

APPLICATION FOR ADMISSION



RAPHAEL ACADEMY

Mailing Address:
517 Soraparu Street, Suite 104
New Orleans, LA 70130
Telephone: 504-524-5955

Date: _____
Applying for School Year: _____
Program / Grade Applying For: _____
Date Received: _____
Fee Received: _____

Please attach a photo of child.

Child's Name: _____
First Middle Last

Date of Birth: _____ Age: _____ Gender: _____

Residential Address: _____
City Zip Code

Mailing Address: _____
City Zip Code

Telephone: _____ Alternate Telephone: _____

Current School / Program: _____
Name of School / Program Address Grades Attended

Previous School / Program: _____
Name of School / Program Address Grades Attended

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian's Name: _____
Relationship to Child

Address: _____
(IF DIFFERENT FROM CHILD'S) City State Zip Code

Home Phone: _____ Mobile Phone: _____

Work/Alternate Phone: _____ Email: _____

Occupation: _____ Location of Work: _____

Parent/Guardian's Name: _____ Relationship to Child _____

Address: _____
(IF DIFFERENT FROM CHILD'S) City State Zip Code

Home Phone: _____ Mobile Phone: _____

Work/Alternate Phone: _____ Email: _____

Occupation: _____ Location of Work: _____

Grandparent's Name: _____ Phone: _____

Address: _____ Email: _____

Grandparent's Name: _____ Phone: _____

Address: _____ Email: _____

Emergency Contact: _____ Relationship to Child _____

Address: _____
City State Zip Code

Home Phone: _____ Mobile Phone: _____

Work/Alternate Phone: _____ Email: _____

Occupation: _____ Location of Work: _____

CHILD'S PROFILE

What Type(s) of intervention/Instruction did your child receive at his previous school? Please attach a copy of the most recent school reports/records/IEP

Has your child been seen by a Psychiatrist, Physiologist, or Counselor? Yes No (Circle one)

Please provide Dr. Name, Profession, Phone, and office address

Name

Profession

Address

Phone

Has your child been seen by a developmental pediatrician or neurologist? Yes No (Circle one)

Please provide Dr. Name, Profession, Phone, and office address

Name

Profession

Address

Phone

Does your child have a diagnosis? If Yes, please indicate the diagnosis, any secondary diagnoses, and who gave the diagnosis.

Please indicate whether your child exhibits any of the following behaviors:

- Self injurious behavior (head banging, cutting, biting, etc.)

YES NO If yes, please describe behavior below:

- Aggression towards others: (biting, kicking, spitting, hitting, etc.)

YES NO If yes, please describe behavior below:

- Does your child have difficulty transitioning from place to place or from task to task?

YES NO If yes, please describe behavior below:

- Does your child exhibit Obsessive Compulsive issues (the need for things to be done a certain way?)

YES NO If yes, please describe behavior below:

- Does your child flee/run away?

YES NO If yes, please describe behavior below:

- Does your child have a sleeping disorder?

YES NO If yes, please describe behavior below:

- Does your child have sensory issues? (sensitive to touch, sound, light, motion, etc.)

YES NO If yes, please describe behavior below:

- Does your child respond to their name when called?

YES NO

MEDICAL NEEDS

Does your Child have a medical diagnosis? If Yes, please describe below: (attach a copy of any psychological evaluations, educational evaluations, Occupational or Speech Therapist evaluations)

Please indicate your Child's Health / Medical Needs other than the predominate medical diagnosis:

Does your Child have Allergies (if yes, please describe):

Does your Child take any routine Maintenance Medication or Supplements: (If Yes, indicate type and dosage)

Does your Child require a special diet of any kind: (if Yes, please describe):

Does your Child have any physical disabilities: (if Yes, please describe):

Is your Child Potty Trained? YES NO If Yes, at what age: _____ If No, please describe toileting needs:

Describe any medical, physical, psychological, behavioral and/or other needs, conditions or concerns about the child that would assist the school & staff to best support the child: (attach a separate sheet if required)

LANGUAGE & COMMUNICATION

Mother's language _____ Others spoken _____

Father's language _____ Others spoken _____

What language is spoken in the home? _____

Is your child verbal? (Does he/she request his/her needs and wants to answer social questions etc.?)
(If yes, please describe your child's verbal skills.) Yes No

Please describe your child's receptive listening skills. (Will he/she follow directions verbally)?

Does your child receive Speech Therapy? Yes No (If yes, how often per week? Indicate name of Therapist.) _____

Does your child receive OT or PT? Yes No (If yes, how often per week? Indicate name of Therapist.)

Please list any other therapies or classes your child attends regularly (music, dance, movement, etc.):

SOCIAL & PLAY SKILLS

ANSWER YES OR NO TO THE FOLLOWING & PROVIDE ANY ADDITIONAL EXPLANATION ON THE BACK OF THE PAGE AS NEEDED

- Does your child prefer to be alone? YES NO
- Does your child prefer to on the fringe of groups of peers? YES NO
- Does your child enjoy social interaction with individual peers? YES NO
- Does your child enjoy social interaction with individual adults? YES NO
- Does your child enjoy social interaction with groups of peers? YES NO
- Does your child play appropriately alone? YES NO
- Does your child play appropriately with peers? YES NO
- Does your child demonstrate repetitive play? YES NO
- Does your child engage in stereotypic activity when undirected? YES NO

RELATIONSHIPS

- Does your child ignore the presence of others? YES NO
- Does your child make eye contact with others? YES NO
- Does your child anticipate with excitement? YES NO
- Does your child enjoy simple adult led games? YES NO
- Does your child participate in partner games? YES NO
- Does your child understand games with rules? YES NO
- Does your child tolerate changes to activities? YES NO
- Does your child improvise when playing? YES NO

LIKES & DISLIKES

Please describe your child's preferred activities, interests and reinforcements:

Please describe activities that your child dislikes:

List any particular object/s or situation/s which your child finds distressing? (E.g. crowds, unfamiliar situations, noises) _____

CHILD'S FAMILY PROFILE

Child Resides With: _____

Parent's Relationship Status: (married, single, divorced) _____

Siblings: _____

Name	Age	School / Program Currently Attending
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Name	Age	School / Program Currently Attending
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Name	Age	School / Program Currently Attending
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Child's Daily Routine: (Describe a typical day for your child)

Child's Daily Sleeping Schedule: (Sleeps through night, only a few hours, needs medication to sleep)

Child's Interests / Hobbies:

Time Spent Watching Television/Movies/Videos: _____
Daily Amount Weekly Amount

Time Spent on Computer / Playing Electronic Games: _____
Daily Amount Weekly Amount

ENROLLMENT RESPONSIBILITY & PROCESS

Raphael Academy is a sponsored project of Waldorf Education Association of New Orleans. Waldorf Education Association of New Orleans is a not for profit 501 c (3).

Complete financial responsibility for student's initial and continued enrollment, until otherwise changed in writing, will be assumed by:

Name Relationship to Child

Name Relationship to Child

- Please complete and submit the Authorization for Release of School Records to the student's previous school / program. Current School Records will need to be obtained by Raphael Academy to a final decision for student's acceptance.
- Please submit a non-refundable Application Fee of \$50.00 along with this completed Application for Admission to the Raphael Academy. Checks are payable to: Raphael Academy.
- Once the above items are received, you will be contacted by phone to schedule an Entrance Interview for you and your child.
- Applicants are considered for admission without regard to race, color, creed, or national or ethnic origin.

Name of Parent / Guardian Signature of Parent / Guardian Date

Name of Parent / Guardian Signature of Parent / Guardian Date