Admissions Application

Summit View School

SUMMIT VIEW SCHOOL

Thank you for your interest in Summit View School. Enclosed you will find a description of our admissions procedures, along with an application. Please complete the application forms to the best of your ability, as this information will assist our admissions team in identifying your child's needs.

The admissions department will contact you, once all of the documentation has been received, in order to set up an interview with both you and your child. The interview is usually 1 to 1 ½ hours in length. Subsequent to the meeting the admissions evaluator may wish to contact professionals who have worked with your child in order to gain their perspective on your child's needs. The information collected by the evaluators is then presented to our admissions committee and we will then contact you with our decision. The entire process usually takes two to four weeks after the complete application is received.

PLEASE RETURN YOUR APPLICATION AND ALL DOCUMENTS TO:

Summit View School
13130 Burbank Blvd.
Sherman Oaks, CA 91401
Attention: Admissions Office

Again, thank you for your interest in our school. We sincerely appreciate your cooperation in this process.

Sincerely,

Karen C, Enyedy, Ph.D
Chief Psycholgist
The Help Group

Si necesita ayuda en español, por favor llame al 818.779.5207.

Please check each box to make sure all of the following are included. (*If not applicable, please mark N/A)*

[ ] Completed Summit View School Application

[ ] Recent photo of your child

[ ] The two most recent **annual IEPs**, and all subsequent addenda

[ ] A copy of the referral letter from your school district (LAUSD only)

[ ] Report cards for the past two academic years

[ ] Transcripts (for students in 7th through 12th grades)

Documentation as to the nature of your child's needs including but not limited to:

[ ] Educational Evaluations

[ ] Psychological Evaluations

[ ] AB3632 Evaluation

[ ] Speech and Language Evaluations

[ ] Occupational Therapy Evaluations

[ ] Other Evaluations (please list) ____

AUTHORIZATION AND AGREEMENT

"I authorize investigation of all statements contained in this Application for Admission to the educational program as may be necessary in arriving at an admission decision. In the event of admission, I agree that false or misleading information, given in the application of my child, or in any interviews, may result in rescission of any admission. I understand also that continued admission to the educational program requires the student to abide by all rules and regulations of the educational institution."

____ ____

Parent/Legal Guardian Parent/Legal Guardian

_________________________ _________________________

DATE DATE

DATE OF APPLICATION: ___________________________________

I. STUDENT INFORMATION

_______________________________ _______________________________ _______________

STUDENT 'S LAST NAME FIRST MIDDLE DATE OF BIRTH

AGE: _________ MALE [ ] [ ] FEMALE

____

STUDENT'S PLACE OF BIRTH: STATE COUNTRY

____ ____________________

CURRENT SCHOOL OF ATTENDANCE GRADE LEVEL

CURRENT RESIDENCE:

[ ] PARENT'S HOME [ ] RELATIVE/GUARDIAN [ ] OTHER ____________________

PLEASE SPECIFY

____(____)_____________

STREET ADDRESS CITY STATE/ ZIP HOME PHONE

_______________________________________ _______________________________________

SOCIAL SECURITY # MEDI-CAL or INSURANCE POLICY NUMBER

_______________________________________ _______________________________________

PARENT'S NAME PARENT'S NAME

_______________________________________ _______________________________________

STREET ADDRESS (if different than student's) STREET ADDRESS (if different than student's)

_______________________________________ _______________________________________

CITY STATE ZIP CITY STATE ZIP

(____)___________________(____)_____________ (____)_______________(_____)_____________

HOME PHONE PAGER/CELL HOME PHONE PAGER/CELL

_______________________________________ _______________________________________

E-MAIL ADDRESS: E-MAIL ADDRESS:

PREFERRED METHOD OF CONTACT :

PHONE [ ] E-MAIL [ ] EITHER [ ]

(Circle: Home Cell Work)

PARENT'S WORK INFORMATION

____
NAME OF BUSINESS

____
JOB TITLE/POSITION

____
STREET ADDRESS

____
CITY STATE ZIP

__(______)______________________
WORK PHONE NUMBER EXTENSION

PARENT'S WORK INFORMATION

____
NAME OF BUSINESS

____
JOB TITLE/POSITION

____
STREET ADDRESS

____
CITY STATE ZIP

_(______)______________________
WORK PHONE NUMBER EXTENSION

II. FAMILY HISTORY

FAMILY MEMBERS / SIBLINGS:

NAME: ________________________________ AGE: _________ RELATIONSHIP: ______________________

NAME: ________________________________ AGE: _________ RELATIONSHIP: ______________________

NAME: ________________________________ AGE: _________ RELATIONSHIP: ______________________

OTHER HOUSEHOLD MEMBERS:

NAME: ________________________________ AGE: _________ RELATIONSHIP: ______________________

NAME: ________________________________ AGE: _________ RELATIONSHIP: ______________________

NAME: ________________________________ AGE: _________ RELATIONSHIP: ______________________

Is your child adopted? [ ] YES [ ] NO If "Yes," at what age? _________________________________

Primary language: ______________________ Languages spoken in the home: _____________________________

(If parents are separated or divorced):

Date of separation or divorce: ______________________ Child's age at time of divorce:___________________

Current custody arrangement: ____

III. MEDICAL HISTORY

Does the applicant have any chronic or serious health problems? [ ] YES [ ] NO
If yes, please describe:

____

Does the applicant have any health restrictions or limitations? [ ] YES [ ] NO

If yes, please describe: ____

Does the applicant have any allergies? [ ] YES [ ] NO

If yes, please describe: ____

Is there a history of the applicant taking medications? [ ] YES [ ] NO
If yes, please list:

