GENERAL / Health & History

NEW STUDENT INFORMATION

Thank you for your interest in Lake Pointe Academy. Please complete the following information to the best of your ability and submit to the school office as soon as possible.

Date of Application: _____ Desired Date of Enrollment: _____ Grade at enrollment:

STUDENT INFORMATION

Students Name_____ Date of Birth____/____/____Age: _____ M / F

Address: _____

Phone: _____

Legal Parents/Guardian(s)_____

Guardian(s) Relationship_____

Guardian/Father: Home Phone (_____)_____ Work Phone(____)_____

Cell(_____)_____ Email: _____

Guardian/Mother: Home Phone (_____)_____Work Phone(____)_____

Cell(_____)_____ Email: _____

In Event of an Emergency Contact:

Name_____Relationship_____

Home Phone (_____)_____ Work Phone(_____)_____ Cell(_____)_____

FAMILY Information:

Mother_____Occupation_____

Father_____Occupation_____

Marital Status_____Student lives with_____

Siblings and their ages:

1)_____ Age_____ Grade_____

2)_____ Age_____ Grade_____

3)_____ Age_____ Grade_____

Medical & Health Information:

Does the student have a medical and/or psychiatric diagnosis: **YES**_____ **NO**_____

Student's Primary diagnosis: _____ Age at discovery: _____

Secondary diagnosis: _____Age at discovery: _____

Other diagnosis: _____Age at discovery: _____

Other diagnosis: _____Age at discovery: _____

Health History (check all that apply)

☐ Chicken Pox	☐ Measles	☐ Epilepsy	☐ Hepatitis
☐ Kidney disease	☐ Asthma	☐ Mumps	☐ Heart conditions
☐ Diabetes	☐ G/I problems	☐ Ear Infections	☐ Sun sensitivity
☐ Seizure disorder	☐ Enuresis (bed wetting)	☐ Other health condition	

Health History (continued)

If you checked any of the above please describe details:

_____

_____

_____

Does student have physical restrictions/limitations? Y / N

If YES, please describe in detail: _____

_____

Does/has student have allergic reactions to:

Medications: Y / N List: _____

Insects: Y / N List: _____ Other: _____

Food allergies: _____

Other sensitivities: _____

- Any dietary restrictions? YES_____ NO _____
  if yes, describe: _____
- Concerns regarding student's VISION ? YES _____ NO _____
- Concerns regarding student's HEARING ? YES _____ NO _____
- Concerns regarding student's WEIGHT? YES_____ NO _____

If YES, please provide details: _____

_____

Is student currently taking medication? YES _____ NO _____

Name of Medication	Date Prescribed	Dosage	Purpose

- Are there any medical conditions to consider affecting the student's educational services? Y / N :

If YES, describe: _____

_____

- Primary Physician: _____ Phone: _____
- Specialists/Therapists (list list Name, Specialty, Location:

  1._____ Phone_____

  2. _____ Phone _____

  3. _____ Phone _____
- Is your child independent in bathroom use? YES _____ NO _____ if No, describe:

  _____

  _____.

NEW STUDENT INFORMATION

SCHOOLS:

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

☐ Public School (K-12) County: _____ School Name: _____

Last grade completed: _____ IEP: Y / N 504: Y / N Date last ARD: _____

Current Services: _____OT _____PT _____Speech _____Other: _____

☐ Private School County: _____ School Name: _____

Last grade completed: _____ Accommodations/Modifications: Y / N

if yes, please list: _____

Current Services: _____OT _____PT _____Speech _____Other: _____

☐ Pre-School or Daycare Name of Program: _____

☐ Home School Provided by: _____Parents _____School/Co-Op _____ Therapist

☐ Early Childhood Intervention Services provided: _____

Have there been problems in school? Y/N If yes, please describe:

_____

_____

_____

Please describe your child's relationship with:

Teachers**:** _____

Peers (amount of play w/others, group activities such as scouts, church groups, etc.):

_____

_____

Is your child currently receiving additional educational/therapeutic services?_____If YES, what services; with whom and how often: _____

