

New Leaf Academy

APPLICATION FORM

SECTION I – Student Information

Student First Name: _____

Middle Name: _____

Last Name: _____

Gender: M F Grade in School: _____ Date of Birth: _____

Social Security Number: _____ Anticipated Enrollment Date: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Shoe Size: _____ Waist Size: _____ Shirt Size: _____

Who Does the Student Live with? _____

Student Birthplace: _____

If Born Outside the U.S. list Current Immigration Status (Check One):

F1 Visa ___ M1 Visa ___ J1 Visa ___ Dual Citizen: ___ Permanent Resident (Green Card) ___

Student Religious Orientation: _____

Section II – Emergency Contact Information

First Name: _____

Last Name: _____

Relationship to Student: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State/Prov: _____ Zip Code: _____

Country: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Fax: _____ Email: _____

Section III – Father Information

Father First Name: _____

Father Middle Name: _____

Father Last Name: _____

Father Date of Birth: _____ Social Security Number: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State/Prov: _____ Zip Code: _____

Country: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Fax: _____ Email: _____

Occupation: _____ Employer: _____

Stepmother Name (if applicable): _____

Section IV – Mother Information

Mother First Name: _____

Mother Middle Name: _____

Mother Last Name: _____

Mother Date of Birth: _____ Social Security Number: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State/Prov: _____ Zip Code: _____

Country: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Fax: _____ Email: _____

Occupation: _____ Employer: _____

Stepfather Name (if applicable): _____

Section V – Marital Status

Are Parents Divorced or Separated: Yes ___ No ___ If yes, what year?: _____

Any Special Circumstances?: _____

Has Divorce Been an Issue for the Student?: Yes ___ No ___

Who Has Custody of the Student?: _____

Who Has Physical Custody of the Student: _____

Can the Non-Custodial Parent have access to information regarding the student's treatment: Yes ___ No ___

Visitation?: _____

Section VI – Referral Information:

How did you hear about New Leaf Academy?: Internet/Website: _____

Doctor/Clinician ___ Educational Consultant: ___ Another Parent: ___ Other: ___

Name: _____ Location: _____

Section VII – Parent/Child Relationship

Describe the relationship between your daughter and her:

Father:

Mother:

Stepfather:

Stepmother:

Brother(s)/Sister(s):

Other Pertinent Information:

Physical Confrontations with Student and Parent(s)/Sibling(s): Yes ___ No ___

Please Describe: _____

Is your daughter adopted: Yes ___ No ___ If yes, at what age?: _____

Special Circumstances?: Yes ___ No ___ Explain: _____

Is adoption an issue for your daughter?: Yes ___ No ___ Explain: _____

Section VIII – Student Academic Record

Highest Grade Completed _____ Name of school currently attending: _____

_____ Student behind credits or grade level?: Yes ___ No ___

List any academic or intellectual testing within the last year (e.g. MMPI, WAIS-3, WISC etc.):

What are your academic goals for your daughter?: _____

Has your daughter received Special Education Services in a previous school?: Yes___No___

Has she had an Individualized Education Plan (IEP)?: Yes___No___

List any academic difficulties or learning differences: _____

Has your daughter had any suspensions or expulsions from school? Yes___No___

Explain: _____

What is her favorite subject?: _____

What is her least favorite subject? _____

Section IX – Emotional Concerns

Describe any traumatic events in your daughter's life: _____

Have there been any difficult moves or relocations to new home/school?: Yes___No___

Has she been hospitalized for psychiatric/psychological reasons?: Yes___No___

If yes, what was her diagnosis?: _____

What were the circumstances?: _____

Name and location of hospital: _____

Physician Name and Contact Number: _____

Has your daughter attempted suicide or had suicide ideation?: Yes___No___

If yes, please explain: _____

Describe any history of self harm or bizarre behavior: _____

Describe any depressive features, mood swings, or periods of isolation: _____

How does your daughter express anger?: _____

What are her positive traits, strengths, hobbies and talents?: _____

Section X – Behavioral Concerns

Describe any Violent/Aggressive Behavior: _____

Is she sexually active or experienced? If yes please describe: _____

Has she run away from home? If yes please describe: _____

Please explain details and give examples of the following where applicable:

Lying: _____

Stealing: _____

Eating Disorders: _____

Inappropriate use of computer: _____

Cruelty to animals: _____

Other: _____

Section XI – Peer Relationships

Can your daughter make and keep friends?: _____

What age group does she affiliate with?: _____

Is she invited to peer events or sleepovers?: _____

Other: _____

Section XII – Substance Abuse

Has your daughter used or experimented with alcohol or drugs?: Yes___No___

If yes, please describe: _____

At what age did this occur?: _____ Socially or alone?: _____ How Often?: _____

Under what circumstances?: _____

Are there other family drug and/or alcohol problems?: Yes___No___

If yes, please explain: _____

Section XIII – Treatment History

List below all professional efforts that have been made to address your daughter's emotional and behavioral needs (i.e. therapy, hospitalization, etc.). List the most current intervention first.

