

Application for Admission

Mid-Year Enrollment

Fall Enrollment

year



Specialized Learning for the Whole Child

4122 Myrtle Avenue
Cincinnati, OH 45236
Phone: 513-984-2215
Fax: 513-984-2272
www.lindengroveschool.org

Full Name of Applicant

I understand that this application is subject to the conditions stated in printed materials and the regulations of the school.

Date

Name of Person Completing Application

Please include the following items with the completed application for admission:

- Copy of current IEP with parent and district signatures
- Copy of current ETR with parent and district signatures
- Copy of most recent Progress Notes
- Picture of your child (you will not get this back)

- \$250 application fee due at time of testing

For office use only

Date Completed Application Received: _____

Enclosed:

- Copy of current IEP with parent and district signatures
- Copy of current ETR with parent and district signatures
- Copy of most recent Progress Notes
- Picture of your child (you will not get this back)
- \$250 application fee due at time of testing

STUDENT INFORMATION

First Name <input type="text"/>	Last Name <input type="text"/>	Middle Name <input type="text"/>	
Student prefers to be called <input type="text"/>	Age <input type="text"/>	Current Grade <input type="text"/>	Gender <input type="text"/>
Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>	Place of Birth <input type="text"/>		Home Phone Number <input type="text"/>
Street Address <input type="text"/>	City <input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/>

HOUSEHOLD INFORMATION**PARENT/GUARDIAN'S INFORMATION**

Name <input type="text"/>	Relationship to Child <input type="text"/>	Occupation <input type="text"/>	
Street Address (If different) <input type="text"/>	City <input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/>
Home Phone <input type="text"/>	Cell Phone <input type="text"/>	Email Address <input type="text"/>	

PARENT/GUARDIAN'S 'S INFORMATION

Name <input type="text"/>	Relationship to Child <input type="text"/>	Occupation <input type="text"/>	
Street Address (If different) <input type="text"/>	City <input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/>
Home Phone <input type="text"/>	Cell Phone <input type="text"/>	Email Address <input type="text"/>	

Marital Status

Married
 Single
 Divorced
 Widowed
 Separated
 Other

List any additional parents/guardians. Please includes names and relationship to student.

With whom does this child reside?

Which parent(s) is the residential parent(s)/guardian?

List any other family members or individuals who reside in your home. Please include names, ages and relationship to student.

SCHOOL INFORMATION

School/Provider <input style="width: 95%;" type="text"/>	Telephone Number <input style="width: 95%;" type="text"/>
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Address <input style="width: 95%;" type="text"/>	City <input style="width: 95%;" type="text"/>	State <input style="width: 95%;" type="text"/>	Zip Code <input style="width: 95%;" type="text"/>
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Principal/Director <input style="width: 95%;" type="text"/>	Public School District in which you reside <input style="width: 95%;" type="text"/>
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Has the child repeated any grades? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list the grade(s) repeated: <input style="width: 100px;" type="text"/>
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Please list below any other schools/programs your child has attended.

Select the option that BEST describes the environment in which your child currently receives their instruction:	
They are in the general education setting and receive no academic supports or accommodations.	<input type="checkbox"/>
They are in the general education setting and receive minor academic supports or accommodations.	<input type="checkbox"/>
They are in the general education setting and receive significant supports and the curriculum is modified.	<input type="checkbox"/>
They are splitting their day between the general education setting and special education/intervention setting.	<input type="checkbox"/>
They are in the special education setting all day.	<input type="checkbox"/>
They are currently receiving instruction at a school that specializes in special education.	<input type="checkbox"/>
They are currently receiving instruction at an ABA center.	<input type="checkbox"/>
They are currently receiving instruction in home via ABA, homeschooling or virtual schooling.	<input type="checkbox"/>
They are not currently receiving instruction of any kind.	<input type="checkbox"/>

Please share any information about your child’s school experiences which you think would be helpful. Include how your child feels in their present learning environment:

Why are you looking for new school placement?

- Unhappy with quality of previous service/lacking knowledge of specialized programming
- The larger environment was overwhelming for my child causing sensory and/or anxiety issues
- Not enough personalized attention for academic support due to number of students in class
- My child was struggling to fit in socially
- My child was struggling with behavior due to
- Other:

How did you hear about Linden Grove School? (check all that apply)

- Internet
- Home School District
- Autism Scholarship/ Jon Peterson Scholarship Listing
- Current LGS Family
- Referral; by whom?
- Other; please list:

LGS has therapy dogs on campus. Is your child afraid of or allergic to dogs? Yes No

Please explain:

What have you told your child about Linden Grove School and what was your child's reaction?

What are your expectations of Linden Grove School if your child is enrolled?

MEDICAL INFORMATION

What (if any) is/are your child's diagnoses?	Official Diagnosis	Suspected	Family History	Receiving Treatment
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PDD-NOS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Processing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auditory Processing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generalized Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Hyperactive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional Defiance Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bi-Polar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other- <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other- <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does your child receive any additional services outside of school?

