SUMMIT ACADEMY MANAGEMENT

2791 Mogadore Road • Akron, Ohio 44312 • (800) 442-5753 • FAX (330) 670-8284
WEBSITE: www.SummitAcademies.com • E-MAIL: Info@SummitAcademies.org

Thank you for your interest in Summit Academy Community Schools for Alternative Learners, which are designed to meet the educational needs of students who are at risk for academic failure due to having ADHD, Asperger's Syndrome or other high-functioning autism spectrum disorders. All Summit Academy Schools are tuition-free and 501(c) (3) non-profit institutes.

No student shall be discriminated against on the basis of race, religion, national origin, financial status or disability.

In this "APPLICATION PACKET" you will find the following forms:

- **Summit Academy Application-** Please complete this form to start the application process.
- **Summit Academy Potential Student MFE/IEP Form-** Please take this form to your child's current school to be completed by appropriate school personnel. When enrolling at Summit Academy, if applicable, you must have copies of your child's MFE/IEP.
- **Summit Academy Authorization for the Release of Student Records-** Please complete this form that authorizes Summit Academy staff and management to obtain your child's previous school records.
- **Summit Academy Physician's Diagnosis Form-** This form should be completed ***only if*** your child has an existing mental health diagnosis, such as ADHD or Asperger's.
- **Parent Intake Questionnaire-** Please complete this form as thoroughly as possible. This form will be reviewed during your application conference.

Please fill out all forms completely and return them to Summit Academy Management or the school of your interest.

Be aware that *all* forms are to be filled out and returned *before* acceptance into the Academy.

If the number of applicants exceeds spaces allotted for each grade, the applicants will be chosen through a lottery selection process. If selected, you will then be notified and asked to complete the enrollment process.

The Summit Academy School admits students of any race, color, national and ethnic origin to all the rights, privileges, programs and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national or ethnic origin in administration of school policies, admission policies, scholarship and loan programs, and athletic and other administered school programs.

APPLICATION – SUMMIT ACADEMY SCHOOLS

To submit an application for the 2010/2011 school year:
1). Complete both sides and sign and date in the spaces provided at the end of this application.
2). Mail to Summit Academy Management – 2791 Mogadore Road – Akron, OH 44312
3). For more information, please call: (800) 442-5753 or visit us on the web at: www.SummitAcademies.com

Today's date: ______________________

STUDENT INFORMATION

Student Name ____ **Jr/Sr/III**

Nickname (if applicable) ______________________ **Date of Birth** ____________________

Social Security Number ______________________ ☐ **Female** ☐ **Male**

Primary Language- Check One:

☐ E **(English)** ☐ S **(Spanish)** ☐ O **(Other, please specify:______________________)**

Ethnic Background- (Is this student Hispanic/Latino?) ☐ YES ☐ NO
(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin, regardless of race.)

Which of the following five racial groups applies to the student? Check all that apply:

☐ American Indian or Alaskan Native - **Persons having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.**

☐ Asian - **Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.**

☐ Black or African American - **Persons having origins in any of the black racial groups in Africa.**

☐ Native Hawaiian or Other Pacific Islander - **Persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or Other Pacific Islands.**

☐ White – **Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.**

Who has legal custody of this student? ________________________________

The student lives with?
Name: ________________________________

Address: ________________________________

____

Please check the grade your child attended in 2009/2010?

☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Student's kindergarten experience: ☐ None ☐ Half Day ☐ Full Day

Has the student been diagnosed with: ☐ ADD/ ADHD ☐ Asperger's Syndrome

Does the student have any medical/ health, or other concerns that the school should be aware of?

☐ Yes ☐ No

Explain: ____

____

Does the student need to take medication(s) at school? ☐ Yes ☐ No

Name of medication(s): ____

CONFIDENTIAL PRIMARY CONTACT INFORMATION

Contact Name (Dr. Ms. Mrs. Mr.) ________________________________ **Jr/Sr/III**

Relationship ______________ **Home Phone** ______________ **Work Phone** ______________

Cell Number ______________ **Email** ______________________________

School District in which the Parent/Guardian resides ______________________________

Home Address* ____

STREET CITY STATE ZIP

* This is where all school correspondence, including report card, will be mailed

PREVIOUS SCHOOL INFORMATION

Name of school previously attended ______________________________

Address of previous school ______________________________

Has your child ever been retained? ☐ Yes ☐ No **If yes, what grade(s)?** ______________