Intervention #1: _____

Therapist or Specialist Name: _____

Address: _____

Phone: _____ Email: _____

Frequency: _____ Duration: _____ End Date: _____

Intervention #2: _____

Therapist or Specialist Name: _____

Address: _____

Phone: _____ Email: _____

Frequency: _____ Duration: _____ End Date: _____

If additional interventions were tried, please attach supplemental sheet.

Section XIV – Medical History

Family Physician Name: _____

Address: _____ Phone: _____

Dentist/Orthodontist Name: _____

Address: _____ Phone: _____

Does your daughter currently have health problems?: Yes___No___

If yes, please describe the condition(s): _____

Does she use an inhaler or Epipen? No___ Inhaler___ Epipen___

If yes, Please describe the condition(s): _____

Date of last physical examination: _____ Name of Physician: _____

Date of last dental examination: _____ Name of Dentist: _____

Is she currently seeing an orthodontist?: Yes___No___

Is she currently fitted with: Retainer(s) ___ Braces ___ No Fittings ___

Does she need to continue orthodontic care while at New Leaf Academy?: Yes ___ No ___

Date of last vision examination: _____ Name of Optometrist: _____

Does she require corrected vision? No ___ Glasses ___ Contact Lenses ___

Are they required for reading?: Yes ___ No ___ Classroom? ___

Does she have any dietary restrictions?: Yes ___ No ___

If yes, please outline the restriction(s): _____

Has she had any significant weight change over the past 12 months?: Yes ___ No ___

How many pounds (+/-)?: _____ Possible cause?: _____

If applicable, date of onset of menstruation: _____ Any difficulties?: _____

Has she ever undergone surgery?: Yes ___ No ___

If yes, please describe circumstances: _____

Please indicate if your daughter has had any of the following diseases or illnesses:

Heart Disease ___ AIDS/HIV ___ Anaphylactic Shock ___

Hepatitis ___ Anemia ___ Hernia ___

Anorexia/Bulimia ___ High Blood Pressure ___ Appendicitis ___

Hives/Skin Allergies ___ Arthritis ___ Hypoglycemia ___

Back Injury ___ Headaches ___ Bladder/Kidney Infection ___

Knee/Ankle Injury ___ Bone Condition ___ Moles/Lumps ___

Bowel Problems ___ Meningitis ___ Cancer ___

Mononucleosis ___ Chest Pain ___ Mumps ___

Chicken Pox ___ Muscle Weakness ___ Convulsions/Seizures ___

Obesity ___ Coughing ___ Pneumonia ___

Cysts/Tumors____	Polio____	Dermatitis____
Red Measles____	Diabetes____	Rheumatic Fever____
Difficulty Walking____	Scarlet Fever____	Epilepsy____
Scoliosis____	Fainting____	Hayfever____
Food Allergies____	Thyroid Disease____	Frequent Colds____
Ulcers____	Diarrhea____	Urination Problems____
Ear Infections____	Venereal Disease____	German Measles____
Whooping Cough____	Other:	

Is your daughter up-to-date on all vaccinations?: Yes____No____

Please complete the following table regarding vaccination information:

Diphtheria/Tetanus/Pertussis	Date: _____
Polio	Date: _____
Measles/Mumps/Rubella (MMR)	Date: _____
Tuberculosis	Date: _____
Hepatitis B	Date: _____
Haemophilus Influenza Type B	Date: _____
Varicella	Date: _____
Meningococcal	Date: _____

Section XV – Medications

Is your daughter currently taking medication?: Yes___No___

If yes, please complete the following table:

Name of Medication(s)	Dosage of Each Pill	Form (Tab/Liquid)	AM Units	Noon Units	Dinner Units	Bedtime Units	As Needed	Other

Name of Prescribing Physician: _____

Student History of Taking Medication: Good___ Resists___ Hordes___ Irregular___

Past medications and results: _____

Has student recently been “taken off” any medication?: Yes___No___

If yes, what was the reason and medication?: _____

Is she allergic to any medication(s)?: Yes___No___

If yes, please list those medications: _____

Please indicate allergic reaction: _____

Section XVI – Insurance

Credit Card Information

Your credit card information will only be used if your daughter enrolls at New Leaf Academy. Once enrolled the credit card would be available to cover tuition, incidental expenses and other costs. These will be further explained in the signature enrollment forms upon admission.

Credit Card Type: Visa ___ MasterCard ___ Discover ___ American Express ___

Credit Card Number: _____ Expiration Date: _____

Verification Number (3 digit on back of card/4 digit on front AmEx): _____

Primary Insurance

Insured First Name: _____

Insured Last Name: _____

Social Security Number of Insured: _____ Insured Date of Birth: _____

Insured Employer: _____

Employer Address: _____

Relationship of Insured to Student: _____

Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Policy Number: _____

Prescription Drug Coverage

Name of Company: _____

Address of Company: _____

Insurance Company Phone: _____ Policy Number: _____

Secondary Insurance (If Applicable)

Insured First Name: _____ Insured Last Name: _____

Social Security Number of Insured: _____ Date of Birth: _____

Employer of Insured: _____

Employer Address: _____

Relationship of Insured to Student: _____

Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Policy Number: _____