	Provider	Focus
<input type="checkbox"/> Mental Health	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Behavioral	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Speech and Language	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Occupational Therapy	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Physical Therapy	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Other	<input type="text"/>	<input type="text"/>

List current medication(s) taken regularly:

Medication: <input type="text"/>	Dosage: <input type="text"/>	Reason: <input type="text"/>
Medication: <input type="text"/>	Dosage: <input type="text"/>	Reason: <input type="text"/>
Medication: <input type="text"/>	Dosage: <input type="text"/>	Reason: <input type="text"/>
Medication: <input type="text"/>	Dosage: <input type="text"/>	Reason: <input type="text"/>
Medication: <input type="text"/>	Dosage: <input type="text"/>	Reason: <input type="text"/>
Medication: <input type="text"/>	Dosage: <input type="text"/>	Reason: <input type="text"/>
Medication: <input type="text"/>	Dosage: <input type="text"/>	Reason: <input type="text"/>

Have any other medications, treatments or therapies been recommended for your child? Yes No

If yes, please describe the current status on the recommendations or decision to decline follow through:

Does this child have allergies (food or environmental)? Yes No

If yes, please list allergies,

Is your child being treated for the allergies? Yes No

Does your child have any frequent illnesses? Yes No

If yes, please explain:

Is your child fully potty trained? Yes No If yes, skip to next page.

At what age did this child achieve control of bladder during the day? the night?

At what age did this child achieve control of bowels during the day? the night?

Is your child wearing underwear throughout the day? Yes No (*Admission Requirement*)

Can your child identify to when they need to use the restroom using words or visuals? Yes No

Does your child need a bathroom schedule? Yes No How frequent are the bathroom breaks?

SPEECH, LANGUAGE AND HEARING HISTORY

At what age did he/she speak the first meaningful word?

Is your child using 2-3 word phrases? Yes No (*Admission Requirement*)

Currently, my child uses speech: frequently occasionally never

Does your child use any secondary forms of communication: Gestures Sign Language PECS Speech Generating Device

If your child is using a second form of communication, please provide details regarding frequency of use, level of independence with use and fluency below:

Can your child be understood by parents/family? Yes No By Friends/Playmates? Yes No By Strangers? Yes No

Are there any known hearing needs or suspicions of hearing needs? Yes No

Is there a language spoken in the home other than English? Yes No

If yes, please explain.

SKILLS INVENTORY

Mark any that are true of your child:

- Difficulty handling transitions, shifting from one mindset or task to another
- Difficulty doing things in a logical sequence or prescribed order
- Difficulty persisting on challenging or tedious tasks
- Poor sense of time
- Difficulty maintaining focus
- Difficulty considering the likely outcomes or consequences of actions (impulsive)
- Difficulty considering a range of solutions to a problem
- Difficulty expressing concerns, needs or thoughts in words
- Difficulty understanding what is being said
- Difficulty managing emotional response to frustration so as to think rationally
- Chronic irritability and/or anxiety that significantly impedes capacity for problem solving or heightened frustration
- Difficulty seeing the “grays”; concrete, literal, black-and-white thinking
- Difficulty deviating from rules, routine
- Difficulty handling unpredictability, ambiguity, uncertainty, novelty
- Difficulty shifting from original idea, plan or solution
- Difficulty taking into account situational factors that would suggest the need to adjust a plan of action
- Inflexible, inaccurate, interpretations/cognitive distortions or biases (i.e. “Everyone’s out to get me.”; “You always blame me.”)
- Difficulty attending to or accurately interpreting social cues/poor perception of social nuances
- Difficulty starting conversations, entering groups, connecting with people/lacking other basic social skills
- Difficulty seeking attention in appropriate ways
- Difficulty appreciating how their behavior is affecting other people
- Difficulty empathizing with others, appreciating another’s perspective or point of view
- Difficulty appreciating how they are coming across or being perceived by others
- Sensory/motor difficulties

Describe any concerns about your child’s social and/or self-concept that would be important for our staff members to know.

FAMILY HISTORY

Is this child adopted? Yes No If yes, at what age did the adoption take place?

Please give all known information regarding biological parents and child's experience up to the time of adoption:

Describe this child's relationship with parents.

Describe this child's relationship with other children in the family.

Describe this child's relationships with peers.

What types of discipline methods are most effective with this child?

Does this child frustrate easily? Yes No

What types of things frustrate this child?

It will help us in our partnership to know the goals you have for your child.

Given your child's overall needs, we know there will be some initial goals that may differ from long term goals. List the top 3 goals you have for your child for the first year at Linden Grove School.

List the goals you have for your child's long term future.



Consent to Communicate With Outside Organizations

I, , give permission for the organizations listed
(name of parent/guardian)
below to communicate and share information with Linden Grove School regarding my child,
, and any educational, behavioral, therapeutic or
medical services that were delivered to my child.

1. Provide name of organization, name of contact and contact numbers.

2. Provide name of organization, name of contact and contact numbers.

3. Provide name of organization, name of contact and contact numbers.

I hereby authorize the above listed communication to occur with Linden Grove School. My typed name below will function as my signature.

Parent/Guardian Name

Date

Linden Grove School strives to work closely with each student enrolled. To be effective, we need to be given full information about each child and assume that you have included all important information of a medical, psychological or disciplinary nature. My typed name below will function as my signature.

Parent/Guardian Name

Date

Return this completed application, completed release of records form, copy of child's current IEP & copy of child's current ETR:

Attn: Kristin Tennyson, Head of School
Linden Grove School
4122 Myrtle Avenue
Cincinnati, OH 45236

Linden Grove School recruits and admits students of any race, color, gender, ethnicity, national origin, religion, disability, age or ancestry to all its rights and privileges, programs and activities. In addition, the school will not discriminate on the basis of any race, color, gender, ethnicity, national origin, religion, disability, age or ancestry in the administration of its educational programs and athletic/extracurricular activities. Furthermore, the school is not intended to be an alternative to court or administrative ordered or public school initiated desegregation.