

# THE KING'S ACADEMY

1015 S. Ebenezer Road Florence, SC 2501



Phone 843. 661.7464 Fax 843. 661.7647

## Application for Educational Therapy School Year \_\_\_\_\_

ET \_\_\_\_ ET-2 \_\_\_\_

Name of Student \_\_\_\_\_ Date \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_ Grade \_\_\_\_ Sex \_\_\_\_ Teacher \_\_\_\_\_

Father \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Referred by \_\_\_\_\_

### **FAMILY HISTORY**

=====  
Child is living with:

\_\_\_ natural father    \_\_\_ stepfather    \_\_\_ natural mother    \_\_\_ step mother

\_\_\_ legal guardian    \_\_\_ other: \_\_\_\_\_

Child is:    \_\_\_ adopted    \_\_\_ foster

Since the child's birth there has been:    Reaction of child:

\_\_\_ death in the family    \_\_\_\_\_

\_\_\_ separation    \_\_\_\_\_

\_\_\_ divorce    \_\_\_\_\_

\_\_\_ remarriage of mother    \_\_\_\_\_

\_\_\_ remarriage of father    \_\_\_\_\_

\_\_\_ other major trauma    \_\_\_\_\_

Other children in the family:

Name	Age	Grade	Present School
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_____	_____	_____	_____
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_____	_____	_____	_____
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\_\_\_\_\_

Is there a history of learning difficulties in your family?      No \_\_\_ Yes \_\_\_

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Briefly describe your child's relationship with you, your spouse, and other members of the family: \_\_\_\_\_

\_\_\_\_\_

Name of the church your family attends: \_\_\_\_\_

**MEDICAL/DEVELOPMENT HISTORY**

=====

Child was: \_\_\_ full term      \_\_\_ premature

State any complications that occurred during pregnancy (e.g., toxemia, diabetes, etc.)

\_\_\_\_\_

State any complications that your child had immediately after birth (e.g. difficulty breathing, blue color, etc.) \_\_\_\_\_

Check where applicable:

___ recent physical exam	date/results _____
___ recent eye exam	date/results _____
___ recent hearing exam	date/results _____
___ recent speech evaluation	date/results _____

Check any problems in infancy or childhood with:

___ colic	___ talking	___ crawling	___ walking/running
___ sleeping	___ bedwetting	___ eating	___ general slow development

Child: (check where applicable)

___ needs glasses	___ wears glasses	___ frequent ear infections
___ has allergies/asthma	___ has/had high fevers	___ has/had hearing difficulties
___ had seizures, convulsions, or staring spells	___ experienced injury/accident to head	

Explain items checked:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EDUCATIONAL HISTORY**

=====  
List all schools previously attended (preschool to present):

School	Grades	Reason for Change
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child writes with:

right hand  left hand  uses both hands  mirror writer

Check where applicable and provide pertinent information:

repeated grade(s); if so, grade(s) repeated \_\_\_\_\_

received tutoring; if so, subjects(s) \_\_\_\_\_

enrolled in a special class; if so, what kind \_\_\_\_\_

receives/received physical/occupational therapy \_\_\_\_\_

receives/received speech therapy or language therapy \_\_\_\_\_

State child's best and worst subject: Best \_\_\_\_\_ Worst \_\_\_\_\_

Child has been tested before: No  Yes

If yes, give date and location of testing:

Child has been diagnosed as: ADHD  Learning Disabled  Other: \_\_\_\_\_

Is your child currently on medication? No  Yes  Type: \_\_\_\_\_

When taken: \_\_\_\_\_ Physician: \_\_\_\_\_

Additional comments or information regarding child's schooling:

\_\_\_\_\_  
\_\_\_\_\_

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State the area(s) in which you feel your son/daughter needs help:

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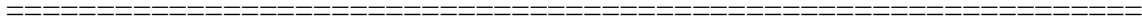
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**SOCIAL/BEHAVIOR HISTORY**



Check where applicable:

- |  |  |                                     |  |
|--|--|-------------------------------------|--|
| <input type="checkbox"/> independent                         | <input type="checkbox"/> lacks common sense                    | <input type="checkbox"/> stubborn   | <input type="checkbox"/> dislikes school   |
| <input type="checkbox"/> anxious                             | <input type="checkbox"/> easily distracted                     | <input type="checkbox"/> aggressive | <input type="checkbox"/> dependent         |
| <input type="checkbox"/> dishonest                           | <input type="checkbox"/> overly fearful                        | <input type="checkbox"/> withdrawn  | <input type="checkbox"/> overly sensitive  |
| <input type="checkbox"/> shy                                 | <input type="checkbox"/> enjoys school                         | <input type="checkbox"/> moody      | <input type="checkbox"/> self-centered     |
| <input type="checkbox"/> passive                             | <input type="checkbox"/> make friends easily                   | <input type="checkbox"/> confident  | <input type="checkbox"/> easily frustrated |
| <input type="checkbox"/> prefers playing with older children | <input type="checkbox"/> prefers playing with younger children |                                     |  |

Is there any additional information you would like to personally share with the Discovery Program Coordinator prior to testing?       Yes       No

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**PERMISSION FOR TESTING**

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We give our permission to \_\_\_\_\_ to perform academic testing with our son/daughter.

\_\_\_\_\_  
*Father*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Mother*

\_\_\_\_\_  
*Date*

**ADDITIONAL PERMISSION TO:**

1. Allow teacher to read the most recent psycho-educational testing report for the purpose of educational planning.

\_\_\_\_\_  
Parent Signature

2. Allow my child's educational therapy session to be recorded for the purpose of evaluation and/or training of therapists.

\_\_\_\_\_  
Parent Signature

3. Allow my child's picture to be used on a brochure, display, or web site for the purpose of providing information about the Discovery Program.

\_\_\_\_\_  
Parent Signature

4. Allow my child's session to be observed by a prospective parent for the purpose of answering questions about the nature of educational therapy.

\_\_\_\_\_  
Parent Signature



**EVALUATION**

An evaluation, including testing, will be done in the spring. A conference will be held with parents (and student if appropriate.) This agreement will be renewable at that time, subject to approval of both parties, for another school year. We acknowledge that we understand the above information and consent to the terms stated in this agreement.

Father \_\_\_\_\_ Mother  
\_\_\_\_\_

Student \_\_\_\_\_ Date \_\_\_\_\_

Revised 6/14/17

