Cornerstone
PREPARATORY SCHOOL FOR THERAPEUTIC EDUCATION

New Student Application

1. Application is to be completed by Parent or Guardian. (All information is confidential). Please send the applicant's current educational records, IEP, educational psychological evaluation, any recent therapy notes, etc to CPS prior to interview.
2. We would appreciate having test results or any information your physician and or specialists might wish to send us.
3. Please include a picture of your child with your application
4. Please include a copy of the front & back of your child's health insurance card
5. Both Parents/Guardians must sign the application.
6. A $150 non refundable deposit is required. Please make checks payable to Cornerstone Prep School.

APPLICANT INFORMATION

_____
Application Date

_____
Students Full Name

_____
Student Nickname

_____
Student Date of Birth

_____
Student Full Address (Street, City, State, Zip)

_____
County of Residence

_____
Student Home Phone Number

Student Gender
☐ Male
☐ Female

Student Race
☐ Asian
☐ Black/African American
☐ I Prefer Not To Answer
☐ More Than One Race
☐ White/Caucasian

_____
Primary Language Spoken at Home

Siblings? ☐ Yes ☐ No

SIBLING NAME	AGE	GRADE	SCHOOL

HOUSEHOLD INFORMATION

Home Address (Street, City, State, Zip)

First Parent/Guardian Full Name

Full Address (Street, City, State, Zip)

Email Address 1 (Required)

Email Address 2

Home Phone Number

Cell Phone Number

Gender? ☐ Male ☐ Female

Relationship to Applicant

Custodial Rights? ☐ Yes ☐ No
Financial Responsibility? ☐ Yes ☐ No
Receive Correspondence? ☐ Yes ☐ No

Marital Status ☐ Divorced ☐ Married ☐ ReMarried ☐ Separated ☐ Single ☐ Widowed

Occupation

Employer

Employer Address (Street, City, State, Zip)

HOUSEHOLD 2

Home Address (Street, City, State, Zip)

Second Parent/Guardian Full Name

Full Address (Street, City, State, Zip)

Email Address 1 (Required)

Email Address 2

Home Phone Number

Cell Phone Number

Gender? ☐ Male ☐ Female

Relationship to Applicant

Custodial Rights? ☐ Yes ☐ No
Financial Responsibility? ☐ Yes ☐ No
Receive Correspondence? ☐ Yes ☐ No

Marital Status ☐ Divorced ☐ Married ☐ ReMarried ☐ Separated ☐ Single ☐ Widowed

Occupation

Employer

Employer Address (Street, City, State, Zip)

PREVIOUS SCHOOLS

CURRENT SCHOOL

Most Recent School Attended

Most Recent School Attended Full Address (Street, City, State, Zip)

From Date - To Date

Teacher's Name

Grade

Have teachers noted any areas of difficulty? ☐ Yes ☐ No

If yes, please explain

Reason for leaving

PRIOR SCHOOL (1)

Prior School Attended

Full Address (Street, City, State, Zip)

From Date - To Date

Teacher's Name

Grade

Have teachers noted any areas of difficulty? ☐ Yes ☐ No

If yes, please explain

Reason for leaving

PRIOR SCHOOL (2)

_____

Prior School Attended (2)

_____

Full Address (Street, City, State, Zip)

_____

From Date - To Date

_____ _____

Teacher's Name Grade

Have teachers noted any areas of difficulty? ☐ Yes ☐ No

_____

If yes, please explain

_____

Reason for leaving

Has your child ever been subject to disciplinary action in any school? ☐ Yes ☐ No

If yes, please explain_____

At what age did your child start school? _____

Where? _____

Please list any academic area where your child was/is having issues:
☐ Math ☐ Reading ☐ Language Arts ☐ Spelling ☐ Handwriting

Additional Information

_____

_____

_____

_____

_____

_____

HEALTH HISTORY

MEDICATIONS:

MEDICATION	DOSE	HOW MANY TIMES A DAY?

Is your child on any medication or supplements that will need to be administered at school?

_____

_____

ALLERGIES (Please Note We Are NOT Nut-Free)

☐ Food ☐ Insects ☐ Medicine ☐ Seasonal/Environmental ☐ Other

_____

If any, please explain

_____

Anaphylactic? Please explain

_____

Please describe the reaction & the required treatment

_____

Does your child have any dietary restrictions?

