



**PLACE
PHOTO
HERE**

A \$150
Application Fee
(non-refundable)
must accompany
this application

Capitol School of Austin

Student Name: _____ Birthdate: _____

Current Grade (if applicable): _____ Date: _____ Info Provided By: _____

This application is for: Immediate enrollment Fall Spring Summer

APPLICATION CHECKLIST

- Application
- Application Fee (\$150)
- One Teacher Observation Form
If enrolled in group previously or currently
- School Records
 - Full & Initial Evaluation (FIE)
 - Speech Language Evaluations, Current Report Card (if applicable)
- Release of Records
- Evaluation and/or Progress Reports from:
 - Speech Language Pathologist
 - Educational Diagnostician
 - Neurologist
 - Physical/Occupational Therapist
 - Psychologist

STUDENT IS APPLYING AS A PEER MODEL

Students who apply must meet these criteria first:

- The student must have a documented language and/or learning disability
- The student must demonstrate average to above-average IQ
- The student's enrollment will have a positive or neutral effect on the school community and learning experiences of other students, rather than a negative one.

WHO WE SERVE:

CSA can best help students with a variety of language and learning disabilities, including:

- Mixed receptive/expressive language disorders
- Speech Disorders (including Apraxia)
- ADD/ADHD
- Dyslexia
- Dysgraphia
- Auditory Processing Disorders
- Executive Functioning Issues
- Dyscalculia
- Low Academic Self-confidence

CSA is NOT equipped to help students who have:

- Limited intellectual functioning
- History of violence or aggression
- Emotional disturbance or mood disorder
- Moderate to severe autism
- Significant behavioral or emotional issues

FOR OFFICE USE ONLY

Date Received: _____ Payment Received: _____



Application for Enrollment

Child's Name: _____ Date of Birth: _____ Age: _____ Gender: _____
FIRST MIDDLE LAST PREFERRED

Address: _____ City/State: _____ Zip: _____

Present School: _____ Grade: _____ District: _____

PARENT 1

PARENT 2

Name _____

Address _____

City/State/Zip _____

Phone C: _____ W: _____ H: _____ C: _____ W: _____ H: _____

Email _____

Occupation _____

Employer _____

Level of Education _____

Marital Status: Married Divorced Separated Widowed Remarried Domestic Partner Cohabiting

Your child's legal custodian: _____ Is your child adopted? At what age? _____ Is your child aware of this? _____

List other occupants in your child's home:

HOUSEHOLD 1

HOUSEHOLD 2

Name _____

Age _____

Relationship _____

Y N
 Is there any language other than English spoken in the home? If so, which language? _____

Does your child understand or speak the language?

How did you hear about CSA? Facebook Google CSA Website Friends/Family Professional Other: _____

EVALUATIONS:

If any of the following evaluations have been administered to your child, indicate the date and name of the administering test professional and request that reports be sent to us.

Y N
 CSA has my permission to contact the professionals I have listed here.
 _____ **« Initial**

*Full & Initial Evaluation: A current speech-language evaluation and/or latest FIE from the public school (within past 12 mo.) is required for all new school-age applications 2nd-4th grade.

**An educational evaluation is required for all new school-age applications 1st grade and higher.

	DATE	PROFESSIONAL
1. Speech and Language Evaluation*	_____	_____
2. Educational Evaluation**	_____	_____
3. OT/PT Assessment	_____	_____
4. Neurological Evaluation	_____	_____
5. Vision/Hearing Evaluation	_____	_____
6. Medical Evaluation	_____	_____
7. Psychological/Play Therapy Evaluation	_____	_____



Case History

Child's Name: _____ Date of Birth: _____

Describe your child's speech/language/learning difficulty. _____

Therapy History

Has **Speech Therapy** been recommended?

Y N

Are services currently being received?

Y N

If yes, where?

If no, explain:

Have services been received in the past?

Y N

If yes, where?

If no, explain:

Has **Occupational Therapy** been recommended?

Y N

Are services currently being received?

Y N

If yes, where?

If no, explain:

Have services been received in the past?

Y N

If yes, where?

If no, explain:

Has **Psychological Counseling** been recommended?

Y N

Are services currently being received?

Y N

If yes, where?

If no, explain:

Have services been received in the past?

Y N

If yes, where?

If no, explain:



Family History

Is there a family history of speech, language or learning difficulties? If so, explain:
(please include aunts, uncles, cousins and grandparents of child)

History Unknown

Birth History

What was the general state of the mother's health during pregnancy? _____

List any substances used during pregnancy *(medication, alcohol, tobacco)*: _____

Delivery: C-Section Anesthesia Inducement Very long labor Very short labor Instruments used

Y N

Full Term? Weight: _____

Was birth normal? If not, explain: _____

Illness during pregnancy? If yes, describe: _____

Did your child have trouble breathing after birth? If yes, describe: _____

Did your child come home from hospital with the mother? If not, why? _____

Any feeding difficulties? Describe: _____

Was weaning a problem? Age off bottle/breast: _____

Any difficulties sleeping? How long? Describe: _____

Did/does your child engage in thumb sucking? How long? _____

Did/does your child use a pacifier? How long? _____

Developmental Data

Speech Language Milestones

Did your child: Smile at others Babble Imitate gestures/sounds Maintain eye gaze

Age of: First words: _____ 2-3 word phrase: _____ First sentence: _____

When was speech/language problem first noticed? _____ By whom? _____

How much of your child's speech can family understand? _____

How much is understood by other adults? _____

Describe any other areas of concern *(articulation, receptive/expressive language, social pragmatic language)*. _____



(DEVELOPMENTAL DATA CONTINUED)

Motor Milestones: FINE MOTOR

Does your child dress his/herself:

- Completely Partially Not at all

Age toilet trained? ____ Day? ____ Night? ____

Problems training? If so, explain: _____

Which hand does your child use to eat? ____ To draw: ____ To write: ____ To throw a ball: ____

Y N

- Is your child a "picky" or fussy eater now?
- Any difficulty chewing or swallowing?
- Do you feel your child is "clumsy" or falls frequently?

