

Student's name: _____

Today's Date: _____

Address: _____

Social security #: _____

PARENT/GUARDIAN INFORMATION:

	Mother	Father	Other Female Caregiver	Other Male Caregiver
Name				
Birth Date				
Home address (if different than above)				
Home phone				
Work phone				
Cell phone				
Occupation				
Education (Level/Degree)				
Marital status				
Frequency of contact with student (i.e. daily, weekends, weekly, etc)				
Describe relationship with child (i.e. good, strained, fair, etc)				
E-mail address				
Permission is granted to use e-mail address for announcements/non-time sensitive communication/information: <div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No </div>				

U.S. Citizen: The Pathway School is not internationally licensed. If you answer "no" and wish to continue the application process, please take steps to gain dual citizenship status and notify The Pathway School Admissions Department when complete. File will remain in pending form until U.S. citizenship is established. **Yes** **No**

Primary language spoken at home: _____

Adopted: Yes No If so, from where: _____ at what age: _____

Please provide guardianship/custodian paperwork with this application.

Who is considered to be the legal guardian and/or person to sign consent forms? _____

Current custody agreement must be provided to The Pathway School with this application

If child is over 18 years of age, has a legal guardian been appointed by a court? Yes No N/A

If yes, when: _____ who is legal guardian: _____

For individuals 18 years and older, guardianship documents must be provided to The Pathway School with this application.

OTHER FAMILY INFORMATION:

Members of the family (give full name)	Age	Education (level and/or degree)
Siblings: At home <input type="checkbox"/> Yes <input type="checkbox"/> No Adopted <input type="checkbox"/> Yes <input type="checkbox"/> No		
Siblings: At home <input type="checkbox"/> Yes <input type="checkbox"/> No Adopted <input type="checkbox"/> Yes <input type="checkbox"/> No		
Siblings: At home <input type="checkbox"/> Yes <input type="checkbox"/> No Adopted <input type="checkbox"/> Yes <input type="checkbox"/> No		
Siblings: At home <input type="checkbox"/> Yes <input type="checkbox"/> No Adopted <input type="checkbox"/> Yes <input type="checkbox"/> No		
Others in household	Age	Relationship to student

DIAGNOSIS:

Current:

Past:

Describe the discipline technique(s) that is/are most effective:

Please mark any of the following as past or current stressors in the student's family (Indicate any stress in the last 6 months as current).

Stress	Past	Current	Stress	Past	Current
Financial problems			Mental illness in the family		
Frequent moves			Physical illness in the family		
Job changes			Psychiatric hospitalization of a parent/sibling		
Alcohol problems			Death in the family		
Drug problems			Sexual promiscuity or other inappropriate sexual behavior in the family		
Physical confrontations between parents			Legal problems		
Remarriage of parents			Major problems/difficulties with other children in the household		
Separation from significant non-family members			Other family problems – Explain:		

Is your child receiving therapy or counseling? Yes No

If yes, inclusive dates: _____ Frequency of sessions: _____

Name of therapist/counselor: _____ Phone number: _____

Have you ever received counseling about your child? Yes No

If yes, inclusive dates: _____ Frequency of sessions: _____

Do you receive any “in home” support? Yes No In process of applying

If so, from whom: _____

If so, to support with what issues/concerns:

**Please provide a copy of the current in-home support plan*

Specifically, what are the current problems presented by your child?

<u>At school:</u>	<u>At home:</u>	<u>In the community:</u>

Which of these do you feel most interferes with learning and life function?

Does your child demonstrate any awareness of these problems? Yes No

If so, what seems to concern your child most?

Does your child have any history of engaging in threatening or attempting injurious or suicidal behavior? Yes No

If yes, please describe:

Has your child had any psychiatric inpatient hospitalizations? Yes No

If yes, please describe episode(s), when and where hospitalized, and follow-up treatment:

Does your child have a history of threatening harm or doing harm to others? Yes No

If yes, please describe;

Does your child or has your child threatened to elope/run away from home? Yes No

If yes, please describe:

Please rate your child in the following areas (fill in appropriate letter): **N** = never **O** = occasionally **M**=most of the time **A**=Always/all the time

Thinks of self in positive terms		Demonstrates a sense of humor		Engages in a variety of age appropriate activities		Respects rules and limits set by adults or society	
Accepts compliments		Worries more than others		Fails to complete things		Bullies others	
Identifies his/her strengths		Acts childish or immature		Treats adults with respect		Has severe mood swings	
Understands relationships between feelings, thoughts and behaviors		Demonstrates an awareness of the consequences of actions		Does things in public which are embarrassing to others		Uses physical aggression when upset or angry	
Treats adults with respect		Accepts role in conflicts		Treats peers with respect		Gets in a lot of fights	
Expresses feelings appropriately		Uses eye contact when speaking		Engages in rituals or has obsessive thoughts		Understands social cues	
Uses drugs		Uses alcohol		Understands give and take in relationships		Thinks of self in negative terms	
Self-mutilates/cuts		Compromises		Has temper outbursts		Destroys property	
Takes turns		Overreacts to a problem		Hurts animals		Shares	
Considers the feelings of others		Repeats actions or words unnecessarily		Suffers from excessive anxieties or fears		Complies with requests from adults	
Acts without thinking		Makes and keeps friends		Overacts to criticism		Fears new situations	
Has trouble sitting still		Argues excessively		Obeys rules		Steals	
Is able to separate from parents		Is willing to try new things/solutions		Tells lies/stories which are not true		Has excessive complaints about not feeling well	
Engages in fantasy play		Displays self confidence					

What are your goals/expectations for your child if he/she were to attend Pathway:

Academically:	Socially:	Emotionally:	Vocationally (n/a for students applying for the Emotional Support Program):

Has your child had any of the following (check those that have been done and provide remaining information):

Yes	Evaluation	Date of eval	Name of professional administering eval	Phone #
	Ear, nose and throat			
	Formal Central Auditory Processing evaluation			
	Neurological evaluation			
	EEG			
	Skull X-ray			
	Other scan (explain):			
	Psychiatric evaluation			
	Psychological/neuropsychological evaluation			
	Speech/Language valuation			
	Occupational Therapy evaluation			
	Sensory Integration evaluation			
	Physical Therapy evaluation			
	Other:			

Please provide copies of any of the above if they were not part of the original paperwork submitted.

