



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:

Parent/Guardian Name:

Address: _____

Address: _____

Telephone: _____

Telephone: _____

Occupation: _____

Occupation: _____

Employer: _____

Employer: _____

Address: _____

Address: _____

Telephone (wk): _____

Telephone (wk): _____

Email Address: _____

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.

<p>Name: _____</p> <p>Telephone: _____</p> <p>Specialization: _____</p>	<p>Name: _____</p> <p>Telephone: _____</p> <p>Specialization: _____</p>
<p>Name: _____</p> <p>Telephone: _____</p> <p>Specialization: _____</p>	<p>Name: _____</p> <p>Telephone: _____</p> <p>Specialization: _____</p>

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?

	No Reaction	Appropriate Reaction	Exaggerated Reaction
• Unexpected change to familiar routines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Changes in activities without preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Interruption to a highly favored activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Stopping a task before it is finished	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Using familiar objects in novel/different ways	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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: _____

Name & Location of School	Years Attended	Type of Program & Student Progress

-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: _____

Applicant's Name: _____

SOCIAL/EMOTIONAL/BEHAVIORAL DEVELOPMENT:

PERSONALITY: (Please check all that apply)

- | | | | |
|------------------------------------|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Happy | <input type="checkbox"/> Shy | <input type="checkbox"/> Easy-Going | <input type="checkbox"/> Angry |
| <input type="checkbox"/> Loving | <input type="checkbox"/> Lively | <input type="checkbox"/> Worrisome | <input type="checkbox"/> Insistent |
| <input type="checkbox"/> Talkative | <input type="checkbox"/> Distractible | <input type="checkbox"/> Eager to please | <input type="checkbox"/> 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)

- | | | |
|---|---|--|
| <input type="checkbox"/> Impatient | <input type="checkbox"/> Withdraws | <input type="checkbox"/> Listless/Tires Easily |
| <input type="checkbox"/> Tantrums | <input type="checkbox"/> Pushes | <input type="checkbox"/> Verbally Aggressive |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Seeks Isolation | <input type="checkbox"/> Pinches/Bites |
| <input type="checkbox"/> Easily Agitated | <input type="checkbox"/> Clumsy | <input type="checkbox"/> Shakes/Flaps Extremities |
| <input type="checkbox"/> Boisterous | <input type="checkbox"/> Passive/Withdrawn | <input type="checkbox"/> Talks Excessively |
| <input type="checkbox"/> Yells at Inappropriate times | <input type="checkbox"/> Inappropriate Behavior in Public | <input type="checkbox"/> 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? _____

