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# 2024- 2025
# 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 and Assessment Fee $300.00

**Administrative Use Only**

**Application Fee:**

**Date Received: _____**

**Amount Received: _____**

**Check # (if applicable): _____**

**Received by: _____**

**Assessment :**

- □ **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- □ **Withdrawn/Not Accepted**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:

- □ 7 Digit Step-Up Student ID number: _____
- □ 6 Digit scholarship number: _____
- □ Amount of approved Step-Up Funds: _____

☐ 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 & ASSESSMENT FEE

**A $300.00 nonrefundable application fee must be submitted . We accept checks or billed Via Bill.com. Please make checks payable to Alpine Academy.**