



**Cole Valley Christian Schools  
APPLICATION FOR TESTING**

Today's Date: \_\_\_\_\_

Name of Student: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Nickname/Name preferred \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

School Child Attends \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

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

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

Email Address \_\_\_\_\_

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

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

Referred by \_\_\_\_\_

**PERMISSION FOR TESTING**

We give our permission to **Cole Valley Christian Schools** to test our son/daughter.

The testing fee of **\$350.00** is due with this application. Please make checks payable to **CVCS**. Please include "**assessment**" in the memo line. Payment plan options are available.

\*Additional testing *may be* recommended which is not included in this fee.

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

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

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

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

Child's Name \_\_\_\_\_

**FAMILY HISTORY**

**Child is living with** (check all that applies):

- Birth Father                       Stepfather                       Legal Guardian
- Birth Mother                       Stepmother                       Other: \_\_\_\_\_

**Child is:**                       Adopted                       Foster

**Since the child's birth there has been:**

- Death in the family
- Separation
- Divorce
- Remarriage of Mother
- Remarriage of Father
- Other major trauma

**Reaction of child:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other children in the family:**

Name:	Age	Grade	Present School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Child's Name \_\_\_\_\_

**MEDICAL/DEVELOPMENTAL HISTORY**



Child was:       Full Term                       Premature

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

---

---

State any complications which 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                       has/had frequent ear infections
- has allergies/asthma                       has/had high fevers                       has/had hearing difficulties
- has/had seizures, convulsions, or staring spells                       experienced injury/accident to head

Explain any items checked: \_\_\_\_\_

---

---

Child's Name \_\_\_\_\_

**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:

- Repeated grade(s); if so, grade(s) repeated \_\_\_\_\_
- Received tutoring; if so, subject(s) \_\_\_\_\_
- Enrolled in special class(es), if so, what kind of class(es) \_\_\_\_\_
- Receives/received physical/occupational therapy
- Receives/received speech or language therapy

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

Child has been tested before  Yes     No

If yes, give date and location of testing \_\_\_\_\_

Child has an:     IEP     504 Plan     Other accommodations \_\_\_\_\_

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

Additional comments or information regarding child's schooling: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Child's Name \_\_\_\_\_

**SOCIAL/BEHAVIORAL HISTORY**



**Check where applicable:**

- independent       lacks common sense       stubborn       dependent
  - anxious       easily distracted       aggressive       complains about school
  - dishonest       overly fearful       withdrawn       overly sensitive
  - shy       enjoys school       moody       self-centered
  - passive       makes friends easily       confident       easily frustrated
- prefers playing with much older children     prefers playing with much younger children

**Is there any additional information you would like to personally share with the SAS Director prior to testing?**

- Yes     No