

THE KING'S ACADEMY

Phone 843. 661.7464 Fax 843.61.7647



1015 S. Ebenezer Road Florence, SC 2501

Application for Educational Therapy – Returning Student

2012-2013

Name of Student _____ Date _____

Birth date _____ Age _____ Grade _____ Sex _____

Father _____ Occupation _____ Work Phone _____

Email _____ Cell Phone _____

Mother _____ Occupation _____ Work Phone _____

Email _____ Cell Phone _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____

EDUCATIONAL HISTORY

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Check where applicable:

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 _____

Date and location of most recent testing _____

Student has been diagnosed as:

ADD ADHD Learning Disabled Other: _____

Is she/he currently on medication? Yes _____ Type _____ When taken _____ Physician _____

Additional comments or information regarding student's schooling: _____

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

PERMISSION FOR TESTING

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We give permission to The King’s Academy Discovery Program to test:

Student’s Name

Father _____ Date _____

Mother _____ Date _____

Rev.1/12

The Discovery Program - Permission Form

I give permission for The King’s Academy Discovery Program to:

1. Allow teachers to read the most recent psycho-educational testing report for the Purpose of educational planning.

Parent Signature

2. Allow my child’s educational therapy session to be recorded for the purpose of evaluation and/or training of therapists.

Parent Signature

3. Allow my child’s picture to be used on a brochure, display, or web site for the purpose of providing information about the Discovery Program.

Parent Signature