IMMUNIZATION HISTORY

To the best of my knowledge my child is up to date on his/her immunizations? ☐ Yes ☐ No

If not, please explain and include signed and notarized GA vaccination exemption form.

HOSPITALIZATIONS

Has your child ever stayed overnight in a hospital? ☐ Yes ☐ No

If yes, please list reason(s) & dates

MEDICAL

Most recent exams (pediatrician, allergist, ENT, neurologist). Please describe.

When/where has his/her hearing been screened?

☐ Pass ☐ Fail

Any concerns?

When/where has his/her vision been screened?

☐ Pass ☐ Fail

Any concerns?

MEDICAL CHECKLIST
Please check any of the illnesses your child has had or is subject to having:

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Asthma
- ☐ Autism
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Congenital Defect
- ☐ Diabetes
- ☐ Diarrhea, Constipation
- ☐ Dizziness
- ☐ Dyslexia
- ☐ Recurrent Ear aches, Ear Infections
- ☐ Eczema, Rashes, Skin Issues
- ☐ Epilepsy
- ☐ Fainting
- ☐ Gastroesophageal reflux disease/Reflux
- ☐ German Measles
- ☐ Glasses, Contacts, or Protective Eyewear
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Congenital Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Immunodeficiency
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis
- ☐ Measles
- ☐ Mononucleosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Seizures
- ☐ Sensory Processing Disorder
- ☐ Sore Throat
- ☐ Speech Issues/Apraxia
- ☐ Toilet Trained
- ☐ Urinary Tract Infections
- ☐ Whooping Cough

Has your child had a communicable disease other than the communicable diseases listed above?
☐ Yes ☐ No

_____

If Yes, please explain

Are there any activities from which your child should be exempted or limited for health reasons?
☐ Yes ☐ No

_____

If Yes, please explain

HEALTH CARE PROVIDERS

Please list any professionals with whom we have permission to speak with prior to the evaluation for the purpose of receiving recent information.

I give my permission for Cornerstone Preparatory School For Therapeutic Education to speak with the below named professionals if needed during the admissions screening process.

Signature Date

*Please provide the name & contact information for any other relevant providers not listed

SPECIALTY	*NAME*	*PHONE NUMBER*
PEDIATRICIAN		
DENTIST		
PSYCHOLOGIST		
PSYCHIATRIST		

MEDICAL EMERGENCY CONTACTS & AUTHORIZED PICKUP

If there is a medical emergency and you or another parent/guardian cannot be reached, we will attempt to contact one of your Emergency Contacts.

Contact 1 Name & Relationship

Contact 1 Home Phone & Cell Phone

Contact 2 Name & Relationship

Contact 2 Home Phone & Cell Phone

Is There Anyone Who Should NOT Be Allowed To Pick Your Child Up?

EMERGENCY MEDICAL TREATMENT

Please carefully read and complete this page before signing this application.

_____

Students Full Name

Students Date of Birth_____/_____/_____ Students Age _____

Student's Physician_____

Physician Address_____

Physician Phone _____

As attested by our signature on this document, we agree that in the event of any situation (emergency, sickness, or accident) involving the student at a time and/or place that it is impractical to contact the parent, or for the parent to be present, the parent authorizes Cornerstone Preparatory School For Therapeutic Education to act in loco parentis (in place of parent) to provide whatever care, assistance, management or services the student may require. The parent agrees to pay for all expenses incurred in providing such needs of the student.

Additionally, I hereby give permission for the above-named student to receive routine or emergency medical treatment or care by Cornerstone Preparatory School For Therapeutic Education staff. In the event of a serious emergency, the student will be transported by medical professionals to a hospital emergency room. Routine medical treatment or care includes administering non-aspirin pain relievers and use of hydrogen peroxide/anti-bacterial agents on minor cuts and/or abrasions.

_____ _____

Signature of Parent or Guardian Date

Name of Insurance Company: _____

Insurance Policy Number:_____

IMPORTANT: If you do not give us permission for your child to receive routine or emergency medical treatment, please sign below and give us your reason.

