



HARBOR SCHOOL WEST

A safe place to be yourself...

ADMISSIONS APPLICATION

Harbor School West is a unique school where students can feel safe to be themselves. At HSW, we focus on students' strengths and accomplishments by tapping into individual needs, interests and goals. Our program nurtures and supports each stage of a child's development by fostering personal growth, building self-esteem and providing a safe, enriching environment where students can learn, grow and thrive.

Harbor School West's team of teachers, therapists and adjunctive staff utilize a collaborative approach in order to deliver a strengths-based academic program within a supportive therapeutic environment. This approach provides students with highly specialized learning opportunities that allow them to be successful in school and to fulfill their potential for a rewarding future.

PLEASE RETURN YOUR APPLICATION AND ALL DOCUMENTS TO:

Harbor School West
Admissions Office
13130 Burbank Blvd. ~ Sherman Oaks, CA 91401

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 amendment IEPs
- A copy of the referral letter from LAUSD (if applicable).
- Report cards for the past two academic years

Any of the following that apply:

- Educational evaluations
- Psychological evaluations
- Department of Mental Health AB3632 Assessment
- Other documents or evaluations that describe your child’s history or the nature of his/her needs

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 (____)

STUDENT'S CURRENT RESIDENCE

With both parents With mother With father 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 CELL

(____) _____
HOME PHONE CELL

E-MAIL ADDRESS

E-MAIL ADDRESS

Best way to contact:
 Phone: Please specify: Home Work Cell
 E-mail

Best way to contact:
 Phone: Please specify: Home Work Cell
 E-mail

STUDENT'S SOCIAL SECURITY #

MEDI-CAL or INSURANCE POLICY NUMBER

II. FAMILY INFORMATION

MOTHER'S WORK INFORMATION

FATHER'S WORK INFORMATION

NAME OF BUSINESS

NAME OF BUSINESS

JOB TITLE/POSITION

JOB TITLE/POSITION

STREET ADDRESS

STREET ADDRESS

CITY STATE ZIP

CITY STATE ZIP

____(____)_____
WORK PHONE NUMBER EXTENSION

____(____)_____
WORK PHONE NUMBER EXTENSION

SIBLINGS

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

OTHER HOUSEHOLD MEMBERS

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

♦ Is child adopted? No Yes: At what age? _____

♦ Languages spoken in the home: _____ Primary language: _____

♦ *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 child have any chronic or serious health problems?

No Yes: Please specify: _____

♦ Does child have any health restrictions or limitations?

No Yes: Please specify: _____

♦ Does child have any allergies?

No Yes: Please specify: _____

♦ Does child currently take any medications? No Yes: Please list below:

<u>Name of Medication</u>	<u>Dosage/Frequency</u>	<u>Prescribing Doctor.</u>	<u>Purpose</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

♦ Has child taken other medications in the past? No Yes: Please list below:

♦ Has child been psychiatrically hospitalized? No Yes: Please list below:

Name of hospital: _____ Dates/Duration of stay: _____

Reason: _____

Name of hospital: _____ Dates/Duration of stay: _____

Reason: _____

IV. SCHOOL HISTORY

NAME OF CURRENT SCHOOL _____ GRADE _____ CURRENT TEACHER'S NAME _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

(_____) _____
PHONE NUMBER _____ DATE STARTED _____

♦ Reason for seeking a new school placement: _____

♦ Current type of school: Nonpublic Public Private

♦ Current type of program: Regular ed classroom Regular ed classroom with resource pull-outs
 Special day class Other: _____

♦ 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:

<u>Name of School</u>	<u>Grade(s)</u>	<u>Reg. Ed.</u>	<u>Special Ed.</u>	<u>Reason for Discontinuation</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

♦ Has child ever been in a Residential Treatment Program? No Yes: Please specify:
Name of residential program: _____ Dates: _____

Reason: _____

♦ Has child ever applied to any other Help Group school? No Yes: Please specify:
Which school, and what was the outcome? _____

