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.

The Help Group
Admissions Office
13130 Burbank Blvd.
Sherman Oaks, CA 91401

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

______________________________ ______________________________________ _____________________

STUDENT 'S LAST NAME FIRST MIDDLE DATE OF BIRTH

____(____)__________________

STREET ADDRESS CITY STATE/ ZIP HOME PHONE

CURRENT RESIDENCE:

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

PLEASE SPECIFY

AGE: _________ MALE [ ] [ ] FEMALE

____

STUDENT'S PLACE OF BIRTH STATE COUNTRY

____ ____

MOTHER'S NAME

FATHER'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

____ ____

STUDENT'S SOCIAL SECURITY #

MEDI-CAL or INSURANCE POLICY NUMBER

PREFERRED METHOD OF CONTACT:

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

(Circle: Home Cell Work)

MOTHER'S WORK INFORMATION

____
NAME OF BUSINESS

____
JOB TITLE/POSITION

____
STREET ADDRESS

____
CITY STATE ZIP
ZIP

__(______)______________________
WORK PHONE NUMBER EXTENSION

FATHER'S WORK INFORMATION

____
NAME OF BUSINESS

____
JOB TITLE/POSITION

____
STREET ADDRESS

____
CITY STATE

_(______)______________________
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.

MEDICATION*	DOSAGE/TIMES	PRESCRIBING DR.	PURPOSE
____________________ ____________*	____________	____________	
____________________ ____________*	____________	____________	
____________________ ____________*	____________	____________	

***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
[ ] Public School
[ ] Private

Current Type of Program

[ ] Full-Inclusion Classroom
[ ] Full-Inclusion Classroom with resource pull-out (specify subject for pull-out)
[ ] 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. 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.	Often	Sometimes	Rarely	Never
1. My child prefers to do things with others rather than on his / her own.				
2. My child prefers to do things the same way over and over again.				
3. My child has been involved in fights at school.				
4. My child has been suspended from school.				
5. My child often notices small sounds when others do not.				
6. In a social group, my child can easily keep track of several different people's conversations.				
7. My child has made inappropriate sexual statements.				
8. My child has engaged in inappropriate sexual activities on one or more occasions.				
9. My child finds social situations easy.				
10. When my child talks, it isn't always easy for others to get a word in edgewise.				
11. My child finds it hard to make new friends.				
12. It upsets my child if the daily routine is disturbed.				
13. My child finds it easy to "read between the lines" when someone is talking to me.				
14. New situations make my child anxious.				

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