CURRENT MEDS	DATES	DOSAGE/TIMES	PRESCRIBING DR.	PURPOSE

PAST MEDS	DATES*	DOSAGE/TIMES	PRESCRIBING DR.	PURPOSE

*** please indicate month/year of initiation and month/year of discontinuation (ex: 03/99-06/02)**

Has your child been hospitalized for any reason? [ ] YES [ ] NO (if yes, please explain below)

1. Reason: ____

Age: ____________ DX: ______________________________________

Duration: ____

2. Reason: ____

Age: ____________ DX: ______________________________________

Duration: ____

Beginning July 1, 2011, California Law (SB 354) requires all students entering 7th through 12th grade to provide proof of a Tdap booster shot against pertussis (Whooping Cough) before starting school.

[ ] My child has already had the Tdap booster shot. (Documentation will be needed)

[ ] My child has not yet had this booster but I understand that this will be needed prior to admission to these grades.

IV. SCHOOL HISTORY

____ ________________________________
NAME OF CURRENT SCHOOL GRADE CURRENT TEACHER'S NAME

____
STREET ADDRESS CITY STATE ZIP

(_____)_________________________ ___________________ __________________
PHONE NUMBER DATE STARTED ENDING DATE

Reason for seeking a new school placement: ____

____

Current Type of School	Current Type of Program
[ ] Nonpublic	[ ] Full-Inclusion Classroom
[ ] Public School	[ ] Full-Inclusion Classroom with resource pull-out (specify subject for pull-out)
[ ] Private	[ ] Special Day Class
	[ ] Special Day Class with some mainstreaming (specify mainstreamed subjects)

Please check any current educational concerns:

- [ ] Difficulty with reading
- [ ] Difficulty with spelling
- [ ] Difficulty with school attendance
- [ ] Difficulty with abstract concepts
- [ ] Difficulty with handwriting
- [ ] Difficulty with arithmetic
- [ ] Difficulty maintaining attention
- [ ] Difficulty with organization (forgets homework, misses assignments)

Other (specify): ____

Please list all schools in which your child was placed prior to his/her current school. Also indicate if it was a special education program and the reason for discontinuation.

Name of School	Grade(s)	Reg. Ed.	Special Ed.	Reason for Discontinuation

Have you ever applied to any other Help Group school? [ ] Yes [ ]No
If yes, which school, and what was the outcome? _______________________________________

____

V. <u>HISTORY OF INTERVENTIONS</u>

A. **Diagnosis**

Does your child currently have a diagnosis (if so, what)? ____

Who diagnosed your child? ____(_____)_____________
Name Agency Phone Number

Date of diagnosis: ___________________________________

What prompted you to seek an evaluation? ____

B. Please reply only if your child has received services in any of the following areas:

1. Speech and Language _______________________________________(____)______________________
Name of Service Provider Phone Number

When was your child last assessed for these services? ____

What are the goals of this intervention?
____

2. Counseling _______________________________________(____)______________________
Name of Service Provider Phone Number

When was your child last assessed for these services? ____

What are the goals of this intervention? ____

3. Occupational Therapy _______________________________________(____)______________________
Name of Service Provider Phone Number

When was your child last assessed for these services? ____

What are the goals of this intervention? ____

4. Educational Therapy or Tutoring _________________________________(_____)_____________________
Name of Service Provider Phone Number

When was your child last assessed for these services? ____

What are the goals of this intervention? ____

<u>Please provide any assessments completed by the professionals above or any other assessments you may have.</u>

VI. ADDITIONAL INFORMATION

Describe your child's strengths.

____

____

What are your child's favorite activities?

____

____

Is your child involved in any extracurricular activities? [ ] YES [ ] NO (if yes please list)

____

____

Please describe your child's social relationships at home and at school.

____

____

____

Please describe any behavioral or attentional problems that have been brought to your attention by the school staff.

____

____

____

Is there any additional information that you feel would be helpful in evaluating your child?

____

____

____

____

____

____

VII. IEP INFORMATION AND FUNDING SOURCE

Please enclose a copy of your child's **two most recent annual IEPs, and all subsequent addenda**. If your child does not have a current IEP, please state where you are in the IEP process. Do you currently have:

[ ] Valid I.E.P. with Non Public School designation [ ] YES [ ] NO

[ ] I.E.P. meeting with district to receive NPS funding [ ] YES [ ] NO
If IEP meeting set, please indicate date: ____

[ ] Mediation Agreement [ ] YES [ ] NO
If Mediation Agreement meeting set, please indicate date: ________________________________

[ ] Fair Hearing [ ] YES [ ] NO
If Fair Hearing meeting set, please indicate date: ____

[ ] Will fund privately [ ] YES [ ] NO

ASSISTED/REPRESENTED BY: ___SELF ___ADVOCATE ___ATTORNEY
Name: ________________________________

SEEKING PLACEMENT FOR: ___ASAP ___FALL ___SPRING ___SUMMER

VIII. REFERRAL SOURCE

Please provide the following information regarding the person or organization that referred you to The Help Group.

1.____
NAME

____
TYPE OF REFERRAL

____
AGENCY

____
STREET ADDRESS

____
CITY STATE ZIP

____
PHONE NUMBER

2.____
NAME

____
TYPE OF REFERRAL

____
AGENCY

____
STREET ADDRESS

____
CITY STATE ZIP

____
PHONE NUMBER