Does the student have an active IEP/MFE? ☐ Yes ☐ No

If yes, what issues are identified on the MFE? ______________________________

What types of special education services were received? ______________________________

Has your child received Title I services in the past? ☐ Yes ☐ No

If yes, for what ☐ Math ☐ Reading

Is your child currently receiving Title I services? ☐ Yes ☐ No

If yes, for what ☐ Math ☐ Reading

CONFIDENTIAL FAMILY INFORMATION

Is there a sibling of the applicant *currently attending* **a Summit Academy School?** ☐ **Yes** ☐ **No**

If yes, please list the sibling(s) name and school location:

Name ____

School Location ____

How did you hear about Summit Academy Schools? ___________________________

By signing, I acknowledge the attached information is accurate and true. I do have legal custody of this child and the right to make decisions regarding educational placement.

Signature: ___________________________ **Date:** ____________

Print Name: ___________________________

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MFE/IEP Form for Potential Summit Academy Student

Dear Parent/ Legal Guardian:

Please take this form to your child's current school and have it completed by the appropriate school personnel (e.g., Special Education Coordinator or School Secretary). Return this form, along with copies of the MFE and IEP, if applicable, to your local Summit Academy with your application materials.

Thank you.

Dear School Administrator:

Please check off the appropriate box(es) below and return this form, along with copies of the appropriate documents as applicable, to the parent/ legal guardian.

Student's Full Name: ________________________________ Date of Birth: ________________

☐ **YES,** Meetings have been held to address needs specific to this student. The following documents have been generated, and copies provided to the parent/guardian:

- ☐ **MFE/IEP** ☐ *(copy provided to parent)*
- ☐ **504 Plan** ☐ *(copy provided to parent)*
- ☐ **IAT Meeting Information** ☐ *(copy provided to parent)*
- ☐ **Other testing or evaluation** ☐ *(copy provided to parent)*

☐ **NO,** meetings have not been held to address needs specific to this student. There is no information regarding available to provide to the parent.

____ ____________________
Authorized School Personnel Signature Date

____ ____________________
Print Name Telephone Number

____
School Name and Address

SUMMIT ACADEMY SCHOOLS

AUTHORIZATION for RELEASE OF STUDENT RECORDS & SPECIAL EDUCATION DOCUMENTATION

When submitted, this authorization will become part of the student's permanent record in accordance with the *Family Educational Rights and Privacy Act of 1974*.

Child's Full Name: ______________________________

Grade: __________ **D. O. B:** ____________ **Present School Attending:** __________________

School Address: ______________________________

Parent/ Legal Guardian's Name: ______________________________

Home Address: ______________________________
(COMPLETE ADDRESS, INCLUDING CITY, STATE and ZIP CODE)

As the parent/ legal guardian of the above-named child, I authorize Summit Academy Community Schools to receive my child's records.

I have been advised that I have the right to request a hearing to review and discuss the contents of the records checked below.

CHECK and INITIAL ONE or MORE:

☐ **Release All** ____

☐ **Permanent/ Cumulative Records** _____

☐ **Health/ Immunization Records** _____

☐ **Special Education/ MFE/ 504/ IEP** _____

☐ **Psychological Reports/ Assessments** _____

☐ **Counseling Reports** _____

☐ **School Disciplinary Records** _____

☐ **Legal Court Documentation** _____

______________________________ **(PARENT/ GUARDIAN SIGNATURE)**

______________________________ **(PARENT/ GUARDIAN NAME IN PRINT)**

__________ **(DATE)**

<u>THE RECORDS SHOULD BE RELEASED TO:</u>

<u>SUMMIT ACADEMY MANAMEGENT C/O SUMMIT ACADEMY SCHOOLS</u>
<u>2791 Mogadore Road ~ Akron, Ohio 44312</u>
<u>Phone: (800) 442-5753</u>
<u>Fax: (330) 670-8284</u>

FOR OFFICE USE ONLY

Date Records Requested	***Initials***	***Date Records Received***	***Initials***

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DIAGNOSIS FORM

STUDENT: ________________________ AGE: ____________ D.O.B: ________________

GRADE: _________ DATE OF ASSESSMENT: ____________________________

PROFESSIONAL EVALUATOR:

______ YES * Based on my examination, the above-named student appears to have limited alertness or a heightened alertness to irrelevant stimuli with respect to the educational environment due to:

PLEASE CHECK ALL THAT APPLY:

______ADD ______ADHD ______ASTHMA

______LEAD POISONING ______EPILEPSY ______BRAIN INJURY

PLEASE INDICATE ANY ADDITIONAL RELATED PHYSICAL, MENTAL, OR EMOTIONAL DIAGNOSIS SUCH AS:

______ASPERGER'S SYNDROME ______PERVASIVE DEVELOPMENTAL DISORDER

______BIPOLAR DISORDER ______DEPRESSION

______OPPOSITIONAL DEFIANT DISORDER ______POST TRAUMATIC STRESS DISORDER

______OBSESSIVE COMPULSIVE DISORDER ______TOURETTE'S SYNDROME

______OTHER (S), please specify: ____

The student is taking the following medication(s): ______________________________

____

Additional Information:

____________________________________ ____________________
SIGNATURE /TITLE OF PROFESSIONAL EVALUATOR DATE

____
PRINT NAME / TITLE OF PROFESSIONAL EVALUATOR

____________________________________ (______)____________
ADDRESS PHONE NUMBER

Summit Academy Community Schools	Parent Intake Questionnaire

Student's First Name:		Middle Name:	Last Name:
Address:		City:	Zip:
DOB:	Age:	SS#:	Phone:
Person Completing Form:		Relationship to Child:	
Today's Date:			

PLEASE LIST THE PEOPLE LIVING IN YOUR HOME:

NAME	RELATIONSHIP	AGE	SEX	OCCUPATION

PLEASE LIST PEOPLE SIGNIFICANT TO YOUR CHILD LIVING OUTSIDE THE HOME:

NAME	RELATIONSHIP	AGE	SEX	OCCUPATION

SCHOOL HISTORY:

Name of current school: ___________________________________Grade: __________________

Telephone number of current school: ____

What grades did your child receive on the last report card? _____________________________

Number of days missed this year: ____________________Last year: ____________________

Has your child ever repeated a grade? Describe: ____________________________________

What other schools has your child attended? _______________________________________

____

Is your child in special classes or receiving special services? Describe: ___________________

____

____

Does your child have an MFE / IEP? ☐ Yes ☐ No (For what disability?________________)

How many days was your child suspended this year? ______________Last Year? _____________

Has your child ever been expelled from school? ☐ Yes ☐ No

If Yes, why? ____

Which areas contribute to your child's difficulties at school?

☐ Organization skill
☐ Problems with Homework
☐ Note-taking
☐ Missed Assignments
☐ Late/Lost Assignments
☐ Poor Test Grades
☐ Out of Class for Behavior
☐ Study Skills
☐ Not Paying Attention in Class
☐ Poor Motivation
☐ Poor Motivation
☐ Poor Student/Teacher Relationship

Please explain items above: ____

____

____

____

How often are you contacted by the school about your child's behavior? ___________________

How long have these difficulties been concern to you? ___________________________________

What have you done in the past to get help for your child?

☐ Get help on your own
(Private tutor, ACLD, Sylvan, etc)
☐ Request extra services from school
☐ Request help from teacher
☐ Request testing from school
☐ Requested help from principal
☐ Requested Help from Board of Education
☐ Consulted an Attorney to take legal action

What happened as a result of your attempts to help your child? ____________________________

____

____

Can your child read? ☐ Yes ☐No

What are your general concerns for your child? ____

____

____

____

MEDICAL HISTORY:

Child's pediatrician: ______________________________

Date of last physical examination: _______________ Immunization up to date? ☐ Yes ☐ No

Problem with: ☐ Speech ☐ Vision ☐ Hearing

Please explain: ______________________________

____

Does you child have allergies? ☐ Yes ☐ No

Please explain: ______________________________

____

Please describe you child's chief medical/physical complaints:______________________________

____

Please list any medications currently taken by your child:

Medication Name	Dosage	Purpose	Prescribed By	Side Effects

Please list any serious illnesses, injuries, or surgeries: ______________________________

____

____

____

Student Medical Illness History:

☐ Measles
☐ Mumps
☐ Chicken Pox
☐ Diphtheria
☐ Scarlet Fever
☐ Meningitis
☐ Encephalitis
☐ Asthma
☐ Fainting Spells
☐ High Fever
☐ Convulsions
☐ Injuries to the Head
☐ Broken Bones
☐ Loss of Consciousness
☐ Dizziness
☐ Suicide Attempt
☐ Ear Infections/Tubes

Family Medical History: check conditions effecting family members, and write name of person(s) effected.

