Samara Learning Center
Soar with your strengths Manage your weaknesses

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DAY SCHOOL APPLICATION

DATE RECEIVED: _____

BY: _____

I. Identifying Data

Student Information

Child's name:_____ Age:_____ Gender:_____ Date of Birth:_____

Home address:_____ City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Alternate Phone: ( )_____

Name of person(s) with whom child lives (if not parents):_____

Relationship to applicant: _____

Ethnicity □ White □ African American □ Asian American □ Latino/Hispanic
□ Indian American □ Other _____ □ Decline to state

Application completed by:_____ Relationship to child: _____

Please describe in your own words the nature of your child's difficulties:

_____

_____

_____

How do you expect the Samara Learning Center to help your child?

_____

_____

_____

Parent (or Guardian) Information

Parent/Guardian Name:_____ Home phone: ( )_____

Address (if different from above): _____

City:_____ State:_____ Zip: _____ e-mail_____

Employer:_____ Work phone: ( )_____

Parent/Guardian Name:_____ Home phone: ( )_____

Address (if different from above): _____

City:_____ State:_____ Zip: _____ e-mail_____

Employer:_____ Work phone: ( )_____

Other Parent Name:_____ e-mail_____

Employer:_____ Work phone: ( )_____

Other Parent Name:_____ e-mail_____

Employer:_____ Work phone: ( )_____

II. School History

Current School Placement

School presently attending:_____ Current grade:_____

Address:_____ City:_____ State:_____ Zip code:_____

Phone: ( ) _____ Date started:_____ Teacher(s):_____

Type of school: • Public • Private

• Regular education • Special education • Homeschool

Type of program: • General education classroom

• General education classroom with resource room, specify time in resource room: _____

• Special day class with mainstreaming, specify time in mainstream: _____

• Special day class without mainstreaming

Other Schools and Special Services

Directions: Please list all schools, including preschool, your child has attended other than his/her current school. Indicate if it was a public or private school and whether your child was in a regular or a special education classroom.

Name	Type of school/program	Dates (From/To)	Reason for change
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Directions: Please list any special services your child is currently receiving or has received in the past. Indicate whether the service was provided at school (S) or privately (P), dates of service, and reason for discontinuation.

Service	Current	Past	S	P	Dates	Reason for discontinuation
Speech/Language	•	•	•	•	_____	_____
Adaptive P.E.	•	•	•	•	_____	_____
Counseling	•	•	•	•	_____	_____
Tutoring	•	•	•	•	_____	_____
_____	•	•	•	•	_____	_____

Directions: Please list any evaluations your child has received through his or her school.

School	Areas evaluated	Date
_____	_____	_____
_____	_____	_____

Additional School Information

How did your child react to his/her initial school experiences (preschool and kindergarten)? _____

_____

_____

When were your child's academic/learning difficulties first noticed? _____

How were the difficulties described to you?_____

_____

_____

Has your child demonstrated visual perceptual difficulties in school (e.g., letter reversals; confusion between similar letters, words, or numbers; copying): • No • Yes If yes, please describe:_____

_____

Has your child demonstrated auditory perceptual difficulties in school (e.g., trouble distinguishing between letter sounds or similar sounding words; sounding out words; blending sounds)? •No • Yes If yes, please describe:_____

_____

_____

Please describe any behavior and attention problems that have been brought to your attention by the school or that concern you: _____

_____

Has your child ever repeated a grade? • No • Yes Which grade(s)? _____

If yes, who recommended it and why? _____

_____

What is your child's understanding of his/her school difficulties?_____

_____

_____

Were there any situations (e.g., teacher or peer relationships) that you feel were significant to your child's school adjustment? • No • Yes If yes, please describe:_____

_____

Please describe your child's current adjustment to school, including his/her relationship to teacher(s):_____

_____

Did/Does your child miss school? • Rarely • Sometimes • Often

Please explain: _____

III. Consultant Information

Physician/Pediatrician

Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: ( ) _____ Date of last Physical Exam:_____

Other Consultants

Directions: Please list medical and other specialists who have evaluated, or are currently treating, your child (e.g., Neurologist, Endocrinologist, Psychologist, Speech and Language Therapist, Occupational Therapist, etc). Please do not include any special service your child may be receiving currently through his/her school.