V. HISTORY OF INTERVENTIONS

DIAGNOSIS

Does your child currently have a diagnosis? No Yes: Please specify:

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

Date of diagnosis: _____

What prompted you to seek an evaluation? _____

SERVICES RECIEVED

♦ Has your child ever received counseling or therapy? No Yes: Please specify:

_____ (____) _____
Name of therapist/counselor Agency Phone number

_____ (____) _____
Name of therapist/counselor Agency Phone number

♦ Has your child ever received Speech and Language Therapy? No Yes: Please specify:

_____ (____) _____
Name of service provider Agency Phone number Dates of service

What were the goals of this service? _____

♦ Has your child ever received Occupational Therapy? No Yes: Please specify:

_____ (____) _____
Name of service provider Agency Phone number Dates of service

What were the goals of this service? _____

♦ Has your child ever received Educational Therapy or Tutoring? No Yes: Please specify:

_____ (____) _____
Name of service provider Agency Phone number Dates of service

What were the goals of this service? _____

Please provide any assessments completed as part of the above services.

VI. ADDITIONAL INFORMATION

♦ Describe your child's strengths:

♦ What are your child's favorite activities?

♦ Describe your child's social relationships, at home and at school:

♦ Please check any of the below that you have observed or that have been brought to your attention by school staff:

- | | | |
|--|--|--|
| <input type="checkbox"/> severe anxiety | <input type="checkbox"/> school refusal | <input type="checkbox"/> isolation |
| <input type="checkbox"/> suicidal statements | <input type="checkbox"/> suicidal actions | <input type="checkbox"/> self-injurious behavior |
| <input type="checkbox"/> physical aggression | <input type="checkbox"/> verbal aggression | <input type="checkbox"/> disruptive in classroom |
| <input type="checkbox"/> profanity | <input type="checkbox"/> provocative to peers | <input type="checkbox"/> stealing |
| <input type="checkbox"/> drug and/or alcohol use | <input type="checkbox"/> sexual comments | <input type="checkbox"/> sexual behavior |
| <input type="checkbox"/> property destruction | <input type="checkbox"/> running away (school or home) | <input type="checkbox"/> hallucinations |
| <input type="checkbox"/> Other: _____ | | |

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 finds social situations easy.				
6. When my child talks, it isn't always easy for others to get a word in edgewise.				
7. My child finds it hard to make new friends.				
8. It upsets my child if the daily routine is disturbed.				
9. New situations make my child anxious.				

♦ Are you aware of or do you suspect any of the following behaviors?

DRUG/ALCOHOL USE:

• Current substance abuse: No Yes: Please specify:

List substances: _____

• Past substance abuse: No Yes: Please specify:

List substances and date of last use _____

• Has your child ever undergone drug treatment? No Yes: Please specify:

Name of program: _____ Dates: _____

Outcome: _____

CRIMINAL/LEGAL INVOLVEMENT:

• Has your child ever been arrested? No Yes: Please specify:

Charge: _____ Date: _____

Outcome: _____

• Is your child currently on probation? No Yes: Please specify:

Date probation ends: _____

• Has your child ever been expelled or asked to leave a school? No Yes: Please specify:

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

VII. IEP INFORMATION AND FUNDING SOURCE

♦ Does your child currently have Non Public School (NPS) funding?

- Yes: Is the funding through: an IEP
 a mediation agreement

No:

- I have requested due process from the school district
Date of scheduled meeting: _____
 I will pay for tuition and services privately

♦ Are you receiving assistance from an education advocate/consultant or attorney?

- No Yes: Name of advocate: _____

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

2. _____
NAME

TYPE OF REFERRAL

TYPE OF REFERRAL

AGENCY

AGENCY

STREET ADDRESS

STREET ADDRESS

CITY STATE ZIP

CITY STATE ZIP

PHONE NUMBER

PHONE NUMBER