_____

Please describe your child's current experience in school:

_____

_____

_____

Academic areas of Strength/Interest: _____ Reading _____ Writing _____ Math _____Science

_____Social Studies_____Music _____ Art _____ Sports

Other activities/Special Interests:_____

Areas student struggles the most in school: _____

_____

Please indicate the current *grade level* you believe your child is **proficient** in the following subjects:

_____Reading _____Math _____Social Studies _____Science

Grades on most recent report card:

_____Reading _____Math _____Social Studies _____Science

Please help us prepare for success:

Strengths and Preferences

What are his/her strengths? (personal, skills, activities, etc.) _____

_____

_____

What does he/she do that is desirable in their routine now (interactions with others, participation in activities, etc). If your job was to "catch him/her being good", what would that be? _____

_____

_____

What does he/she do well now, that you would like to see them increase during the day? _____

_____

List three activities (e.g. playing catch, puzzles, games, etc.) you can easily engage (do together) with the him/her? _____

When student is calm, relaxed, and having fun, what is he/she usually doing?_____

_____

When does your child feel the most competent? _____

What helps your child feel safe and secure (type of physical surroundings, type of activity, the way people interact with him/her, etc.) _____

What makes him/her scared, fearful, and anxious? _____

What makes your child the happiest? _____

_____

Reinforcers: What are the student's likes and desires in the following areas?:

(From the preferences listed please list in the strongest order of preference)

Food/Liquids

(Favorite food and drink)

1. _____
2. _____
3. _____
4. _____
5. _____

Social Interaction

(praise, hugs, high five, tickle, rough-house, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Toys/Objects

(toys, jewelry, purse, clothing, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Activities

(music, TV, playing catch, game, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Sensory Stimulation

(visiual tactile, auditory, moment, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Self-Initiated Behavior

(Any activity person initiates during free time, including constructive activity and self-stimulation)

1. _____
2. _____
3. _____
4. _____
5. _____

BEHAVIOR

NEW STUDENT INFORMATION

When your child is upset, describe behaviors he/she display's most often: _____

_____

_____

How is frustration/aggression displayed: _____

_____

Please check any of the following that seem to present (or trigger) behavior difficulties:

___ wants something
___ told cannot have something
___ something is taken away
___ not receiving attention
___ staff/parent withdraws attention
___ when attention is turn to others
___ behavior stops soon after attention or desired item is obtained
___ requested to do something
___ frustrated with difficult task
___ pressured into unwanted events
___ someone tries to control or lead his/her activity
___ asked to stop doing something
___ novel/new situations
___ unexpected change
___ when left alone or during downtime
___ doesn't understand expectations
___ doesn't know how to respond
___ transitions
___ pain/discomfort
___ something scares him/her
___ noisy, active settings
___ peers are pestering him/her
___ others are disruptive
___ experiencing pain/discomfort
___ difficulty communicating need/want
___ happy/excited with upcoming event
___ before, during, or after an outing
___ during group activities
___ riding in car
___ prior to or during menses

Describe specifics about the items *checked* above:

_____

_____

How do you most often respond (intervene) when behavior occurs?

_____

_____

How do others (peers, other adults, etc.) around him/her respond?

_____

_____

How does the student respond when you intervene/redirect?

_____

_____

What interventions have you tried?

_____

_____

What techniques have shown success?

_____

_____

Are there family situations that you feel may impact your child's academic, social, or emotional capabilities?

_____

_____

BEHAVIOR

NEW STUDENT INFORMATION

How does student communicate needs and wants? _____

_____

How does he/she ask for help? _____

_____

How does he/she communicate distress/discomfort? _____

_____

How does your child communicate something they don't want to do?

_____

_____

What might your child be trying to communicate with problem behavior?

_____

_____

Social Relations:
How does your child interact/get along with:
Peers:_____

_____

Staff/teachers?

_____

_____

Does he/she initiate/seek out interactions with others?

_____

_____

What is student's general ability in participating in an activity with others?