_____ _____

Signature of Parent or Guardian Date

Reason:_____

BEHAVIORAL CHECKLIST

Please check any of the following behaviors your child exhibits. Please rate with the following scale:

0 = Never **1 = Sometimes** **2 = Often** **3 = Always**

BEHAVIOR	RATING	BEHAVIOR	RATING
Bullies/Threatens Others		Uses Bad Language	
Sensitive Hearing		Passive	
Touchy/Easily Annoyed		Fearful/Worrisome	
Compliant		Friendly/Caring	
Anxious		Self Abusive	
Easily Frustrated		Eager To Please	
Impulsive		Defiant	
Quiet/Shy		Manipulative	
Talkative		Transition Issues	
Crying Spells		Helpful	
Dishonest		Confident	
Can Work Independently		Easily Distracted	
Tics		Short Attention Span	
Hyperactive		Team Player	
Aggressive		Can't Sit Still/Fidgets	
Doesn't Like Authority		Control Issues	
Temper Tantrums		Screams	
Runs Away		Oblivious	
Likes To Work Alone		Flexible	
Disrespectful/Talks Back		Stimming Behaviors	
Perfectionist		Demonstrates Self Control	
Fearless		Is Physical With Others	

PRENATAL AND BIRTH HISTORY

During the pregnancy, did the mother experience any unusual illness, condition or accident, such as German measles, Rh incompatibility, false labor, etc? ☐ Yes ☐ No

_____

If yes, please describe.

_____

List medications taken by mother during pregnancy.

Were there any problems with delivery such as a breech birth, Cesarean, etc? ☐ Yes ☐ No

_____

If yes, please explain.

Length of pregnancy: _____

Child's birth weight: _____

Hospital name: _____

What were the conditions immediately following birth?

_____

Did the infant have trouble starting to breathe? ☐ Yes ☐ No

Did the infant have sucking/swallowing difficulty? ☐ Yes ☐ No

Was the birth weight re-gained quickly? ☐ Yes ☐ No

Did the infant have feeding problems? ☐ Yes ☐ No

Did the infant have other problems? ☐ Yes ☐ No

If yes, please explain._____

Was infant blue? ☐ Yes ☐ No

Did infant have seizures? ☐ Yes ☐ No

Did infant have scars/bruises? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

Approximate age when your child:

Pulled to standing position? _____

Walked without assistance? _____

Slept through the night? _____

Sat alone without support? _____

Began to crawl? _____

Fed self with spoon? _____

Toilet trained at what age? DAY _____ NIGHT_____

Could dress self (except for tying? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY CONT'D

Managed snaps? ☐ Yes ☐ No
Managed Zippers? ☐ Yes ☐ No
Managed Buttons? ☐ Yes ☐ No
Tie Shoes? ☐ Yes ☐ No
Draw shapes/write letters? ☐ Yes ☐ No
Skip? ☐ Yes ☐ No
Hop on one foot? ☐ Yes ☐ No
Cut with scissors? ☐ Yes ☐ No
Fall or lose balance easily? ☐ Yes ☐ No
Climb stairs using alternate feet? ☐ Yes ☐ No
Open doorknobs? ☐ Yes ☐ No
Climb on high play equipment? ☐ Yes ☐ No
Ride a bicycle? ☐ Yes ☐ No
Does your child have any difficulty tolerating?
Being held? ☐ Yes ☐ No
Having hair groomed? ☐ Yes ☐ No
Brushing teeth? ☐ Yes ☐ No
Loud Noises? ☐ Yes ☐ No
Certain specific noises? ☐ Yes ☐ No

THERAPEUTIC HISTORY

Please list any therapies your child has participated in:
☐ Speech ☐ OT ☐ Sensory Integration ☐ PT ☐ Vision Therapy ☐ Feeding Therapy

Other

Clinic or Practitioner	From/To	Reason Left

OCCUPATIONAL THERAPY CHECKLIST

Please check any of the following behaviors your child exhibits. Please rate with the following scale:

