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TOLL-FREE PHONE: (800) 442-5753 ■ WEBSITE: [www.summitacademies.com](http://www.summitacademies.com) ■ E-MAIL: [info@summitacademies.org](mailto:info@summitacademies.org)

We are a free, non-profit 501(c)(3) Community School for Alternative Learners

Thank you for your interest in Summit Academy Community Schools for Alternative Learners. Summit Academy Schools are designed to meet the educational needs of at-risk students struggling with ADHD, Asperger's Syndrome, high-functioning Autism and related disorders.

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

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 your local Summit Academy Community School at the time of your application conference.

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

If you have questions or concerns, feel free to contact Enrollment Coordinator, Mrs. Blanks, at the toll-free number or email address shown above.

We are confident that your child will have a rewarding educational experience and we welcome the opportunity to share in part of it.



# APPLICATION

To submit an application for the 2009/2010 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. 175 Montrose West Avenue, Copley OH 44321
- 3). For more information, please call: 800.442.5753 or visit us on the web at: [www.SummitAcademies.com](http://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- Circle One:  W (White)  B (Black-Non Hispanic)  H (Hispanic)  I (American Indian or Alaskan Native)

A (Asian or Island Pacific)  M (Multi-racial)  O (Other, please specify \_\_\_\_\_)

Check the grade your child attended in 2008/2009?  K  1  2  3  4  5  6  7  8  9  10  11  12

Who has legal custody of the student? \_\_\_\_\_ The student lives with: \_\_\_\_\_

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): \_\_\_\_\_

{NEXT PAGE PLEASE}





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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 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:
- |   |   |
|---|---|
| <input type="checkbox"/> <b>MFE/IEP</b>                     | <input type="checkbox"/> <i>(copy provided to parent)</i> |
| <input type="checkbox"/> <b>504 Plan</b>                    | <input type="checkbox"/> <i>(copy provided to parent)</i> |
| <input type="checkbox"/> <b>IAT Meeting Information</b>     | <input type="checkbox"/> <i>(copy provided to parent)</i> |
| <input type="checkbox"/> <b>Other testing or evaluation</b> | <input type="checkbox"/> <i>(copy provided to parent)</i> |

- 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



*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 Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_  
**D. O. B:** \_\_\_\_\_

**Present School Attending:** \_\_\_\_\_  
\_\_\_\_\_

**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 School 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:

- |  |  |
|--|--|
| <input type="checkbox"/> <u>Release All Assessments</u>          | <input type="checkbox"/> <u>Psychological Reports/ Assessments</u> |
| <input type="checkbox"/> <u>Permanent/ Cumulative Records</u>    | <input type="checkbox"/> <u>Counseling Reports</u>                 |
| <input type="checkbox"/> <u>Health/ Immunization Records</u>     | <input type="checkbox"/> <u>School Disciplinary Records</u>        |
| <input type="checkbox"/> <u>Special Education/ MFE/ 504/ IEP</u> | <input type="checkbox"/> <u>Legal Court Documentation</u>          |

\_\_\_\_\_  
**(PARENT/ GUARDIAN SIGNATURE)** **(PARENT/ GUARDIAN NAME IN PRINT)**

THE RECORDS SHOULD BE RELEASED TO:

Name of Person/ Agency: Summit Academy Management

Address: 175 Montrose West Ave, Copley, OH 44321

Toll-Free Phone: (800) 442-5753

Local Phone: (330) 670-8470

Reason for Release: Student Application Process

\*\* This form is active for the 2009 – 2010 school years only \*\*

FOR SCHOOL OFFICE USE ONLY:

Date Records Requested: \_\_\_\_\_ Requesting  
Records From: \_\_\_\_\_

Date Records Received: \_\_\_\_\_ Records Received By: \_\_\_\_\_

Filed in Records By: \_\_\_\_\_ Date: \_\_\_\_\_



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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

( ) \_\_\_\_\_

|                         |      |                             |                        |       |
|-------------------------|------|-----------------------------|------------------------|-------|
| Summit Academy Schools  |      | Parent Intake Questionnaire |                        |       |
| Student's First Name:   |      | Last Name:                  |                        | Date: |
| Address:                |      |                             | City:                  | Zip:  |
| DOB:                    | Age: | SS#                         | Phone:                 |       |
| Person Completing Form: |      |                             | Relationship to Child: |       |

**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: \_\_\_\_\_

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?