Name:_____ Specialty:_____ Type of Service:_____

Address:_____ Citv:_____ State:_____ Zip:_____

Phone: ( )_____ Date(s):_____

Name:_____ Specialty:_____ Type of Service:_____

Address:_____ Citv:_____ State:_____ Zip:_____

Phone: ( )_____ Date(s):_____

Name:_____ Specialty:_____ Type of Service:_____

Address:_____ Citv:_____ State:_____ Zip:_____

Phone: ( )_____ Date(s):_____

IV. Medical History

Health Record

Please describe your child's current health: _____

_____

Please check illnesses that your child has or has had:

- Allergies
- Asthma
- Bronchitis
- Chicken pox
- Cholera
- Croup
- Cystic fibrosis
- Diabetes
- Ear infections
- Encephalitis
- Epilepsy
- High fevers
- Leukemia
- Measles
- Meningitis
- Mumps
- Muscular dystrophy
- Pneumonia
- Polio
- Rheumatic fever
- Rubella
- Scarlet fever
- Seizures/Convulsions
- Tonsillitis
- Other:_____

Please describe any complications or limitations associated with these illnesses: _____

_____

Accident(s):_____

Hospitalization(s): Reason: _____ Age: _____ Duration: _____

Reason: _____ Age: _____ Duration: _____

Vision: • Normal • Vision problem (please describe):_____

• Wears glasses/contact lens • Won't wear prescribed glasses/contact lens

Date of last vision exam:_____ Examined by:_____

Hearing: • Normal • Hearing problem (please describe):_____

• Uses hearing aid Date of last hearing exam:_____ Examined by:_____

Physical Handicap(s):_____

Medications

<u>Directions</u>: Please list significant medications (e.g., stimulants, antidepressants, tranquilizers, painkillers) your child has taken beyond those prescribed for common illnesses.

Past Medication(s):

Name: _____Type: _____Dose: _____

Name: _____Type: _____Dose: _____

Current Medication(s):

Name: _____Type: _____Dose: _____

Name: _____Type: _____Dose: _____

V. Family History

Parents

Directions: Please use the extra lines below as needed for step parent(s) or guardian(s).

Name	Age	Occupation	Highest Educational Level	Marital Status

If parents are separated or divorced:

Date of Separation/Divorce:_____ Child's age at time:_____

Child's reaction:_____

What is the current legal custody arrangement? _____

_____

_____

What is the current living and visitation arrangement? _____

If a parent is deceased, indicate the date of death and child's age at time:_____

Child's reaction: _____

_____

Are there any family problems or recent changes which you feel might be contributing to your child's difficulties?

• No • Yes

If yes, please describe: _____

_____

Child

Is your child adopted? • No • Yes If yes, at what age? _____

If yes, does s/he know s/he's adopted? • No • Yes

Is the child under guardianship? • No • Yes

If yes, please describe: _____

Primary language of the child?_____ Language learned first (if different):_____

Other languages spoken in the home? _____

Other languages spoken by significant caregivers (e.g., nanny, daycare center staff) other than the parents? _____

Other languages the child understands and/or uses? _____

Family

Siblings: Name	Age	Sex	Relationship to child: Full	Half	Step	Living at home?

Please describe your child's response to the birth of siblings (e.g., cooperative, angry, withdrawn, became more immature, became independent, shifted attachment) and how you handled this:

VI. Pregnancy, Birth, and Early Development

Pregnancy and Birth

Please describe any pregnancy and/or delivery/birth complications :

Early Development

What was the general temperament of your child during the early years? • Easy going, adaptable

• Difficult, sleep/feeding irregularities, intense reactions • Withdrawn, slow to adapt

Please describe your relationship with your child during the first year:

Would you consider the early attachment between you and your child:

• Strong • Moderate • Weak

Please describe your child's response to changes or new situations:

Please note any difficulties your child may have had during the first year (e.g., colic, excessive crying, activity, passivity, sleeping, responsiveness to being held):

In general, was your child: • easy to care for •difficult to care for

Parent work history within the first 2 years after birth:

Parent 1: • Did not work • Full-time • Part-time Child's age when work resumed:_____