0 = Never **1 = Sometimes** **2 = Often** **3 = Always**

Does the child exhibit the following behaviors?	RATING	COMMENTS
Gross Motor Skills		
Seems weaker or tires more easily than other children his/her age.		
Difficulty with hopping, jumping, skipping or running compared to others his/her age.		
Appears stiff and awkward in movements.		
Clumsy or seems not to know how to move body/bumps into things.		
Tendency to confuse right and left body sides.		
Hesitates to climb or play on playground equipment.		
Reluctant to participate in sports or physical activity; prefers table activities.		
Seems to have difficulty learning new motor tasks.		
Difficulty pumping self on swing; poor skills in rhythmic clapping games.		
Fine Motor Skills		
Poor desk posture (slumps, leans on arm, head too close to work, other hand does not assist).		
Difficulty drawing, coloring, copying, cutting - avoidance of these activities.		
Poor pencil grasp; drops pencil frequently.		
Pencil lines are tight, wobbly, too faint or too dark; breaks pencil more often than usual.		
Tight pencil grasp; fatigues quickly in writing or other pencil and paper tasks.		
Hand dominance not well established (after age six).		
Difficulty in dressing; clothing off or on, buttons, zippers, tying bows or shoes.		

Touch		
Seems overly sensitive to being touched, pulls away from light touch.		
Has trouble keeping hands to self, will poke or push.		
Touches constantly; “learns” through his/her fingers.		
Has trouble controlling his interactions in group games such as tag, dodge ball.		
Avoids putting hands in messy substances (clay, finger paint, paste).		
Seeks out opportunities to get “messy”.		
Leaves clothes twisted on body.		
Is overly sensitive to certain fabrics (clothing, sheets).		
Seems to be unaware of being touched or bumped.		
Has trouble remaining in busy or group situations (e.g. cafeteria, circle time).		
Movement and Balance		
Fearful moving through space (teeter-totter, swing).		
Avoids activities that challenge balance; poor balance in motor activities.		
Seeks quantities of movement including swinging, spinning, bouncing and jumping.		
Difficulty or hesitance learning to climb or descend stairs.		
Seems to fall frequently.		
Gets nauseated or vomits from other movement experiences (e.g. swings, playground merry-go-rounds.)		
Appears to be in constant motion, unable to sit for an activity.		
Takes excessive risks during play (i.e., climbs high into a tree, jumps off tall furniture, etc).		
Dislikes activities where head is upside down or tilted backward.		
Tends to avoid sit-down, hand games (such as legos, puzzles, or board games).		

Visual Perception		
Difficulty naming or matching colors, shapes or sizes.		
Difficulty in completing puzzles; trial and error and placement of pieces.		
Reversals in words or letters after first grade.		
Difficulty coordinating eyes for following a moving object; keeping place in reading; copying from blackboard to desk.		
Auditory/Language		
Appears overly sensitive to loud noises (e.g. bells, toilet flush).		
Is hard to understand when he/she or he speaks.		
Appears to have difficulty in understanding or paying attention to what is said to him or her.		
Talking interferes with his/her listening.		
Appears to frequently make excessive noise.		
Easily distracted by sounds; seems to hear sounds that go unnoticed by others.		
Has trouble following 2-3 step commands.		
Taste/Smell		
Chews or puts in his/her mouth non food items		
Tastes or smells toys or other objects more than usual.		
Over sensitive to odors.		
Avoids certain tastes/smells that are typically part of children's diets.		
Oral Motor		
Expresses discomfort at dental work or tooth brushing.		
Limits self to particular food textures or temperatures.		
Picky eater.		
Gags easily or has a history of other feeding problems.		
Eats excessively neatly or messily for age.		

SPEECH AND ORAL MOTOR HISTORY

Did your child have any difficulty:

Nursing or taking a bottle? ☐ Yes ☐ No

Eating solid foods? ☐ Yes ☐ No

Transitioning to baby food? ☐ Yes ☐ No

Drinking with a straw? ☐ Yes ☐ No

Drinking from a cup? ☐ Yes ☐ No

With reflux? ☐ Yes ☐ No

Chewing, swallowing or clearing food from mouth? ☐ Yes ☐ No

Tolerating a variety of food textures and tastes? ☐ Yes ☐ No

Does your child:

Suck thumb, fingers or other objects such as clothing or blanket? ☐ Yes ☐ No

Chew on fingers, toys or blanket? ☐ Yes ☐ No

Drool? ☐ Yes ☐ No

Blow bubbles? ☐ Yes ☐ No

Click his/her tongue? ☐ Yes ☐ No

Make raspberry sounds? ☐ Yes ☐ No

At approximately what age did your child:

