



What school is child coming from? \_\_\_\_\_

I understand the following records/information is needed to complete the application process.

Records needed for application at Mary Immaculate School:

**School:**

- Current Grades
- Transcript of Past Grades
- Standardized Test Results
- Copy of Attendance
- Discipline Records/Suspension Records
- Current ETR/MFE
- Current IEP/ISP/504 Plan

**Medical:**

- Medical records relevant to the education of this child
- Diagnosis relevant to the education of this child
- Treatment plan relevant to the education of this child
- Psychological evaluation records relevant to the education of this child

**Other:**

- Birth Certificate
- Custody Papers/Legal Guardianship Papers
- Any other assessment or documentation regarding your child's academic and social development.

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(Parent/Guardian signature)

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(Date)

**Mary Immaculate School 2011-2012**

Application for: \_\_\_\_\_  
(Student's Name) (Date)

What are your concerns about the educational needs of your child?

Has your child received any detentions, suspensions, or expulsions during the last two years? If yes, please explain:

Why do you feel the current school is not meeting your child's needs?

What other pertinent information is needed to understand your child?

Is your child on any medications? Please list.

<b>Name of Medication</b>	<b>Reason for Medication</b>	<b>How Long on Medication</b>

Does your child have any allergies? What accommodations are needed?

<b>Type of Allergy</b>	<b>List any Allergies</b>	<b>Accommodations</b>
Food		
Medication		
Environment		

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(Parent/Guardian signature)

(Date)

**(OVER)**

**Mary Immaculate School 2011-2012**

Application for: \_\_\_\_\_  
(Student's Name) (Date)

Has your child been diagnosed with a disability? Please check all that apply:

**Medical   School   Both**

- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ADD/ADHD                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autism  |
|                          |                          |                          | <input type="checkbox"/> PDD                  |
|                          |                          |                          | <input type="checkbox"/> High Functioning     |
|                          |                          |                          | <input type="checkbox"/> Asperger's Syndrome  |
|                          |                          |                          | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cognitive Disabilities                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Deaf-Blindness                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Deafness (Hearing Impairment)                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emotional Disturbance (SBH)                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | FASD  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Disabilities (other than Deaf-Blind) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic Impairments                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other Health Impaired (Major) _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other Health Impaired (Minor) _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Specific Learning Disabilities                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Speech and Language Impairments               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Traumatic Brain Injury (TBI)                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Visual Impairments                            |

**(OVER)**

Does your child receive any of the following services in school or out of school?

<b><u>In School</u></b>	<b><u>Out of School</u></b>	<b><u>N/A</u></b>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adapted Physical Education
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aide Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attendant Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Audiological Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Counseling/Guidance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interpreter Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orientation & Mobility
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parent Counseling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reading Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreational Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rehabilitation Counseling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School Nurse Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School Psychological Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Special Transportation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social Work Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other_____

Application for: \_\_\_\_\_  
(Student's Name) (Date)

Does your child exhibit any of the following characteristics?

<b><u>Always</u></b>	<b><u>Sometimes</u></b>	<b><u>Never</u></b>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aches or pains (without medical cause)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acts too young for age
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Afraid to try new things
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angry moods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoids looking others in the eye
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can't concentrate, can't pay attention for long
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can't sit still or restless
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can't stand having things out of place
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can't stand waiting, wants everything now
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clings to adults or too dependent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consequences do not change behavior
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constantly seeks help
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cries a lot
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Defiant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Demands must be met immediately
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Destroys things belonging to him or to others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea or loose bowels when not sick
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disturbed by any changes in routine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doesn't answer when people talk to him/her
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doesn't get along with other children
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doesn't know how to have fun, acts like a little adult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doesn't seem to feel guilty after misbehaving
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doesn't want to leave home
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily frustrated
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily jealous
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fears certain animals, situations, or places (describe): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feelings are easily hurt

**Always**      **Sometimes**      **Never**

- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gets hurt a lot, accident prone                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gets in many fights   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gets into everything  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gets upset when separated from parents                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has trouble getting to sleep                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches (without medical cause)                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hits others   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Holds his/her breath  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hurts animals or people without meaning to                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Looks unhappy without good reason                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Angry moods   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea, feels sick (without medical cause)                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous movements or twitching<br>(describe): _____               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous, high-strung, or tense                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nightmares  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Overtired   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physically attacks people   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Picks nose, skin, or other parts of the body<br>(describe): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Plays with own genitalia too much                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poorly coordinated or clumsy                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Problems with eyes (without medical cause)<br>(describe): _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Quickly shifts from one activity to another                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Refuses to eat  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Refuses to play active games                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Repeatedly rocks head or body                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Resists going to bed at night                                     |