



The Academy In Manayunk

169 Conarroe Street, Philadelphia, PA 19127
215-483-2461 ~ www.aimpa.org

APPLICATION FOR ADMISSION

Name of Applicant _____ Sex Male Female

Name child prefers to be called _____ Date of Birth _____ Birthplace _____

Home Address _____

City/State/Zip _____ Home Phone _____

Present Grade _____ Present School _____ Principal _____ Teacher _____

Address of School _____ School District _____

May we contact child's school for additional information? Yes No

NAME AND ADDRESS OF PARENTS OR GUARDIANS (if information is the same as child write SAME)

Father's Name Age

Mother's Name Age

Street

Street

City, State, Zip Code

City, State, Zip Code

Home Phone Cell Phone

Home Phone Cell Phone

Email:

Email:

PROFESSION OF PARENTS OR GUARDIANS

Father's Profession

Mother's Profession

Place of Employment

Place of Employment

Address

Address

Phone

Phone

EDUCATIONAL BACKGROUND OF PARENTS OR GUARDIANS

Father

Mother

Name of person who referred you to the Academy of Manayunk _____

FAMILY INFORMATION

In family, child is # _____ of _____ children Brothers/sisters (ages) _____

If your child is adopted, at what age did he/she join your family? _____

Has any family member been previously diagnosed with dyslexia, or learning disabilities/differences? Yes No
If yes, number of relatives _____

HEALTH INFORMATION

General health: check one Good Fair Poor

Please list any special health issues, including allergies _____

Does your child have a history of any of the following?

- | | | | |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> Constant colds | <input type="checkbox"/> Asthma | <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Dizziness/fainting spells | <input type="checkbox"/> Adenoids |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> Accidents/broken bones | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Abdominal pains | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Other | |

Is your child currently taking any medication? Yes No If yes, please list below:

Medication	Dosage	Times per day	Condition	Supervising Physician

BIRTH Premature Normal Late Complications, if any

CURRENT DEVELOPMENT

Name of child's pediatrician _____ Date of last physical exam _____

Address _____

Telephone _____

Date eyes last examined _____ By whom? _____ Vision problems _____ Glasses? Yes

Date hearing last examined _____ By whom? _____ Hearing difficulties _____ Hearing aid? Yes

Has your child had a neurological examination Yes If so, when? _____ Physician's name _____

Address _____

Telephone _____

SCHOOL HISTORY – PREVIOUS SCHOOLS YOUR CHILD HAS ATTENDED. (DO NOT LIST CURRENT SCHOOL HERE).

School	Address	Grades attended

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What are your child's strengths? _____

What has your child liked most in school? _____

What has your child disliked most in school? _____

When were you first aware of your child's learning disabilities? _____

Has your child been identified by a public school system as being learning disabled? _____

TESTING HISTORY/INTERVENTION

Date of most recent psychoeducational testing _____ Examiner _____

Date(s) of previous psychoeducational testing _____

Date of most recent speech/language evaluation _____ Examiner _____

Is your child currently receiving speech/language therapy? _____ If yes, please describe _____

Date of most recent occupational therapy evaluation _____ Examiner _____

Address

Telephone

Is your child currently receiving occupational therapy? _____ If yes, please describe _____

Has your child previously received instruction in any of the following:

Wilson Reading System Yes No

What step in the WRS program did your child achieve? _____

How many times a week was instruction given and for how long? _____

Lindamood-Bell instruction Yes No

How frequently was instruction delivered? _____

Instruction in any Orton-Gillingham based program? Yes No

RAVE-O Yes No

Math Yes No

Writing Yes No

Has your child ever received counseling? Yes No If yes, list:

Beginning Date	Ending Date	Frequency	Therapist	Address

Please list sports that your child most likes to take part in _____

Please list your child's favorite hobbies, activities and games, other than sports _____

Please list any organizations, clubs, teams or groups your child belongs to _____

Please list any part time jobs or chores your child has _____

Does your child play a musical instrument? _____

Does your child have difficulty in establishing and maintaining relationships? Yes No

Please describe _____

Please describe any concerns you may have about your child's social, emotional or behavioral functioning:

Please state briefly why you think the **Academy In Manayunk** might be a good school for your child:

Application completed and signed by _____
Parent or guardian Date

ATTACH

PHOTO

HERE

It will be helpful if you paper clip a small photograph of your child here.

Please write child's name on back of photo.

A one hundred dollar (\$100) processing and record review fee must be enclosed with this form. Please make check payable to The Academy in Manayunk*

The Admissions Committee will not process any application which fails to include copies of the most recent school reports, current intelligence evaluations and all assessments you have listed in the application. It is the parents' responsibility to secure copies of all reports and forward them to The Academy in Manayunk.

The Academy in Manayunk encourages applications from and admits students of any racial, ethnic, or religious background. Its programs and policies are applied with equal consideration to all of its applicants and students.

*Kindly note there is a \$35.00 fee for checks returned due to insufficient funds.