Say first word?_____

Make babbling sounds (like "gaga")?_____

Use 2-word phrases to communicate ("me go, mama eat")?_____

Can you understand everything your child says? ☐ Yes ☐ No

If no, please explain: _____

Can others understand everything your child says? ☐ Yes ☐ No

If no, please explain: _____

Does your child seem to have trouble understanding/following directions? ☐ Yes ☐ No

Does your child stutter (get stuck on words, repeat words, restart sentences)? ☐ Yes ☐ No

Is your child's voice:

Hoarse? ☐ Yes ☐ No

Too nasal? ☐ Yes ☐ No

Too soft or too loud? ☐ Yes ☐ No

High or low pitched? ☐ Yes ☐ No

Has your child had a speech examination prior to this time? ☐ Yes ☐ No

If so, when, where and with whom? _____

Describe how your child expresses his/her ideas:_____

Did speech and language development ever seem to stop for a period of time? ☐ Yes ☐ No

If so, did it correspond to any specific event (ear infections, stress, illness)? ☐ Yes ☐ No

SPEECH AND ORAL MOTOR HISTORY CONT'D

Has there been a change in your child's speech in the last six months? ☐ Yes ☐ No

If so, please explain: _____

Are there any instances of speech or hearing problems in the family (siblings, parents, grandparents)?

☐ Yes ☐ No

If so, please explain: _____

SOCIAL SKILLS CHECKLIST

Please check any of the following behaviors your child exhibits. Please rate with the following scale:

0 = Never **1 = Sometimes** **2 = Often** **3 = Always**

SOCIAL PLAY & EMOTIONAL DEVELOPMENT	RATING	COMMENTS
1.1 Beginning Play Behaviors		
Maintains proximity to peer within 1 foot.		
Observes peers in play vicinity within 3 feet.		
Parallel play near peers using the same or similar materials.		
Physically imitates peer.		
Verbally imitates peer.		
Takes turns appropriately during simple games.		
1.2 Intermediate Play Behaviors		
Shares toys and talks about the activity with peers, even if play agenda is different.		
Physically and verbally responds to interactions from peers (accepts toy, questions).		
Returns and initiates greetings with peers.		
Knows appropriate ways of joining in an activity with peers.		
Invites others to play.		
Takes turns during structured activities.		
Obeys game rules.		
Requests toys, food and materials from peers.		

1.3 Advanced Play Behavior		
Plays cooperatively with peers during imaginative play.		
Makes comments about what he/she is playing to peers.		
Organizes play (suggests ideas to peers on how to play).		
Follows peer play plans.		
Takes turns during unstructured activities without a time limit.		
Offers toys, food and materials to peers.		

EMOTIONAL REGULATION	**RATING**	**COMMENTS**
2.1 Understanding Emotions		
Identifies likes and dislikes.		
Identifies emotions in self.		
Identifies emotions in others.		
Justifies emotions once identified (eating because I'm hungry).		
Demonstrates affection and empathy towards peers.		
Refrains from aggressive behaviors towards peers.		
Refrains from aggressive behaviors toward self.		
Does not exhibit intense fears or phobias.		
Interprets body language.		
Uses different tone of voice to convey messages.		
2.2 Self-Regulation		
Allows others to comfort him/her if upset or agitated.		
Self regulates when tense or upset.		
Self regulates when energy is high.		
Deals with being teased in acceptable ways.		
Deals with being left out of a group.		
Accepts not being first in a game or activity.		
Accepts losing at a game without becoming upset/angry.		

Says “no” in acceptable way to things he/she does not want to do.		
Accepts being told “no” without becoming upset/angry.		
Able to say “I don’t know”.		
Able to end conversations appropriately.		
2.3 Flexibility		
Accepts making mistakes without being upset/angry.		
Accepts consequences of his/her behavior.		
Accepts unexpected changes.		
Continues to try when something is difficult.		
Ignores others or situations when it is desirable to do so.		
2.4 Problem Solving		
Identifies/defines problems.		
Generates solutions to problems.		
Carries out solutions by negotiating or compromising.		
Understands impact his/her behavior has on peers.		

COMMUNICATION SKILLS	**RATING**	**COMMENTS**
3.1 Conversational Skills		
Imitate conversation when it is appropriate to do so.		
Initiates conversation around specific topics.		
Asks “Wh” questions.		
Responds to “Wh” questions.		
Makes a variety of comments, related to the topic during conversation.		
Introduces him/herself to someone new.		
Introduces people to each other.		
Ends conversations appropriately.		