Parent 2: • Did not work • Full-time • Part-time Child's age when work resumed:_____

Please describe the child care arrangements during parents'absence:_____

_____

Were both parents involved in the caregiving of the child? • Yes • No

Please describe each parent's caregiving role:_____

_____

Age toilet training started: _____

Age toilet training concluded for: day wetting _____ night wetting _____ bowel _____

In general, did toilet training present any difficulties? • Yes • No

If yes, please describe: _____

_____

Please describe any significant events that occurred within the family during the early years (e.g., postpartum depression, illnesses, moves, marital difficulties, or other events) and their impact on your child:_____

_____

_____

_____

VII. Language Development

During the first year, other than crying, would you say that your child was a:

• silent or very quiet baby • very noisy baby • verbally interactive baby

Directions: For the following questions, please give your best estimate regarding the age at which your child developed each skill. If you do not remember, please indicate DK (don't know).

At what age did your child say his/her first words? _____

What were they? _____

At what age did your child use word combinations such as "me go"? _____

At what age did your child use complete sentences? _____

Did your child's language develop consistently over time or were you aware of significant breaks (e.g., cooed but did not babble, said one or two words but then there was a long delay before new words were added, appeared to understand language but did not use language expressively)?

• Consistent development • Significant breaks in development

Please describe: _____

Does your child seem to have trouble making certain speech sounds? • No • Yes

If yes, please describe:_____

_____

Does your child seem to have trouble understanding language? • No • Yes

If yes, please describe:_____

_____

Does your child seem to have trouble describing events and/or telling a story coherently? • No • Yes

If yes, please describe:_____

Do you feel that your child's language development was . . .

• slower than • about the same as • ahead of . . . his/her peers?

Do you feel your child's language development was influenced by exposure to more than one language?

• Not applicable • No • Yes If yes, please describe:_____

Please describe any other special concerns you have had, or currently have, about your child's speech, language, or communication abilities:_____

_____

VIII. Motor Development

Directions: For the following questions, please give your best estimate regarding the age at which your child developed each skill. If you do not remember, please indicate DK (don't know).

At what age was your child able to:

sit alone without support? _____

pull him /herself up to a standing position? _____

walk unaided? _____

Have you ever been, or are you currently, concerned about any of the following aspects of your child'smotor development?

• balance • hopping • skipping • running speed • ball skills • bicycle/tricycle skills

• use of scissors • control of pencils/crayons • dressing skills • eating skills • writing skills

Please describe your concerns regarding the above areas:_____

_____

_____

Does your child indicate a hand preference? • Yes - Left hand • Yes - Right hand • No

If yes, when did you first notice a consistent hand preference?_____

Was hand preference influenced by adults? • Yes • No

If yes, please describe: _____

Overall, do you feel that your child's motor development was . . .

• slower than • about the same as • ahead of . . . his/her peers?

Please describe any other special concerns you have had, or currently have, about your child's fine or gross motor abilities:

_____

_____

_____

IX. Personality and Social Relationships

Personality

Please describe your child's personality (e.g., outgoing, keeps to him/herself, friendly, sensitive, loving, self centered):

Have you noticed a change in your child's personality over the years? • Yes • No

If yes, please describe: _____

Please describe your child's favorite activities/interests._____

What are your child's chores and responsibilities at home? _____

Does s/he complete these responsibilities regularly and willingly? • Yes • No

Please describe:_____

Please describe your child's strengths and weaknesses: _____

Is your child aware of his/her strengths and weaknesses? • Yes • No

Please give examples: _____

Does your child accept his/her strengths and weaknesses: • Yes • No

Please give examples: _____

Does your child become easily frustrated? • Yes • No

Please describe:_____

Does your child persist during difficult tasks? • Yes • No

Please describe:_____

Does your child set reasonable goals for him/herself? • Yes • No

Please describe:_____

Does your child demonstrate organizational and time management skills (e.g., study habits, scheduling)?

• Yes • No Please give examples: _____

Family Relationships

Directions: Please describe your child's relationships with the following family members.

