LearningSpring School
247 East 20th Street
New York, N.Y.  10003
Phone: 212-239-4926/Fax: 212-239-5226
Web: www.learningspring.org  Email: whar@learningspring.org

ADMISSIONS PROCEDURE

Please return this checklist along with the following documents for your child to be considered for admission to LearningSpring School.

☐ Application for Admission
☐ Photograph of Applicant
☐ Application Processing Fee ($50 non-refundable fee)
☐ Applicant’s most recent Individualized Education Program (IEP)
☐ Psychological/Psycho-Educational Evaluation
☐ Speech and Language Evaluation
☐ Occupational Therapy Evaluation
☐ Related Service Provider Reports
☐ Educational/Teacher Progress Reports

PLEASE NOTE: All of the above items are required before an application can be reviewed by the admissions coordinator.

Upon receipt, the admissions coordinator will review application, evaluations and reports. If student appears to be appropriate, an appointment for observation will be scheduled at your child’s current school setting. You will be informed of this date.

Following this initial observation, the Admissions Team will determine if your child will be invited in to be observed by the classroom and admissions team. This observation will better determine if your child’s needs will best be served at LearningSpring.

Once all applicants have been observed, parents will be notified if we have an appropriate class grouping to meet your child’s needs.

Please email whar@learningspring.org if you have any specific questions.
LearningSpring School

Applicant’s Name:  

Address:  

Telephone:  

Date of Birth:  Age:  

CSE #:  NYC ID/OSIS #:  

Ethnicity:  African American  Asian  Caucasian  
Hispanic/Latinx  Native American  Pacific Islander  
Prefer Not to Answer  Other  

ATTACH CURRENT PHOTO HERE

LearningSpring School (LSS) affirms a policy of nondiscrimination and admits students of any religion, race, sexual orientation, or national origin to all rights, privileges, programs, and activities generally accorded or made available to students at LSS, and further states that LSS does not discriminate on the basis of religion, race, sexual orientation, or national origin in the administration of its educational policies, admissions policies, scholarship and loan programs, and athletic and other school administered programs.
Applicant’s Name: __________________________

Parent/Guardian Name: __________________________

Address: __________________________

Telephone: __________________________

Occupation: __________________________

Employer: __________________________

Address: __________________________

Telephone (wk): __________________________

Email Address: __________________________

SIBLINGS:

Name: __________________________  Age: _____  School: __________________________

Name: __________________________  Age: _____  School: __________________________

Name: __________________________  Age: _____  School: __________________________

OTHER INDIVIDUALS: (Relatives, childcare giver, housekeeper)

Name: __________________________  Age: _____  Relationship/Position: __________________________

Name: __________________________  Age: _____  Relationship/Position: __________________________
Applicant’s Name: ____________________________

DIAGNOSIS:

Has your child been evaluated/diagnosed? ______

By Whom? ________________ What is the diagnosis? __________________________

Does your child know about his/her diagnosis? _______yes _______no

If yes, how has this been presented to your child, and how does he/she respond to this information?

________________________________________________________________________________________

________________________________________________________________________________________

REFERRAL AND PROFESSIONAL INFORMATION:

Who referred you to LearningSpring School?

Name: ____________________________ Telephone: ____________________________

Address: ____________________________ Relationship to Child: ________________

* Please list any professionals currently working with your child and/or family on a regular basis. By providing this information, you are giving your consent for LearningSpring School to contact these individuals.

| Name: ____________________________ | Name: ____________________________ |
| Telephone: ____________________________ | Telephone: ____________________________ |
| Specialization: ____________________________ | Specialization: ____________________________ |

| Name: ____________________________ | Name: ____________________________ |
| Telephone: ____________________________ | Telephone: ____________________________ |
| Specialization: ____________________________ | Specialization: ____________________________ |
Applicant’s Name: ________________________________

SOCIAL/FAMILY HISTORY:

- At what age did you suspect your child was not developing appropriately? __________

- Please describe some of the behaviors that led you to seek advice? _______________________

____________________________________________________________________________________________________

- Have any other relatives been diagnosed? ______ If so, with what? ______________________

- What is that person’s relationship to your child? ________________________________

- Have there been any important life events (move, divorce, illness, death, etc.) in your family that may have affected your child? If so, when did they occur, how did they affect your child, and how were they dealt with?

