848 Executive Dr., Oviedo, FL 32765
Tel: 407-678-8889 Toll Free: 1-866-569-7395 Fax: 407-678-8885
Email: info@myalpine.org Website: www.myalpine.org

Enrollment Application

Instruction: Please complete this document to the best of your ability.

Student Name: _____

Areas of Information:

- ☐ General Information
- ☐ Medical and Health Information
- ☐ Educational and Other Therapy Information
- ☐ Behavior Information
- ☐ Goals
- ☐ Supplemental Information
- ☐ Application Fee

Administrative Use Only

Application Fee:

Date Received: _____

Amount Received: _____

Check # (if applicable): _____

Received by: _____

Evaluation:

- □ **1st Day Scheduled:** _____
- □ **2nd Day Scheduled (if needed):** _____
- □ **Accepted**
- □ **Withdrawn/Not Accepted**

Enrollment Paperwork Received

Received by: _____

Enrollment Deposit:

Date Received: _____

Amount Received: _____

Check # (if applicable): _____

Received by: _____

Scheduled Start Date: _____

GENERAL INFORMATION

Student's Name: _____ _____
First *Middle* *Last* *Date of Application*

Sex: M F Date of Birth: _____

Parents' Name: _____

Home Address: _____

_____

Phone Number**:** _____

E-Mail Address: _____

MEDICAL AND HEALTH INFORMATION

Does the student have a medical diagnosis? **YES_____ NO_____**

Student's Primary diagnosis: _____ Age at Diagnosis: _____
Secondary diagnosis: _____ Age at Diagnosis: _____
Other diagnosis: _____ Age at Diagnosis: _____
Other diagnosis: _____ Age at Diagnosis: _____

Health History

(Check all that apply)

☐ Chicken Pox	☐ Measles	☐ Epilepsy	☐ Hepatitis
☐ Kidney disease	☐ Asthma	☐ Mumps	☐ Heart conditions
☐ Diabetes	☐Ear infections	☐ Enuresis (bed wetting)	
☐Severe stomach aches	☐Seizure disorder	☐ Sun sensitivity	☐ Other health condition

If you checked any of the above please explain in detail:

_____
_____
_____
_____

Please be specific in answering the following:

- Does the student have physical restrictions/limitations? YES ___ NO____
  If YES, explain: _____
  _____
- Does the student suffer from any allergic reactions to:
  Penicillin:_____ Other drugs:_____ Bee or wasp sting:_____ Foods:_____

Others :_____

Please specify which foods he/she is allergic to:

_____

_____

- Any dietary restrictions? YES ____NO____
  If YES, explain: _____
  _____
- Is the student's vision within normal limits? YES ____ NO____
  If NO, explain: _____
  _____
- Is the student's hearing within normal limits? YES ____ NO____
  If NO, explain: _____
  _____
- Is the student's weight within normal limits? YES ____ NO____
  If NO, explain: _____
  _____
- Is the student currently on any medications? YES ____ NO____
  If YES, please list medications below:

Name of Medication	Date Prescribed	Dosage	Purpose

- Are there any medical conditions to consider when delivering ABA/Educational services?
  YES ____ NO____
  If YES, explain: _____
  _____
- Are there any other medical treatment interventions? YES ____ NO____
  If YES, explain: _____
  _____
- Student's Primary Physician: _____
  Address of the physician: _____
- Is your child toilet trained? YES ____ NO____
  If No, please provide more information:
  _____

  _____

IMPORTANT: For health and sanitary reasons, children who are not toilet trained must wear protective undergarments.

EDUCATIONAL AND OTHER THERAPY INFORMATION

Please list the services the student is currently receiving (or the last place attended):

☐ Public School (K – 12) County:_____ Name of School:_____

Grade:_____ ☐ESE Program: _____

☐Has current IEP

Current Services: ☐OT ☐PT ☐Speech ☐Other:_____

☐ Private School County:_____ Name of School:_____

Grade:_____ ☐ESE Program: _____

☐Has current IEP

Current Services: ☐OT ☐PT ☐Speech ☐Other:_____

☐ Pre-School or Daycare Name of Program: _____

☐ Home School Provided by: ☐School ☐Therapist ☐Parents

☐ Early Steps Program Services:_____

BEHAVIOR INFORMATION

The focus of our school programs is social and academic development. It may not be suitable for children with high levels of problem behaviors. These behaviors can be better addressed through our ABA therapy program.

What motivates your child? (List your child's LIKES and DISLIKES: any items, activities, or foods)

LIKES	DISLIKES

Are there any behavior concerns that we should be aware of:

_____

_____

_____

_____

Does or has your child participated in other therapies? If so, what kind?

_____

_____

GOALS

Please list some goals that you would like you child to achieve by attending Alpine Academy.

_____

_____

_____

_____

List some of your child's STRENGTHS and CHALLENGES:

STRENGTHS	CHALLENGES

SUPPLEMENTAL INFORMATION

Please provide additional information to this Enrollment Application.

☐ Scholarship Information:

- ☐ Gardiner Scholarship
- ☐ McKay Scholarship Matrix #: _____

☐ Student current or most recent IEP, school reports/notes, data

☐ Other psychological or educational evaluations

☐ Other applicable medical evaluations

On behalf of my son ( ) daughter ( ) _____ / _____
(first or given name) (last or family name)

I wish to apply for admission to Alpine Academy.

Parent Signature: _____

APPLICATION FEE

A $290.00 (before June 30) or $350 (after June 30) nonrefundable application fee must be submitted with the application. We accept check or cash only. Please make checks payable to Alpine Academy.