

School
Application



Date: _____ Child's name: _____

Age: _____ Date of Birth: _____

Parent/s name: _____

Address: _____

Home phone number: _____

Work phone number: _____

Email address: _____

Child's primary diagnosis: _____

Secondary diagnosis: _____

Please describe previous school experience: _____

Did/does your child have a shadow? _____

Please check Y (yes) if the skill is in your child's repertoire, E (emerging) for emerging skills, and N (no) if your child has not yet learned this skill.

Academic Skills	Y	E	N	Comments
Identifies letters				
Tacts (labels) letters				
Identifies numbers				
Recites alphabet				
Matches sight words				
Reads sight words				
Phonetic awareness				

Decodes words				
Reads sentences				
Reads w/ comprehension				
Tacts numbers?				
Counts sets of objects				
Counts to 10—rote				
Adds single-digits				
Tells time				
Identifies coins				
Completes patterns				
Imitates strokes				
Writes name				
Academics Skills	Y	E	N	Comments
Copies words				
Writes sentences				
Completes mazes				
Cuts straight line				
Cuts out shapes				
Social Skills				
Interested in peers				
Plays next to peers				
Plays with peers				
Asks peers questions				
Comments to peers				
Shares materials				
Gives directions to peers				
Takes direction from peer				
Communication Skills				
Uses signs				
Single words				
Phrases				
Sentences				
Mands (requests) help				
Communication skills	Y	E	N	Comments
Mands materials				

Mands information				
Classroom Skills				
Sits in small group				
Participates in small group				
Puts materials away				
Gets needed materials				
Follows group directions				

Medical History/Sensory Deficits

Current medications: _____

Is your child on a special diet? If so, please describe: _____

Allergies: _____

Do you suspect any of the following?

Hearing difficulties: _____

Visual difficulties: _____

High/low pain tolerance: _____

Fears/sensitivities: _____

Inappropriate Behaviors

Describe any inappropriate behaviors that are of concern: _____

Describe any repetitive or ritualistic behaviors: _____
