

Mother's Name: _____

Home Address: (if different from above) _____

City State Zip County of Residence

Occupation: _____

Place of Employment: _____

Name Address

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email: _____

(Please circle preferred method of contact)

Siblings: _____

Name Age School Attending

Name Age School Attending

Name Age School Attending

Name Age School Attending

Name Age School Attending

Medical History:

Child's Pediatrician: _____

Address Phone

Has your child been seen by a Psychiatrist, Psychologist or Counselor? YES NO (Circle one)

Date of most recent psychological _____

Child's Psychiatrist: _____

Address Phone

Child's Psychologist: _____

Address Phone

Child's Counselor: _____

Address Phone

Has your child been seen by a developmental pediatrician or neurologist? YES NO (Circle one)

Please provide Dr. Name, Profession, Phone and Office Address:

| | |
|---------|------------|
| _____ | _____ |
| Name | Profession |
| _____ | _____ |
| Address | Phone |

Date of last visit: _____

Does your child have a diagnosis? _____

Please list any other medical conditions _____

Is your child currently taking any medication? Yes _____ No _____

| | | | |
|--------------------|-------|------|-------|
| Name or Medication | _____ | Dose | _____ |
| | _____ | Dose | _____ |
| | _____ | Dose | _____ |
| | _____ | Dose | _____ |

Is your child independent in the bathroom for all his/her needs? If not, please explain. _____

Please list any known allergies: _____

Has your child ever had seizures? Yes _____ No _____ If yes, please describe: _____

Is your child on a special diet? Yes _____ No _____ If yes, please describe: _____

Therapeutic Services:

Has your child been seen by an Occupational Therapist, Speech/Language Therapist, Physical Therapist?

Yes _____ No _____

Occupational Therapist

| | |
|------------------|-----------|
| _____ | _____ |
| Name | Phone |
| _____ | _____ |
| Address | |
| _____ | _____ |
| Dates of Service | Frequency |

Speech/Language Therapist

Name Phone

Address

Dates of Service Frequency

Physical Therapist

Name Phone

Address

Dates of Service Frequency

Does your child use any augmentative communication systems? Yes___ No___ If yes, please describe:

Educational History

Name of Current School

Address

Contact Person Phone

Dates of Attendance

Type of Classroom Grade

Reason for leaving

Do you receive or are you eligible for SB-10 Funds: _____

Do you receive or are you eligible for HB-1133 Funds (SSO funds): _____

Do you receive the Katie Beckett Deeming Waiver? Yes___ No___ Do you receive the NOW Waiver? Yes___ No___

What are you looking for in a facility based program for your child? _____

If applicable, describe your child's reading level, decoding skills, fluency, comprehension, and phonemic awareness

If applicable, describe your child's math level, understanding of basic concepts, rote skills

Social Emotional History

Please describe how your child interacts with you.

Please describe how your child interacts with siblings.

Please describe how your child interacts with peers.

What are your child's favorite activities/topics of interest?

Describe what happens when your child is upset. What do you typically see? (kicking, biting, hurts self/others, withdrawn)

What does your child do to calm him/herself? _____

How long does it take your child to "recover" when upset?

Does your child exhibit impulsive or aggressive behavior? If yes, please describe:

Is your child supported by a behavior plan? If yes, please describe.

Does your child exhibit anxiety? If yes, please describe: _____

Please describe how your child makes transitions between people, activities, or environments (include level of independence during transitions, need for transitional objects or advance preparation about schedule changes)

Other: _____

Please provide any assessments made by outside professionals, and school progress reports.

I certify that the information contained in this application is complete and accurate to the best of my knowledge.

Signature

Date

PROCEDURES AND POLICIES FOR APPLICATION TO LIONHEART

Lionheart School has a rolling admissions policy. Applications will be accepted and admission to the school will be considered when the following items listed below are complete.

- Parent(s) of applicant have visited the school.
- Lionheart has received a completed application.
- Lionheart has received a non-refundable processing fee of \$100.
- Lionheart has received a Psychological Evaluation (required). If there are no comprehensive psychological reports from the past three years, Lionheart reserves the right to ask an applicant to acquire one.
- Lionheart welcomes other assessment reports from additional therapists and/or most recent school/teacher.
- Applicant has met with the Head of School and Head of Therapeutic Services and completed a classroom visit.
- Lionheart reserves the right to ask for additional visits before making a determination regarding the applicant's admission.

Once all items are received from applicant, the review process will begin. Lionheart professionals and outside consultants will help determine if your child is an appropriate fit for Lionheart and whether Lionheart can meet your child's needs. If admitted, parents are asked to commit to enrollment for the entirety of the following academic year.

Lionheart will notify parents of acceptance into the program. Parents will then be required to send in the tuition deposit of **\$2,600 (non-refundable)** within 10 days to secure their child's placement into the program.

NOTICE OF NONDISCRIMINATORY POLICY

The Lionheart School, Inc., admits students of any race, creed, or national and ethnic origin to all the rights and privileges, programs and activities generally accorded and made available to students at the school. It does not discriminate on the basis of race, creed, color, or national and ethnic origin in administration of its educational policies, admissions policies, or other school-administered programs.