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 Signature *Date*

____ ______________________
Mother Signature *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:	**Reaction of child:**
□ Death in the family	________________________________
□ Separation	________________________________
□ Divorce	________________________________
□ Remarriage of Mother	________________________________
□ Remarriage of Father	________________________________
□ Other major trauma	________________________________

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