_____

_____

Instructional Skills:
Briefly describe your child's attention span/task performance skills (ability to stay on task, complete simple tasks).
Direction following skills?

_____

_____

Frustration tolerance?

_____

_____

Acceptance of criticism?

_____

_____

Most responsive to: ____ verbal directions ___ demonstration ___ picture/visual cues ___ gestures

Sensory Checklist - (if applicable, please check any symptoms the student exhibits or write "N/A" on page.

PROPRIOCEPTIVE

- ❑ Poor muscle tone.
- ❑ Weak grip.
- ❑ Tires easily
- ❑ Passive unless encouraged or assisted.
- ❑ Slurred speech.
- ❑ Clumsy/awkward
- ❑ Awkward getting on and off furniture.
- ❑ Overly rough with objects and people.
- ❑ Likes to rough house, wrestle.
- ❑ Flaps hands, claps, jumps, hops, stamps feet.
- ❑ Bites, chews on objects.
- ❑ Presses or bangs wrists.
- ❑ Climbs in inappropriate places.
- ❑ Pushes or leans heavily against people of objects.
- ❑ Slams furniture, pounds on wall, throws things.
- ❑ Hits, slaps or bangs head.
- ❑ Bites self.
- ❑ Grinds teeth.
- ❑ Butts head or body into things.
- ❑ Hits, kicks, pushes objects/others.

VESTIBULAR

- ❑ Tenses or becomes irritable when moved.
- ❑ Displays gravitational insecurity.
- ❑ Poor balance, anxious when moving.
- ❑ Drops to floor when anxious or walking distance.
- ❑ Hesitant on stairs or ramps.
- ❑ Resists being moved by others.
- ❑ Resists participating in movement activities.
- ❑ Loses balance easily.
- ❑ Falls or trips easily.
- ❑ Holds onto staff, railing, wall.
- ❑ Prefers to sit on the floor.
- ❑ Bumps into things, difficulty walking around things
- ❑ Rocks frequently.
- ❑ Jumps, twirls, spins or bounces.
- ❑ Wags head
- ❑ Paces, seeks frequent movement.
- ❑ Likes to swing.
- ❑ Likes movement activities.
- ❑ Waves or flicks finger(s) near eyes
- ❑ Has spurts of running.

Comments:

TACTILE

- ❑ Dislikes being touched.
- ❑ Resist hugs and kisses.
- ❑ Fearful when others approach.
- ❑ Withdraws or hits when approached or touched.
- ❑ Rubs spot after being touched.
- ❑ Exhibits clingy behavior.
- ❑ Tries to handle or touch everything/others.
- ❑ Resists others holding hand.
- ❑ Insists on large personal space.
- ❑ Prefers to be in corner, under table, behind furniture
- ❑ Likes/dislikes tight clothing.
- ❑ Layers clothing
- ❑ Pushes up pant legs, sleeves, shirts.
- ❑ Strips off clothing.
- ❑ Only will wear certain texture of clothing.
- ❑ Removes tags, collars, or cuffs
- ❑ Frequently adjusts clothing or bedding.
- ❑ Insists on something wrapped around wrist, arm, and finger.
- ❑ Dislikes being barefoot.
- ❑ Insists on being barefoot.
- ❑ Walks on toes.
- ❑ Spits out/rejects certain food textures.
- ❑ Picky eater.
- ❑ Resists grooming: face washing, bathing, shaving, hair combing, tooth brushing, and nail cutting.
- ❑ High tolerance for pain.
- ❑ Over or under sensitive to hot or cold.
- ❑ Dislikes wearing hats.
- ❑ Graves deep pressure
- ❑ Persistent hand to mouth activity.
- ❑ Mouths objects or clothing.
- ❑ Rubs or plays with spit, feces.
- ❑ Persistently has hand in pants or pants pocket.
- ❑ Sits on hands/feet
- ❑ Pushes or rubs body against objects/walls/people.
- ❑ Insists on holding an object in hands.
- ❑ Rubs fingers against hand or other fingers.
- ❑ Masturbates frequently.
- ❑ Self-injurious behavior- Scratches, pinches, rubs, hits/slaps, pulls hair, bites hand/wrist/arm.