Describe any other areas of concern (fine or gross motor, balance, coordination). _____

GROSS MOTOR:

What age did your child:

- ____ Sit alone
- ____ Crawl
- ____ Walk alone
- ____ Run smoothly
- ____ Climb playground equipment
- ____ Jump with both feet
- ____ Skip

Ride bike:

- ____ Three-wheeler Two-wheeler Training wheels

Social/Emotional/Behavioral

Y N

- Does your child play well with siblings or friends?
- Does your child prefer to play alone?
- Does your child prefer: Older Younger Same-age peers

Who is usually responsible for discipline? _____

What methods of discipline are used and how does your child react to discipline? _____

Describe any other areas of concern (behaviorally/socially/emotionally). _____



Medical History

Please list any illnesses or conditions for which your child received in-depth medical attention (do NOT list routine illnesses).

Illness/Condition _____
Date _____

Y N
 Does your child have any long-term medical conditions for which he/she is currently being treated? If so, explain:

PRIMARY PHYSICIAN: _____ PHONE: _____

- Does your child have food allergies? If so, list: _____
- Does your child have seasonal allergies?
- Does your child have frequent colds? If so, how often? _____
- Does your child take medication regularly? If so, what? _____
- Has your child had his/her hearing tested? If so, when? Results? _____
- Has your child had his/her vision tested? If so, when? Results? _____
- Does your child have PE tubes? Is your child's general health: Poor Good Excellent
- Has your child had a neurological exam? If so, when? Results? _____
- Has your child had a psychological exam? If so, when? Results? _____

Education History

Name of current school placement and grade/class: _____

In your current placement, what is the number of: _____ Teachers _____ Students

Please list any other schools/programs (including preschool) your child has attended:

SCHOOL/PROGRAM	GRADE/CLASS	DATES ATTENDED	REASON FOR WITHDRAWAL
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child repeated any grades or been held back in a younger classroom? If so, which and why? _____

In what area(s) does your child excel? _____ Find difficult? _____

- Y N
- Has your child received any interventions to help with difficult areas? If yes, describe: _____
 - Does your child seem to enjoy school?
 - Does your child's teacher seem to enjoy him/her?
 - Does your child seem to have friends at school?



(EDUCATION HISTORY CONTINUED)

Does your child's teacher report any of the following behaviors:

- Hard time paying attention
- Will not follow directions
- Is physical with other kids
- Does well with visual material
- Cannot sit still
- Sensitivity to changes in routine
- Bothers or bullies other children
- Has difficulty expressing thoughts
- Repetitive behavior
- Does not seem to comprehend what is being said
- Aggressive behavior
- Cannot complete tasks

General Information

What are your child's favorite activities? _____

Describe any behavior which is a problem to the parents: _____

Please check personality traits or behaviors that describe your child:

- Looks happy
- Shows repetitive behaviors (*i.e. flapping*)
- Resistant to change
- Aggressive to others
- Has trouble sleeping (*nightmares*)
- Seems unusually fearful
- Very independent
- Dislikes being touched
- Appears sad
- Even tempered
- Cries frequently
- Sensitive to loud noises
- Friendly/outgoing
- Dependent on adults
- Sensitive to certain textures/clothing
- Screaming/tantrums. How often? _____
- Non-compliant
- Is withdrawn
- Very active
- Distractible
- Irritable
- Calm & quiet
- Throws/breaks
- Self-injurious

Y N

- Has child ever been tested or diagnosed with ADD/ADHD? By whom and when? _____
- Is child currently taking medication for attention difficulties? If so, what? _____
- If not currently medicated, are you willing to seek pharmacological intervention? _____



Authorization for Request/Release of Information

I hereby authorize Capitol School of Austin to request/release information which may be helpful in providing services for my child (full name), _____.

Below are the persons, therapists, and agencies that Capitol School of Austin may contact:

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that any information obtained is strictly confidential and privileged.

Parents or Legal Guardians:

SIGNATURE: _____ DATE: _____ SIGNATURE: _____ DATE: _____

A COPY OF THIS AGREEMENT IS AS VALID AS THE ORIGINAL
CAPITOL SCHOOL OF AUSTIN DOES NOT DISCRIMINATE ON THE BASIS OF A CHILD'S RACE, GENDER, CREED OR RELIGIOUS BELIEFS.

Educational Release:

Information from your student's school is necessary in determining possible class placement. Please complete the release below. We must have complete information in order to process this release.

To: Name of School: _____ School District: _____
 Teacher's Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Child's Name: _____ Date of Birth: _____ Grade: _____

CSA REQUESTS PSYCHO-EDUCATIONAL, ACADEMIC AND/OR OTHER INFORMATION ON THE ABOVE NAMED CHILD.

_____ Has my permission to release any information on my child to Capitol School of Austin.
NAME OF SCHOOL

Parent/Guardian Signature: _____ Date: _____

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