Condition	Name	Condition	Name
☐ allergies		☐ suicide	
☐ degenerative disease		☐ mental health problems	
☐ diabetes		☐ obesity	
☐ high blood pressure		☐ cancer	
☐ alcoholism/drug use		☐ epilepsy/seizures	
☐ heart trouble		☐ mental retardation	
☐ other:		☐ other:	

MEDICAL CONDITIONS AND SYMPTOMS:

Past	Now	Never	Symptom	Past	Now	Never	Symptom
☐	☐	☐	Academic Underachievement	☐	☐	☐	Food Cravings for Sweets
☐	☐	☐	Anxiety	☐	☐	☐	Fatigue
☐	☐	☐	Anger Outbursts	☐	☐	☐	Headaches (Morning)
☐	☐	☐	Argumentative	☐	☐	☐	Headaches (Evenings)
☐	☐	☐	Asthma	☐	☐	☐	Headaches (lasting ___hours)
☐	☐	☐	Baby Talk	☐	☐	☐	Hearing Voices
☐	☐	☐	Bedwetting	☐	☐	☐	Itchy Skin
☐	☐	☐	Broken Sleep	☐	☐	☐	Poor Appetite
☐	☐	☐	Constipation	☐	☐	☐	Immature
☐	☐	☐	Cries Easily	☐	☐	☐	Distractibility
☐	☐	☐	Depression	☐	☐	☐	Loses Temper Easily
☐	☐	☐	Difficulty Going to Sleep	☐	☐	☐	Lying
☐	☐	☐	Difficulty Staying Asleep	☐	☐	☐	Moody Often
☐	☐	☐	Difficulty Concentrating	☐	☐	☐	Memory Problems
☐	☐	☐	Encopresis	☐	☐	☐	Nervous Breakdown
☐	☐	☐	Eats Non-edibles	☐	☐	☐	Nervousness
☐	☐	☐	Emotional Upsets	☐	☐	☐	Nightmares
☐	☐	☐	Excessive Demands for Attention	☐	☐	☐	Over Dependent
☐	☐	☐	Excessive Dieting	☐	☐	☐	Overeating
☐	☐	☐	Excessive Worrying	☐	☐	☐	Perfectionist
☐	☐	☐	Excessive Sexual Interest	☐	☐	☐	Poor Nutrition
☐	☐	☐	Sleep Walking	☐	☐	☐	Rebellious
☐	☐	☐	Temper Tantrums	☐	☐	☐	Stealing
☐	☐	☐	Worrier, Feels Insecure	☐	☐	☐	Thumb - sucking
☐	☐	☐	Bad Dreams	☐	☐	☐	Stomach Upsets
☐	☐	☐	Other:	☐	☐	☐	Vomiting

DEVELOPMENTAL HISTORY:

Describe any problems during pregnancy with this child: ________________________________

____

____

List any drugs, alcohol, or medication used during pregnancy by mother: __________________

____

Type of Delivery: ____

Problems during delivery: ____

Problems with the following:

☐ low birth weight ☐ colic ☐ feeding
☐ incubator ☐ convulsions ☐ birth defects

Compare to other children, describe this child's development:

	Early	Average	Delayed		Age
Motor: (crawling, walking)				Age child Walked	
Speech: (words, sentences)				Age child used sentences	
Self-help: (dressing, toileting)				Age child toilet trained	

Which of the following are true for your child?

☐ Has strange sense of humor
☐ Makes comments or facial expressions that don't match the situation.
☐ Has a particular routine for doing daily activities
☐ Becomes very upset when things change suddenly
☐ Doesn't interact with other children when playing
☐ Becomes obsessive with particular subjects or themes (Pokemon, Spiderman, horses, etc.)
☐ Doesn't identify when others are teasing him/her
☐ Difficulty with pretend or make-believe play
☐ Avoids physical affection or contact
☐ Over-reacts to lights, noises, smells, etc.