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

- Does your child have any history of chronic illness and/or hospitalization? ______

- How does your child respond to the following?

  - Unexpected change to familiar routines  
  - Changes in activities without preparation  
  - Interruption to a highly favored activity  
  - Stopping a task before it is finished  
  - Using familiar objects in novel/different ways

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- How does your family set limits at home? What types of discipline are used?

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

247 East 20th Street. N.Y., N.Y. 10003 (212) 239-4926/Fax (212) 239-5226
Applicant’s Name: __________________________________________

-At what age did your child:

  Sit up_________________________________________  Stand_________________________________________

-Is your child toilet trained? _____________________

-Please describe your child’s sleeping habits: ____________________________________________________________

-Please describe your child’s eating habits: ________________________________________________________________

SENSORY:

-Is your child overly sensitive to sound(s)? Yes____ No_______
  What types? ________________________________________________
  What does he/she do? ________________________________________

-How does your child react to:
  Groups of 3-6____________________________________________
  Groups of 8-12____________________________________________
  Groups of 12-25____________________________________________

-Is your child sensitive to touch? Yes____ No_______
  Bothered by clothing labels? _________________________________
  Exaggerated reaction to being touched or bumped? _________________
  Displays anxiety/aggression when touched? _______________________

-Does your child have food allergies? ________________________________
  ______________________________________________________________

-Does your child have any other sensory issues? (taste, smell, sound, etc.) Please explain:
  ______________________________________________________________
  ______________________________________________________________
Applicant’s Name: _______________________________________

LANGUAGE DEVELOPMENT:
- What languages are spoken at home? ________________________________________________

- What is your child’s primary language? ______________________________________________

- At what age did your child first begin to babble? ______________
  
  Imitate sounds? ______________

- What is your child’s primary means of communication? (ex. if necessary)

  Gestures: ____________________________  2 or more words: ____________________________

  Sounds: ____________________________  Sentences: ____________________________

  Single Words: ____________________________  Combination: ____________________________

- What were your child’s first words? ________________________________________________

  At what age? ______________

- Do strangers understand your child’s language? ________________________________________

- Does your child repeat words or phrases? Yes ________  No ________

  Are they:

  ___ The same words  Example: _____________________________________________

  ___ The same topic  Example: ________________________________________________

  ___ Echoing what was heard  Example: __________________________________________

- Does your child use language to make needs known?

  Words __________  Phrases __________  Sentences ______________

- Does your child have difficulty expressing his/her ideas in a logical manner? Can he/she tell a story?

  ____________________________________________________________________________

  ____________________________________________________________________________

  ____________________________________________________________________________
Applicant’s Name: ________________________________

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<th>Name &amp; Location of School</th>
<th>Years Attended</th>
<th>Type of Program &amp; Student Progress</th>
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-Has your child received intervention services? How many hours?

  EI_________________________________________     OT_____________________________________________
  ABA______________________________________     PT_____________________________________________
  SEIT______________________________________     Speech________________________________________

-What was your child’s first reaction to school?

__________________________________________________________________________________________________

-Is your child motivated to learn?

__________________________________________________________________________________________________

-What academic area(s) of school has given your child the most difficulty?

__________________________________________________________________________________________________

__________________________________________________________________________________________________

-Is the completion of homework a problem? Yes______ No_______

-If yes, what are the issues and what strategies have been attempted?