HEALTH/MEDICAL INFORMATION

Is your child toilet trained for bladder Yes No for bowels Yes No

Can you child care for their toileting needs independently Yes No

Please check any current sleep difficulties that your child has:

Nightmares Insomnia Sleep walking Nigh terrors

Does your child fatigue easily? Yes No Does your child experience difficulty waking? Yes No

Please describe any other sleep problems:

Has your child reached puberty? Yes No

If female, at what age did menstruation begin? _____

What changes have you seen since the onset of puberty?

Describe your child's past or current eating habits:

Is your child: Overweight Yes No Underweight Yes No On a diet Yes No

Date of most recent hearing screening: _____ Results: Pass Fail

If 'Fail', was there a follow up with Ear, Nose & Throat Doctor Yes No – what were results:

Does your child require any assisted/corrective devices for hearing? Yes No

If yes, please describe:

	Name	Phone #	Date of last visit
Primary care physician			
Psychiatrist			
Dentist			
Wrap-around			
Behavior Support Consultant			
Other:			

MEDICATION:

Current					Past				
Drug	Dosage	Time given	Date started	Reason for medication	Drug	Dosage	Time given	Date started	Reason for medication

Is your child compliant with taking all medication: Yes No

If note, please describe the difficulty, and strategies which have been helpful:

Describe any injuries, operations, illnesses or hospitalizations for medical reasons:

Nature of injury, operation or illness	Age	Hospitalized		Duration of hospitalization
		Yes	No	

Please indicate any areas in which your child is currently experiencing problems. Describe the difficulty, how often the problem occurs and the current treatment:

Yes	Condition	Additional Information	Yes	Condition	Additional Information
	Allergies			Joint disease	
	Asthma			Connective tissue disease	
	Frequent strep throat			Eczema	
	Sinus problems			Bruises easily	
	Condition of tonsils/adenoids			Sunburns easily	
	Heart murmur			Hyperactive	
	Loss of consciousness (if yes, how long)			Seizures/convulsions (if yes, include date and type of last one)	
	Dizziness			Infection	
	Activity limitations			Tics/twitches	
	Frequent diarrhea			Traumatic brain injury	
	Frequent constipation			Shortness of breath	
	Frequent vomiting			Neurological surgeries	
	Stomach pain			Ear tubes	
	Bladder infections			Difficulty seeing	
	Frequent urination			Color blind	
	Painful urination			Sun sensitivity	
	Frequent yeast infection			Diabetes	
	Bone disease				

Please explain any medical concerns which require monitoring and/or follow-up medical care:

Please describe any medical conditions or physical handicaps which would limit their participation in any activities, require special accommodations or in any way impair his/her ability to function:

SCHOOL HISTORY

Please list your child's previous schools/programs

Name of school	City/State of school	Grades attended	Regular program or Special Program (list type)	Full-time or Part-time	Dates attended

If homeschooled, please list dates:

Have any grades been repeated? Yes No

If yes, which grade(s) and why?

Is your child currently placed in (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Early intervention services | <input type="checkbox"/> Gifted services | <input type="checkbox"/> Emotional Support |
| <input type="checkbox"/> Part-time special education | <input type="checkbox"/> Full-time special education | <input type="checkbox"/> Residential placement w/special education |

In school, has your child received any of the following services as identified on their IEP (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Early intervention services | <input type="checkbox"/> Title 1 services | <input type="checkbox"/> Individual counseling |
| <input type="checkbox"/> Occupational Therapy services | <input type="checkbox"/> Reading Therapy | <input type="checkbox"/> Adaptive equipment |
| <input type="checkbox"/> Tutoring/remedial work | <input type="checkbox"/> Speech/Language services | <input type="checkbox"/> One on one aid (or Personal Care assistant) |
| <input type="checkbox"/> Behavior Support Plan | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Assistive Technology |
| <input type="checkbox"/> Other - explain: _____ | | |

Have there been frequent absences from school? Yes No

If yes, please explain:

Describe your child's attitude toward school:

At what age did your child do the following:

_____ Turn over

_____ Sit alone

_____ Stand alone

_____ Make speech sounds (babble)

_____ Speak single words

_____ Speak using phrases

_____ Speak in sentences

_____ Walk alone

Does your child communicate using clear speech? Yes No

If no, please describe

Parent/Guardian Signature: _____ Date: _____

Signature of other's assisting with/providing information: _____

Relationship to student: _____ Date: _____

**THIS APPLICATION MUST BE RETURNED TO THE ADMISSIONS DEPARTMENT
AT LEAST 2 BUSINESS DAYS PRIOR TO THE ADMISSIONS INTERVIEW. ADMISSIONS INTERVIEW MAY BE CANCELLED
OR ADMISSIONS DECISIONS WILL BE DELAYED FOR APPLICATIONS NOT RETURNED WITHIN THIS TIMEFRAME.
PLEASE RETURN BY FAX TO 610-539-1493 ATTN: ADMISSIONS DEPARTMENT.**