

**All Saints Catholic School**

**Application for Admission**

School Year Beginning: \_\_\_\_\_

I. STUDENT INFORMATION

CHILD'S NAME: Last: \_\_\_\_\_ First: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: Male: \_\_\_\_\_ Female \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PARISH: \_\_\_\_\_ GRADE ENTERING: \_\_\_\_\_

CITY and STATE of BIRTH: \_\_\_\_\_

II. PARENTAL INFORMATION

FATHER'S NAME: Last: \_\_\_\_\_ First: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

MOTHER'S NAME: Last: \_\_\_\_\_ First: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CHILDREN IN FAMILY: Older: \_\_\_\_\_ Younger: \_\_\_\_\_

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III. PARENT OBSERVATION FORM

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parents Name: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation

Father's: \_\_\_\_\_

Mother's: \_\_\_\_\_

Child's Family Includes:

Brothers (names and ages)

Sisters (names and ages)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please answer the questions on this form in the best way that you can. You will be able to answer some quite easily and you will have difficulty in making decisions on others.

Your answers on this form will help the school staff and will involve you in deciding with the teacher what kind of educational program is best suited for your child.

The questionnaire is confidential and your response will be shared with only professional personnel and only if the information learned will help in planning an educational program for your child.

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IV. General Health History

Please check any health concerns you or your doctor has noticed.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma                                  | <input type="checkbox"/> Bed Wetting           | <input type="checkbox"/> Lack of consciousness    |
| <input type="checkbox"/> Indigestion                             | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Chronic Ear Infections   |
| <input type="checkbox"/> Constipation                            | <input type="checkbox"/> Serious blows to head | <input type="checkbox"/> Overtired or lacking pep |
| <input type="checkbox"/> Diarrhea                                | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Heart Trouble            |
| <input type="checkbox"/> Vomiting                                | <input type="checkbox"/> Nightmares            | <input type="checkbox"/> Hyperactivity            |
| <input type="checkbox"/> Stomachaches                            | <input type="checkbox"/> Thumb sucking         | <input type="checkbox"/> Medical problems         |
| <input type="checkbox"/> Frequent Fevers                         | <input type="checkbox"/> Nail biting           | (immediately after birth)                         |
| <input type="checkbox"/> Sinus Trouble                           | <input type="checkbox"/> Epilepsy (seizures)   |   |
| <input type="checkbox"/> Nose Bleeding                           | <input type="checkbox"/> Diabetes              |   |
| <input type="checkbox"/> Other Physical Problems (explain) _____ |  |   |

Is this child presently on medication?  What? \_\_\_\_\_

Has child had any significant injuries or hospitalization? \_\_\_\_\_

Is child healthy on day of screening? \_\_\_\_\_

Hearing Assessment

Has this child ever had any ear/hearing examinations or treatment? Y  N

When? \_\_\_\_\_ By whom? \_\_\_\_\_ Results? \_\_\_\_\_

Do you suspect hearing problems? Y  N

Does your child seem to have difficulty hearing? Y  N

Does your child turn up the TV louder than other family members? Y  N

Does your child seem to favor one ear over the other? Y  N

Does your child jump or appear to be startled if there is a sudden noise? Y  N

Does your child seem to hear you if you talk in a whisper? Y  N

Does your child become confused in following more than two verbal  
at a time? Y  N

Does your child have difficulty remember things for a long time? Y  N

Does your child have difficulty remembering things for a short time? Y  N

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### V. Language Development

At what age did your child first begin to speak? Give approximate age if you do not remember exact age:

First Words: \_\_\_\_\_ Two or three words together: \_\_\_\_\_ Sentences: \_\_\_\_\_

Does your child stutter? \_\_ Have difficulty expressing ideas or concepts? \_\_

### Visual Assessment

Has your child ever had a vision examination or treatment? \_\_

When? \_\_\_\_\_ By whom? \_\_\_\_\_ Results? \_\_\_\_\_

Do you suspect any vision problems? Y \_\_ N \_\_

Does your child seem to have a problem seeing things far away? Y \_\_ N \_\_

Does your child squint? Y \_\_ N \_\_

Does your child wear glasses? Y \_\_ N \_\_

Does your child have eyes that turn in? Y \_\_ N \_\_

Does your child have eyes that turn out? Y \_\_ N \_\_

Does your child sit very close to the television? Y \_\_ N \_\_

Does your child rub his eyes a lot? Y \_\_ N \_\_

Does your child turn head as to use primarily one eye? Y \_\_ N \_\_

Does your child lower one side of the head when looking at others? Y \_\_ N \_\_

### VI. Motor Development

This child began walking at age: \_\_\_\_\_.

Does your child catch a ball thrown to him? Y \_\_ N \_\_

Does your child enjoy physical activity? Y \_\_ N \_\_

Does your child lose balance, trip and fall more often than normal? Y \_\_ N \_\_

Does your child have difficulty running? Y \_\_ N \_\_

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VII. Social Development

- Does your child have regular playmates the same age? Y \_\_ N \_\_
- Does your child have difficulty getting along with others? Y \_\_ N \_\_
- Does your child prefer to play with others instead of alone? Y \_\_ N \_\_
- Does your child become easily frustrated? Y \_\_ N \_\_
- Does your child cry often? Y \_\_ N \_\_
- Does your child have a bad temper? Y \_\_ N \_\_
- Does your child enjoy cooperating with others? Y \_\_ N \_\_
- Does your child become frequently irritated or moody? Y \_\_ N \_\_
- Does your child become upset by changes in routine? Y \_\_ N \_\_
- Does your child have difficulty dealing with family stress such as illness, death or separation? Y \_\_ N \_\_
- Does your child demand much individual adult attention? Y \_\_ N \_\_
- Does your child accept discipline and limits? Y \_\_ N \_\_

VIII. Personal Information

- Has the child attended a preschool? Y \_\_ N \_\_
- Did your child receive any special services in preschool?  
(i.e. speech, therapy, learning support, etc.) Y \_\_ N \_\_
- If yes, please state what services were provided? \_\_\_\_\_
- Does your child know how to read? Y \_\_ N \_\_
- Does your child know how to write? Y \_\_ N \_\_
- Has your child received therapy or counseling for emotional or other problems? Y \_\_ N \_\_
- If yes, please explain: \_\_\_\_\_
- Has your child ever been suspended or required to withdraw from school at any time? Y \_\_ N \_\_

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If yes, please explain: \_\_\_\_\_

Are there any special family or home conditions of which the school should be aware? Y \_\_ N \_\_

If yes, please explain: \_\_\_\_\_

Is there any additional information that the school should know about this child? Y \_\_ N \_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THANK YOU FOR YOUR PATIENCE IN FILLING OUT THIS QUESTIONNAIRE!

The person asking for this application understands that acceptance depends upon availability of space and the presentation of a satisfactory report from the school previously attended. Acceptance is at the discretion of the school.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_