Admissions Application

The Help Group
"Because Every Child Deserves a Great Future"

APPLICATION TO:

☐ Village Glen School *

☐ Village Glen, Beacon Program

☐ Sunrise School

☐ Bridgeport School

* Village Glen School has a campus both in Sherman Oaks and Culver City.

CAMPUS: ☐ Sherman Oaks ☐ Culver City

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 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) if available

[ ] 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

[ ] Department of Mental Health 3632 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 understand 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                               DATE         Parent/Legal Guardian                              DATE

DATE OF APPLICATION: ____________________________________
### I. STUDENT INFORMATION

<table>
<thead>
<tr>
<th>STUDENT 'S LAST NAME</th>
<th>FIRST</th>
<th>MIDDLE</th>
<th>DATE OF BIRTH</th>
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<tr>
<th>STREET ADDRESS</th>
<th>CITY</th>
<th>STATE/ ZIP</th>
<th>HOME PHONE</th>
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**CURRENT RESIDENCE:**

- [ ] PARENT’S HOME
- [ ] RELATIVE/GUARDIAN
- [ ] OTHER

**PLEASE SPECIFY**

AGE: _________

- [ ] MALE
- [ ] FEMALE

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<thead>
<tr>
<th>STUDENT’S PLACE OF BIRTH</th>
<th>STATE</th>
<th>COUNTRY</th>
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<th>MOTHER’S NAME</th>
<th>FATHER’S NAME</th>
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<th>STREET ADDRESS (if different than student’s)</th>
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<td>HOME PHONE</td>
<td>PAGER/CELL</td>
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<th>ZIP</th>
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<td>HOME PHONE</td>
<td>PAGER/CELL</td>
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<th>E-MAIL ADDRESS</th>
<th>E-MAIL ADDRESS</th>
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<tr>
<th>STUDENT’S SOCIAL SECURITY #</th>
<th>MEDI-CAL or INSURANCE POLICY NUMBER</th>
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**PREFERRED METHOD OF CONTACT:**

- PHONE [ ]
- E-MAIL [ ]
- EITHER [ ]

( Circle: Home Cell Work )

3
MOTHER’S WORK INFORMATION

NAME OF BUSINESS ________________________________________________

JOB TITLE/POSITION ________________________________________________

STREET ADDRESS ________________________________________________

CITY __________________________________________ STATE ______ ZIP __

(_____) _________________________________ EXTENSION

WORK PHONE NUMBER ________________________________________________

FATHER’S WORK INFORMATION

NAME OF BUSINESS ________________________________________________

JOB TITLE/POSITION ________________________________________________

STREET ADDRESS ________________________________________________

CITY __________________________________________ STATE ______ ZIP __

(_____) _________________________________ EXTENSION

WORK PHONE NUMBER ________________________________________________

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: ______________________________

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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.

<table>
<thead>
<tr>
<th>MEDICATION*</th>
<th>DOSAGE/TIMES</th>
<th>PRESCRIBING DR.</th>
<th>PURPOSE</th>
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*Please indicate month/year of initiation and month/year of discontinuation

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

[ ] Nonpublic  [ ] Special Day Class
[ ] Public School  [ ] Special Day Class with some mainstreaming
[ ] Private  (specify mainstreamed subjects)

Please check any current educational concerns:

[ ] Difficulty with reading  [ ] Difficulty with handwriting
[ ] Difficulty with spelling  [ ] Difficulty with arithmetic
[ ] Difficulty with school attendance  [ ] Difficulty maintaining attention
[ ] Difficulty with abstract concepts  [ ] 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.

<table>
<thead>
<tr>
<th>Name of School</th>
<th>Grade(s)</th>
<th>Reg. Ed.</th>
<th>Special Ed.</th>
<th>Reason for Discontinuation</th>
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Have you ever applied to any other Help Group school? [ ] Yes  [ ] No
If yes, which school, and what was the outcome? __________________________________________
V. HISTORY OF INTERVENTIONS

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? _________________________________________________________

Please provide any assessments completed by the professionals above or any other assessments you may have.
VI. **ADDITIONAL INFORMATION**

Describe your child’s strengths.

For each question identified below, place an X in the box to the right that appropriately describes your child.

<table>
<thead>
<tr>
<th>Question</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
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<tbody>
<tr>
<td>1. My child prefers to do things with others rather than on his / her own.</td>
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<td>2. My child prefers to do things the same way over and over again.</td>
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<td>3. My child has been involved in fights at school.</td>
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<td>4. My child has been suspended from school.</td>
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<td>5. My child often notices small sounds when others do not.</td>
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<td>6. In a social group, my child can easily keep track of several different people’s conversations.</td>
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<td>7. My child has made inappropriate sexual statements.</td>
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<td>8. My child has engaged in inappropriate sexual activities on one or more occasions.</td>
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<td>9. My child finds social situations easy.</td>
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<td>10. When my child talks, it isn’t always easy for others to get a word in edgewise.</td>
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<td>11. My child finds it hard to make new friends.</td>
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<td>12. It upsets my child if the daily routine is disturbed.</td>
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<td>13. My child finds it easy to “read between the lines” when someone is talking to me.</td>
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</table>

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

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
VIII. 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

IX. 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