- |   |  |
|---|--|
| <input type="checkbox"/> Organization skill     | <input type="checkbox"/> Out of Class for Behavior         |
| <input type="checkbox"/> Problems with Homework | <input type="checkbox"/> Study Skills                      |
| <input type="checkbox"/> Note-taking            | <input type="checkbox"/> Not Paying Attention in Class     |
| <input type="checkbox"/> Missed Assignments     | <input type="checkbox"/> Poor Motivation                   |
| <input type="checkbox"/> Late/Lost Assignments  | <input type="checkbox"/> Poor Motivation                   |
| <input type="checkbox"/> Poor Test Grades       | <input type="checkbox"/> Poor Student/Teacher Relationship |

Please explain items above: \_\_\_\_\_

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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?

- |   |   |
|---|---|
| <input type="checkbox"/> Get help on your own<br>(Private tutor, ACLD, Sylvan, etc) | <input type="checkbox"/> Request testing from school                |
| <input type="checkbox"/> Request extra services from school                         | <input type="checkbox"/> Requested help from principal              |
| <input type="checkbox"/> Request help from teacher                                  | <input type="checkbox"/> Requested Help from Board of Education     |
|   | <input type="checkbox"/> Consulted an Attorney to take legal action |

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

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Can you child read?  Yes  No \_\_\_\_\_

What are your general concerns for your child? \_\_\_\_\_

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**MEDICAL HISTORY:**

Child's pediatrician: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_ Immunization up to date?  Yes  NoProblem with:  Speech  Vision  Hearing

Please explain: \_\_\_\_\_

\_\_\_\_\_

Does your child have allergies?  Yes  No

Please explain: \_\_\_\_\_

\_\_\_\_\_

Please describe your 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:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Measles       | <input type="checkbox"/> Encephalitis         | <input type="checkbox"/> Broken Bones          |
| <input type="checkbox"/> Mumps         | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Fainting Spells      | <input type="checkbox"/> Dizziness             |
| <input type="checkbox"/> Diphtheria    | <input type="checkbox"/> High Fever           | <input type="checkbox"/> Suicide Attempt       |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Convulsions          | <input type="checkbox"/> Ear Infections/Tubes  |
| <input type="checkbox"/> Meningitis    | <input type="checkbox"/> Injuries to the Head |  |

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

| Condition                                     | Name | Condition                                       | Name |
|---|------|---|------|
| <input type="checkbox"/> allergies            |      | <input type="checkbox"/> suicide                |      |
| <input type="checkbox"/> degenerative disease |      | <input type="checkbox"/> mental health problems |      |
| <input type="checkbox"/> diabetes             |      | <input type="checkbox"/> obesity                |      |
| <input type="checkbox"/> high blood pressure  |      | <input type="checkbox"/> cancer                 |      |
| <input type="checkbox"/> alcoholism/drug use  |      | <input type="checkbox"/> epilepsy/seizures      |      |
| <input type="checkbox"/> heart trouble        |      | <input type="checkbox"/> mental retardation     |      |
| <input type="checkbox"/> other:               |      | <input type="checkbox"/> other:                 |      |

**MEDICAL CONDITIONS AND SYMPTOMS:**

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

|   |  |   |
|---|--|---|
| <input type="checkbox"/> Frequent Moves     | <input type="checkbox"/> Alcohol / Drug Use    | <input type="checkbox"/> Death of Family Member |
| <input type="checkbox"/> Parents Divorce    | <input type="checkbox"/> Legal Problems / Jail | <input type="checkbox"/> Abuse / Neglect        |
| <input type="checkbox"/> Parents Remarriage | <input type="checkbox"/> Parent Conflicts      | <input type="checkbox"/> Sexual Abuse           |
| <input type="checkbox"/> Parent Separated   | <input type="checkbox"/> Parent Job Loss       | <input type="checkbox"/> Domestic Violence      |
| <input type="checkbox"/> Family Illness     | <input type="checkbox"/> Financial Stress      | <input type="checkbox"/> Emotional Problems     |
| <input type="checkbox"/> Personal Illness   | <input type="checkbox"/> Learning Problems     | <input type="checkbox"/> 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).

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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.)

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**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.

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Describe your child's relationship with those in authority.

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Has your child ever threatened or attempted suicide?  Yes  No

If yes, describe \_\_\_\_\_

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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 \_\_\_\_\_

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Describe any personality changes/mood swings \_\_\_\_\_

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

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

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

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

**What goals do you have for child in the coming school year?** \_\_\_\_\_

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\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Summit Academy Received By

\_\_\_\_\_  
Date