Please explain: ____

____

____

Has child ever been abused physically, emotionally or sexually? ☐ Yes ☐ No

If yes, please explain: ____

____

____

ENVIRONMENTAL HISTORY:

PLEASE LIST ANY PLACES YOUR CHILD HAS LIVED OUTSIDE THE HOME:

Placement:	Date from: to:
Reason for Placement:	

Placement:	Date from: to:
Reason for Placement:	

Placement:	Date from: to:
Reason for Placement:	

Do you live in: ☐ home you own ☐ home you rent ☐ apartment ☐ trailer
Do you live in: ☐ city ☐suburb ☐ rural area

Please check any family issues that have made a significant impact on your child:

☐ Frequent Moves	☐ Alcohol / Drug Use	☐ Death of Family Member
☐ Parents Divorce	☐ Legal Problems / Jail	☐ Abuse / Neglect
☐ Parents Remarriage	☐ Parent Conflicts	☐ Sexual Abuse
☐ Parent Separated	☐ Parent Job Loss	☐ Domestic Violence
☐ Family Illness	☐ Financial Stress	☐ Emotional Problems
☐ Personal Illness	☐ Learning Problems	☐ Other

Please list any changes in the past 1 year that have created stress in your family. (Example: births, deaths, marriages, separations, divorces, moves, school changes, financial stress, etc).

____

____

____

____

Please list any changes in your child's lifetime that have created stress in your family. (Example: births, deaths, marriages, separations, divorces, moves, school changes, financial stress, etc.)

____

____

____

____

TREATMENT HISTORY:

Is your child diagnosed with Attention Deficit Disorder (ADD or ADHD)? ☐ Yes ☐ No

Is your child diagnosed with any other conditions? ____

____

Is your child currently receiving counseling services? ☐ Yes ☐ No

Is your child currently prescribed any medications for these conditions? ☐ Yes ☐ No

If "yes" please list medications. ____

____

Mental Health Agency:	Date of Service: to
Worker(s):	
Reason for seeking treatment:	

Has your child received counseling services in the past? ☐ Yes ☐ No

Mental Health Agency:	Date of Service: to
Worker(s):	
Reason for seeking treatment:	

Hospital/ Facility:	Date of Service: to
Admitting Doctor(s):	
Reason for seeking treatment:	

LEGAL HISTORY:

Has your child ever been arrested, on probation, or involved with a Juvenile Diversion Program? ☐ Yes ☐ No

If "Yes" please explain: ____

____

____

BEHAVIORAL HISTORY:

Describe your child's relationship with peers including recent changes.

____

____

____

Describe your child's relationship with those in authority.

____

____

Has your child ever threatened or attempted suicide? ☐ Yes ☐ No

If yes, describe ____

____

____

Has your child ever threatened or attempted to runaway? ☐ Yes ☐ No

Have you ever needed to have your child live with someone else due to conflicts at home?☐ Yes ☐ No

If yes, describe ____

____

____

Describe any personality changes/mood swings ____

____

____

Please check any of the following that apply to your child:

☐ Head Injury	☐ Talking	☐ Learning
☐ Poor Coordination	☐ Feeling Rejected	☐ Behavioral Problems
☐ Leaving a loved One	☐ Overweight	☐ Frequent Tantrums
☐ Engages in Dangerous Behavior	☐ Did not like to be held as a baby	☐ Avoiding Others
☐ Refusing to Talk	☐ Strong Willed	☐ Small for Age
☐ Fighting	☐ Reading Problems	☐ Too Active
☐ Fidgety/Restless	☐ Eating Problems	☐ Fearful Leaving Home
☐ Few Friends	☐ Shy	☐ Picked On
☐ Prefers to be Alone	☐ Developmental Delays	

Please check and describe any behaviors which apply to your child.

☐	Aggression to Others:
☐	Verbal Abuse to Others:
☐	Destruction to Home/Property:
☐	Cruelty to Animals
☐	Threats to Kill Others:
☐	Stealing:
☐	Lying to Parents:
☐	Breaking Curfew:
☐	Fighting/Refusing Household Chores:
☐	Fire-starting:
☐	Bedwetting/Soiling Self:
☐	Change in Eating Habits:
☐	Change in Sleeping Pattern/Nightmares:
☐	Change in Hygiene:
☐	Loss of Interest in Activities:
☐	Drug or Alcohol Use:

What goals do you have for child in the coming school year? ___________________________

____

____

____

____

____

____

____

______________________	________	______________________	________
Parent/Guardian Signature	Date	Summit Academy Received By	Date
______________________		______________________	
Print Name		Print Name	