# Assumption B.V.M. School

## Application for Admission

School Year Beginning: _____Grade _____

I. STUDENT INFORMATION

CHILD'S NAME: Last: _____First: _____

DATE OF BIRTH: _____ SEX: Male: _____ Female: _____

HOME ADDRESS: _____

HOME PHONE: _____CELL PHONE: _____

PARISH: _____

CITY and STATE of BIRTH: _____

II. PARENTAL INFORMATION

FATHER'S NAME: Last: _____First: _____

HOME ADDRESS: _____

HOME PHONE: _____CELL PHONE: _____

OCCUPATION: _____WORK PHONE: _____

MOTHER'S NAME: Last: _____First: _____

HOME ADDRESS: _____

HOME PHONE: _____CELL PHONE: _____

OCCUPATION: _____WORK PHONE: _____

CHILDREN IN FAMILY:

Name: _____ Age: _____ Attending: _____

Name: _____ Age: _____ Attending: _____

Name: _____ Age: _____ Attending: _____

Name: _____ Age: _____ Attending: _____

Name: _____ Age: _____ Attending: _____

Name: _____ Age: _____ Attending: _____

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III. PARENT OBSERVATION FORM

Name of Child:_____ Date of Birth: _____

Parents Name: _____

Address: _____

Occupation

Father's: _____

Employer: _____

Mother's: _____

Employer: _____

Please answer the questions on this form in the best way that you can. You will be able to answer some quite easily and you will have difficulty in making decisions on others.

Your answers on this form will help the school staff and will involve you ion deciding with the teacher what kind of educational program is best suited for your child.

The questionnaire is confidential and your response will be shared with only professional personnel and only if the information learned will help in planning an educational program for your child.

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IV. General Health History

Please check any health concerns you or your doctor has noticed.

__ Asthma
__ Indigestion
__ Constipation
__ Diarrhea
__ Vomiting
__ Stomachaches
__ Frequent Fevers
__ Sinus Trouble
__ Nose Bleeding
__ Bed Wetting
__ Allergies
__ Serious blows to head
__ Headaches
__ Nightmares
__ Thumb sucking
__ Nail biting
__ Epilepsy (seizures)
__ Diabetes
__ Lack of consciousness
__ Chronic Ear Infections
__ Overtired or lacking pep
__ Heart Trouble
__ Hyperactivity
__ Medical problems (immediately after birth)
__ Other Physical Problems (explain) _____

Is this child presently on medication? __ What? _____

Has child had any significant injuries or hospitalization? _____

Is child healthy on day of screening? _____

Hearing Assessment

Has this child ever had any ear/hearing examinations or treatment? Y __ N __

When? _____ By whom? _____ Results? _____

Do you suspect hearing problems? Y __ N __

Does your child seem to have difficulty hearing? Y __ N __

Does your child turn up the TV louder than other family members? Y __ N __

Does you child seem to favor one ear over the other? Y __ N __

Does your child jump or appear to be startled if there is a sudden noise? Y __ N __

Does your child seem to hear you if you talk in a whisper? Y __ N __

Does your child become confused in following more than two verbal commands at a time? Y __ N __

Does your child have difficulty remember things for a long time? Y __ N __

Does your child have difficulty remembering things for a short time? Y __ N __

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V. Language Development

At what age did your child first begin to speak? (Give approximate age if you do not remember exact age) First Words: _____ Two or three words together: _____ Sentences: _____

Does your child stutter? _____ Have difficulty expressing ideas or concepts? _____

Visual Assessment

Has your child ever had a vision examination or treatment? __

When? _____ By whom? _____ Results? _____

| | |
|---|---|
| Do you suspect any vision problems? | Y __ N __ |
| Does your child seem to have a problem seeing things far away? | Y __ N __ |
| Does your child squint? | Y __ N __ |
| Does your child wear glasses? | Y __ N __ |
| Does your child have eyes that turn in? | Y __ N __ |
| Does your child have eyes that turn out? | Y __ N __ |
| Does your child sit very close to the television? | Y __ N __ |
| Does your child rub his eyes a lot? | Y __ N __ |
| Does your child turn head as to use primarily one eye? | Y __ N __ |
| Does your child lower one side of the head when looking at others? | Y __ N __ |

VI. Motor Development

This child began walking at age: _____.

| | |
|---|---|
| Does your child catch a ball thrown to him? | Y __ N __ |
| Does your child enjoy physical activity? | Y __ N __ |
| Does your child lose balance, trip and fall more often than normal? | Y __ N __ |
| Does your child have difficulty running? | Y __ N __ |

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VII. Social Development

Does your child have regular playmates the same age? Y __ N __

Does your child have difficulty getting along with others? Y __ N __

Does your child prefer to play with others instead of alone? Y __ N __

Does your child become easily frustrated? Y __ N __

Does your child cry often? Y __ N __

Does your child have a bad temper? Y __ N __

Does your child enjoy cooperating with others? Y __ N __

Does your child become frequently irritated or moody? Y __ N __

Does your child become upset by changes in routine? Y __ N __

Does your child have difficulty dealing with family stress such as illness, death or separation? Y __ N __

Does your child demand much individual adult attention? Y __ N __

Does your child accept discipline and limits? Y __ N __

VIII. Personal Information

Has the child attended a preschool? Y __ N __

Did your child receive any special services in preschool? (i.e. speech, therapy, learning support, etc.) Y __ N __

If yes, please state what services were provided? _____

Does your child know how to read? Y __ N __

Does your child know how to write? Y __ N __

Has your child received therapy or counseling for emotional or other problems? Y __ N __

If yes, please explain: _____

Has your child ever been suspended or required to withdraw from school at any time? Y __ N __

If yes, please explain: _____

Are there any special family or home conditions of which the school should be aware? Y __ N __

If yes, please explain: _____

Is there any additional information that the school should know about this child? Y __ N __

If yes, please explain: _____

_____

_____

_____

_____

_____

THANK YOU FOR YOUR PATIENCE IN FILLING OUT THIS QUESTIONAIRE!

The person asking for this application understands that acceptance depends upon availability of space and the presentation of a satisfactory report from the school previously attended. Acceptance is at the discretion of the school.

Parent Signature: _____ Date: _____

Please return completed application to:

**Assumption B.V.M. School**
112 South 7th Street
Pottsville, PA 17901
(570) 622-0106
(570) 622-4737