__________________________________________________________________________________________________

__________________________________________________________________________________________________

EVALUATION OF YOUR CHILD’S ACADEMIC ABILITIES:

Strengths:_______________________________________________________________________________________

___________________________________________________________________________________________________

Weaknesses:_____________________________________________________________________________________  

___________________________________________________________________________________________________

Study/Work Habits:____________________________________________________________________________

___________________________________________________________________________________________________

Organizational Skills:___________________________________________________________________________

___________________________________________________________________________________________________

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Applicant’s Name: ____________________________

SOCIAL/EMOTIONAL/BEHAVIORAL DEVELOPMENT:

PERSONALITY: (Please check all that apply)

_____Happy                   _____Shy                        _____Easy-Going                   _____Angry
_____Loving                   _____Lively                     _____Worrisome                     _____Insistent
_____Talkative                _____Distractible              _____Eager to please               _____Irritable

-Is your child anxious?    _____Seldom    _____Sometimes    _____Frequently    _____Always
-What makes him/her anxious? ______________________________________________________________
___________________________________________________________________________________________________

-Does he/she do better:    _____At home           _____At School             _____With Adults
                           _____Peers                _____One on One          _____Groups

-What are your child’s interests?
___________________________________________________________________________________________________

-What are your child’s favorite activities?
___________________________________________________________________________________________________

BEHAVIOR: (Please check all that apply)

_____Impatient                  _____Withdraws                         _____Listless/Tires Easily
_____Tantrums                    _____Pushes                            _____Verbally Aggressive
_____Impulsive                    _____Seeks Isolation                     _____Pinches/Bites
_____Easily Agitated            _____Clumsy                             _____Shakes/Flaps Extremities
_____Boisterous                  _____Passive/Withdrawn                _____Talks Excessively

_____Yells at Inappropriate times  _____Inappropriate Behavior in Public  _____Low Frustration Tolerance

-What makes your child upset or angry? __________________________________________________________
___________________________________________________________________________________________________

-How does he/she show his/her feelings? __________________________________________________________
___________________________________________________________________________________________________
Applicant’s Name: _______________________________________

SOCIAL/EMOTIONAL COMMUNICATION:

- Does your child have friends? _____none _____1-2 _____3-5 _____more
- Play dates? _____never _____seldom _____sometimes _____frequently _____always
- Does your child prefer to play: _____alone _____w/adults _____w/peers _____w/siblings
- Is your child motivated to be social/make friends? _________________________________________
- How does your child make attempts to be social or interact with peers? _________________
- Who does he/she play with? __________________________________________________________
- How do they play? __________________________________________________________________

DOES YOUR CHILD:

- Initiate reciprocal conversation with adults?
  _____Never _____Seldom _____Sometimes _____Frequently _____Always
- Limit conversation to his/her interests?
  _____Never _____Seldom _____Sometimes _____Frequently _____Always
- Listen to directions?
  _____Never _____Seldom _____Sometimes _____Frequently _____Always
- Respond to his/her name?
  _____Never _____Seldom _____Sometimes _____Frequently _____Always
- Please describe your child’s strongest qualities: _____________________________________________
  ________________________________________________________________________________
  ________________________________________________________________________________
- Please describe your child’s greatest area of difficulty? _____________________________________
  ________________________________________________________________________________
  ________________________________________________________________________________
- What are your greatest concerns for your child at the present time? ______________________
  ________________________________________________________________________________
  ________________________________________________________________________________
- What are your long-term concerns and wishes for your child? _____________________________
  ________________________________________________________________________________
  ________________________________________________________________________________
LearningSpring School

Applicant’s Name: _______________________________________________________

Address: __________________________________________________________________

Parent/Guardian Name: _________________________________________________

Parent/Guardian Name: _________________________________________________

Current School: __________________________________________________________

Address: __________________________________________________________________

Telephone: ________________________________ Ext:_____________________

Contact Person: __________________________________________________________

I hereby give permission to the LearningSpring School (LSS) to observe
________________________________ in the school setting indicated above, and to re-
lease to LSS any reports, evaluations, or information requested.

__________________________________________     ___________________________________
Signature                                         Date

__________________________________________  
Printed Name

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