Parent 1:_____

Parent 2: _____

Siblings:_____

Others:_____

Directions: Please indicate the parenting style of each parent/step-parent, and/or guardian using the following description. Parenting styles: ***I.*** *Little parental structure and guidance; child has major responsibility for decision making;* ***II.*** *Firm parental control with open communication allowing for child input in decision making;* ***III.*** *Strong parental structure and control; child has minimal role in decision making;* ***IV.*** *Combination of styles.*

Name	**Style**
Parent 1	_____
Parent 2	_____
_____	_____
_____	_____

Please describe your child's behavior at home: _____

_____

_____

At present, what behavior is the most difficult for you to handle? _____

_____

How do you handle discipline issues? _____

_____

Who is the primary limit setter in the family? _____

_____

How do you and your spouse resolve differences you may have about discipline? _____

_____

How much supervision does your child need?

• more than peers • about the same as peers • less than peers

Please describe:_____

Peer Relationships

Directions: For each of the following questions,please check the box that is most representative of your child's peer relationships.

My child: • prefers to play alone. • has one or two friends only. • has many friends.

My child plays mostly with other children who are: • younger. • same age. • older.

My child prefers: • same sex playmates. • opposite sex playmates. • playmates of both sexes.

My child:

• forms close friendships with peers. • is somewhat close with his/her peers. • does not form close friendships.

In general, the friendships that my child forms:

• last several years. • last several months. • last several weeks. • last several days.

In play interactions with his/her peers, my child tends to:

• be the leader • prefers to be a co-leader • prefers others to lead.

In competitive games, my child seems:

• to need to win. • to want to win. • unconcerned about winning or losing. • to want to lose.

In competitive situations, my child: • does her/his best. • seems to perform below abilities. • gives up.

Please describe any difficulties your child may have with peer interactions (e.g., gets teased, has difficulty making friends, loses friends). _____

_____

_____

Please describe your child's sexual maturation (e.g., onset of puberty, dating, interests and/or problems):_____

_____

_____

_____

Directions: We find that many children who are experiencing difficulties in school sometimes show some of these behaviors. Please indicate which behaviors apply to your child. Please check all ages that apply for each behavior. Check the box marked "NA" (not applicable) if that behavior has never applied to your child.

Behavior	**Ages:**	**yrs 0-2**	**yrs 3-4**	**yrs 5-8**	**yrs 9-12**	**yrs 13-18**
Aggression toward others	• NA	•	•	•	•	•
Aggression toward self	• NA	•	•	•	•	•
Anxious	• NA	•	•	•	•	•
Bed wetting	• NA	•	•	•	•	•
Depression	• NA	•	•	•	•	•
Distractible	• NA	•	•	•	•	•

Eating problems	• NA	•	•	•	•	•
Finger sucking	• NA	•	•	•	•	•
Immature	• NA	•	•	•	•	•
Lying	• NA	•	•	•	•	•
Nail biting	• NA	•	•	•	•	•
Oppositional	• NA	•	•	•	•	•
Overactive/Hyperactive	• NA	•	•	•	•	•
Passive/Withdrawn	• NA	•	•	•	•	•
Physical complaints	• NA	•	•	•	•	•
Restless	• NA	•	•	•	•	•
Rocking/rhythmic movements	• NA	•	•	•	•	•
Separation difficulties	• NA	•	•	•	•	•
Sexual acting-out	• NA	•	•	•	•	•
Sleeping problems	• NA	•	•	•	•	•
Stealing	• NA	•	•	•	•	•
Stuttering	• NA	•	•	•	•	•
Substance abuse	• NA	•	•	•	•	•
Tearful	• NA	•	•	•	•	•
Temper tantrums	• NA	•	•	•	•	•
Tired	• NA	•	•	•	•	•
Trouble with the law	• NA	•	•	•	•	•
Truancy	• NA	•	•	•	•	•

Has your child experienced significant trauma in their life? If so please describe (use addition page if needed):

Has your child taken the ACE (Adverse Childhood Experiences) test? Yes No

If so, would you like to sign an Exchange of Informationso that we may access your ACE score and information with the provider who administered the test? Yes No

Goals and Expectations

Please use additional pages if needed.

What goals and expectations do you have for your child?

What goals and expectations do you have for your child's learning environment?

Please feel free to write down any other comments: