



APPLICATION FOR ADMISSION

TODAY'S DATE: _____

Student Information

Legal Name: <i>(First, Middle, Last)</i>		Nickname:
DOB:	Age:	Social Security Number:
Home Street Address:		Apt. No.:
City:	State:	Zip:
Current School / Phone Number:	Current Grade:	Contact at Current School:
Current Status of Parent(s)/Guardian(s): ≥ Married ≥ Single Parent ≥ Widowed ≥ Domestic Partners ≥ Divorced (if divorced, please indicate which parent has legal custody of child: ≥ Mother ≥ Father ≥ Both)		
If parents do not live in the same household, with whom does the child reside?		
What concerns brought you to Sage Alliance NYC? <u>How did you hear about our school?</u>		

Parent/Guardian Information

Parent/Guardian 1:

Name:	Relation to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other:		
Home Street Address: <input type="checkbox"/> (Check box if same as student)			
City:	State:	Zip:	Apt. No.:
Home Phone:	Work Phone:	Parent's Profession and Workplace:	
Cellular Phone:	Email Address:		

Parent/Guardian 2:

Name:	Relation to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other:		
Home Street Address: <input type="checkbox"/> (Check box if same as student)			
City:	State:	Zip:	Apt. No.:
Home Phone:	Work Phone:	Parent's Profession and Workplace:	
Cellular Phone:	Email Address:		

Persons in Household

Name:	Relation to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Step Parent <input type="checkbox"/> Caretaker <input type="checkbox"/> Other: <input type="checkbox"/> Sibling (if sibling please provide Age:_____ School:_____)
Name:	Relation to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Step Parent <input type="checkbox"/> Caretaker <input type="checkbox"/> Other: <input type="checkbox"/> Sibling (if sibling please provide Age:_____ School:_____)
Name:	Relation to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Step Parent <input type="checkbox"/> Caretaker <input type="checkbox"/> Other: <input type="checkbox"/> Sibling (if sibling please provide Age:_____ School:_____)
Name:	Relation to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Step Parent <input type="checkbox"/> Caretaker <input type="checkbox"/> Other: <input type="checkbox"/> Sibling (if sibling please provide Age:_____ School:_____)

Developmental and Medical History

Pediatrician _____ Phone _____

Is your child adopted? _____ Country of Birth _____ Age at adoption _____

(If your child was adopted, please include as much developmental history as is known to you on a separate sheet.)

Were there any complications during pregnancy or birth or after? _____

Was your child full term? Yes No If No, in what week was he/she born? _____ Weight _____

Describe your child as an infant (Check all that apply): Active ☐ Colicky ☐ Content ☐ Unresponsive ☐ Fussy ☐

At what age did your child?: Sit _____ Walk _____ Say first words _____

Does your child experience sleeping problems? Yes No

If yes, explain _____

Describe your child's general health, including any recent illness, special medical problems, allergies or dietary restrictions.

Is your child on medication? Yes No

If so, name of medication? _____ Prescribing Physician _____

Does your child wear glasses? Yes No If yes, for what purpose? _____

Does your child have frequent ear infections? Yes No

Has your child had any surgical or medical procedures, i.e. adenoids or tonsils removed? Yes No

If yes, explain _____

Intervention History

Has your child received the following intervention services? (please check all that apply, past or present)

Psychiatric/Psychological Services ____

Academic Support ____

Audiological/Hearing Service ____

PROMPT Therapy ____

Occupational Therapy ____

Therapeutic Listening ____

Physical Therapy ____

Counseling Services ____

SEIT Services ____

Peer/Social Skills Group ____

Speech/Language Therapy ____

Cognitive Behavioral Therapy ____

OTHER ____

Please list the therapists, frequency of treatment (including private and school sessions) and contact information:

Has your child been evaluated/diagnosed? Yes No

By whom and when? _____

Diagnosis _____

I give representatives of Sage Alliance NYC permission to speak to the professionals named above regarding my child's learning styles and progress.

Your name _____

Relationship to applicant:

Signature _____
Date _____

School History *(Please list all schools attended)*

Name of School

Dates Attended

Early Intervention	_____	_____
Preschool/Nursery	_____	_____
Kindergarten	_____	_____
Elementary	_____	_____
Middle School	_____	_____
High School	_____	_____

Did your child repeat a grade? Yes No Grade Repeated ____ Please explain

Social and Emotional Development

How does your child respond to new situations?

What is your child like at home? (Include activity level and relation to siblings)

Does your child have difficulty with transitions from one activity to another? Yes No

Explain_____

Does your child have frequent tantrums? Yes No How long do tantrums last?_____

Explain_____

[illegible][illegible]

[illegible]

Thank you for taking the time to complete this application