CENTER:	

ADMISSION APPLICATION

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Date	
Child's Name	🗖 Male 📮 Female
Date of Birth	Grade
Parent(s) Name	
Address	
City	State Zip
Telephone: Home ()	Work ()
Email	
Name of School	
Address	
City	State Zip
Telephone ()	Fax ()
Has child been evaluated? \Box Yes \Box No	If yes, please send copy of evaluation. \Box
Evaluator's Name	Telephone ()
Authorization to check reference: (Pa	arent's Signature)
Is there a history of learning problems in the	family?
If yes, what are they?	
Describe your child's learning problem(s)	
Does your child know the alphabet? (If 5 or	6 years old) □ Yes □ No
Can your child write his name?	es 🗖 No 💮 Handedness: 🗖 Left 🗖 Right
Does your child understand words? $\ \square$ Ye	es 🗆 No Questions? 🗀 Yes 🗀 No
	Directions? ☐ Yes ☐ No

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How well do other people understand your ch	nild's speech?
Do you know of any other problems, including	g medical? ☐ Yes ☐ No
If yes, what are they?	
Most recent eye exam date	Results
Hearing exam date	Results
Does your child have behavioral problems in	school? 🗖 Yes 📮 No
If yes, what are they?	
Is English the child's primary language?	/es □ No If no, what is?
Has your child applied to or received services	at any other Children's Dyslexia Center?
☐ Yes ☐ No If yes, Center(s)	Child's ID
How did you hear of us?	
Siblings/Ages	
Interests	
Deleges of Inform	mation for Doggovsh
	mation for Research
·	
	,
(Parent Signature)	 (Date)