SENSORY

NEW STUDENT INFORMATION

AUDITORY

- ❑ Sensitive to loud noises.
- ❑ Can hear frequencies that others cannot.
- ❑ Can her humming of lights, electrical wires, other breathing that others cannot.
- ❑ Speaks loudly.
- ❑ Hums constantly.
- ❑ Covers ears with hands.
- ❑ Distracted by background noises.
- ❑ Becomes agitated in large group activities.
- ❑ Very noisy person.
- ❑ Listens to tv or music in loud volume.
- ❑ Becomes agitated, disruptive in noisy activities.
- ❑ Relaxes when whispered to.
- ❑ Loves music
- ❑ Frequent ear infection.
- ❑ Sometimes "tunes out" or "turns off" from world

VISUAL

- ❑ Oversensitive to sunlight.
- ❑ Oversensitive to bright lighting
- ❑ Squints frequently, looks down a lot.
- ❑ Becomes overwhelmed with strong visual changes..
- ❑ Flaps hands, usually around eye level.
- ❑ Rolls head usually from side to side.
- ❑ Enjoys staring at lights.
- ❑ Enjoys turning lights on and off.
- ❑ Enjoys things that spin or turn.
- ❑ Plays with hands in front of eyes.
- ❑ Presses eyes with hands, usually at corners.
- ❑ Has difficulty moving from one surface to another
- ❑ Page turner.
- ❑ Loves shiny or reflective objects.
- ❑ Loves mirrors.
- ❑ Poor eye contact.
- ❑ Appears to stare through people.
- ❑ Fascinated with fans, things that spin.
- ❑ Eyes tire easily/quickly when reading.

Comments:

SMELL/TASTE

- ❑ Smells everything.
- ❑ Will not eat without smelling food first.
- ❑ Likes to smell other's hair.
- ❑ Loves the smell of cologne or perfume.
- ❑ Dislikes smell of cologne or perfume.
- ❑ Strong emotional reactions to smells.
- ❑ Becomes disorganized, irritable in activities with strong smells.
- ❑ Avoids things with strong smells, especially cleanser.
- ❑ Frequently smelling hands/fingers.
- ❑ Very picky eater.
- ❑ Dislikes certain textures or taste of food.
- ❑ Loves only strong tasting food.
- ❑ Eats only bland food.
- ❑ Puts everything in mouth
- ❑ Chews on string, clothing, fingers.
- ❑ Has many allergies.
- ❑ Will spit out foods they do not like.

GENERAL REACTIONS:

- ❑ Poor frustration tolerance.
- ❑ Needs to control all activity and interaction.
- ❑ Inability to delay gratification.
- ❑ Poor attention span, distractible.
- ❑ Noncompliant, resistant to direction.
- ❑ Unpredictable emotional outbursts.
- ❑ Constantly moving, difficulty sitting still
- ❑ Difficulty with transitions between activities, places, and people.
- ❑ Generally anxious, easily upset, disorganized.
- ❑ Becomes overwhelmed with high stimulating activities.
- ❑ Becomes upset with change in routine.
- ❑ Needs rigid schedule.
- ❑ Seeks constant attention or reassurance.

NEW STUDENT INFORMATION

Todays Date: _____

It is extremely important that the goals of the school and the parents match so that we work as a team for the overall progress of the student. Please carefully consider the following questions:

Why are you considering Lake Pointe Academy?

_____

_____

_____

What are the greatest achievements, concerns & goals you have about your child at this time?

Educational:

Strengths**:** _____

Needs: _____

Goals: _____

Social:

Strengths**:** _____

Needs: _____

Goals: _____

Psychological:

Strengths**:** _____

Needs: _____

Goals: _____

Physical:

Strengths**:** _____

Needs: _____

Goals: _____

Family/Home:

Strengths**:** _____

Needs: _____

Goals: _____

What are your expectations at Lake Pointe Academy?

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian **Date**