

Prescribing Physician: _____

Additional comments or information regarding child's schooling:

State the area(s) in which you feel your son/daughter needs help:

SOCIAL/BEHAVIOR HISTORY

=====

Check where applicable:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> independent | <input type="checkbox"/> lacks common sense | <input type="checkbox"/> stubborn | <input type="checkbox"/> dependent |
| <input type="checkbox"/> anxious | <input type="checkbox"/> easily distracted | <input type="checkbox"/> aggressive | <input type="checkbox"/> complains about school |
| <input type="checkbox"/> dishonest | <input type="checkbox"/> overly fearful | <input type="checkbox"/> withdrawn | <input type="checkbox"/> overly sensitive |
| <input type="checkbox"/> shy | <input type="checkbox"/> enjoys school | <input type="checkbox"/> moody | <input type="checkbox"/> self-centered |
| <input type="checkbox"/> passive | <input type="checkbox"/> make friends easily | <input type="checkbox"/> confident | <input type="checkbox"/> easily frustrated |
| <input type="checkbox"/> prefers playing with older children | | <input type="checkbox"/> prefers playing with younger children | |

Is there any additional information you would like to personally share with the Discovery Program Coordinator prior to testing? Yes No

PERMISSION FOR TESTING

We give our permission to _____ to perform academic testing with our son/daughter.

Father

Date

Mother

Date