3.2 Nonverbal Conversational Skills		
Maintains appropriate proximity to conversational partner.		
Orients body toward speaker.		
Pays attention to person's nonverbal language; such as facial expressions and hand gestures. Understands what is communicated.		
Waits to interject.		
Maintains eye contact when speaking or being spoken to.		
Posture is erect.		
3***.3 Compliments***		
Gives appropriate compliments to peers.		
Appropriately receives compliments.		
Asks for a favor appropriately.		
Apologizes independently.		

PERSONAL AND FAMILY HISTORY

How does your child get along with other children in your family?

_____

How does your child get along with friends/playmates?

_____

What are your child's favorite activities?

_____

What type(s) of discipline work(s) best for your child?

_____

How long can your child attend to:

TV?_____

Listen to a story?_____

Occupy him/herself with toys?_____

How much screen time does your child receive each week?_____

Has your child been seen by a psychologist/social worker/psychiatrist for behavior management?

☐ Yes ☐ No

If yes, when and with whom did it occur? _____

SCHOOL HISTORY

How does your child get along with others at school? _____

What are the child's usual grades?_____

Does your child receive any supportive services (tutoring, occupational therapy, counseling, other)?

☐ Yes ☐ No

If yes, please describe. _____

Has your child received any previous psychoeducational evaluations, speech/language evaluations, or occupational therapy evaluations? ☐ Yes ☐ No

If yes, please attach a copy of the results with this application.

If there is any additional information that you feel will help us to understand your child and his/her problem better, please describe.

_____

_____

_____

_____

_____

_____

PARENT QUESTIONNAIRE

Why have you chosen to apply to Cornerstone Preparatory School For Therapeutic Education?

_____

_____

_____

_____

In your own words, describe as completely as possible the concerns you have in regard to your child._____

_____

_____

_____

When did you first become concerned with the problem?_____

_____

_____

_____

Please list any diagnosis(es) your child has._____

_____

_____

_____

Does your child have any behavioral issues? If so please describe._____

_____

_____

_____

What therapies or interventions have been the most beneficial to your child?_____

_____

_____

_____

What interventions have been tried at home and in school settings? How successful have they been? What worked and what didn't?_____

_____

_____

_____

How dedicated are you to helping your child be successful?_____

_____

_____

_____

Please describe your child's academic strengths and weaknesses. How does your child best learn (visually, hands on, sensorial approach, reduced language, etc?)_____

_____

_____

_____

What are your child's interests?_____

_____

_____

_____

What does your child like and/or not like about school? _____

_____

_____

_____

What are your expectations for your child at Cornerstone Preparatory School For Therapeutic Education? _____

_____

_____

_____

REQUEST FOR RELEASE OF SCHOOL INFORMATION

CORNERSTONE PREPARATORY SCHOOL FOR THERAPEUTIC EDUCATION
445 South Burgess Trail Milton GA 30004

Parents: Please fill out this top portion of this form and send it directly to the last school attended by your child. (Do not return this form to Cornerstone Preparatory School for Therapeutic Education).

To Be Completed By Parents:

CHILD:_____BIRTHDATE_____
SCHOOL: _____ DATE: _____ GRADE: _____

My child is applying for services at Cornerstone Preparatory School for Therapeutic Education. You have my permission to fill out the following questionnaire, send requested data, and speak with specific Cornerstone Preparatory School personnel.

_____
Parent/Guardian Signature

To Be Completed By Advisor and/or Principal and Teachers:
We are greatly assisted in evaluation and/or placement by comments and data from the child's school. Please help us by mailing to us as much of the following data as possible. We appreciate your time and effort in gathering materials and completing this form.
1. Previous educational test data (achievement tests, psychological evaluations, etc).
2. Grade Record
3. Individual Education Plan (if applicable).
4. Reports and/or comments of previous and present teachers.
5. Progress reports from special programs such as speech therapy, individual tutorial help.
6. Illustrative samples of work when pertinent.

Do you have concerns about this child? YES or NO

If so, what are your major concerns? _____
_____

What is your opinion of this child's self-esteem. _____
_____

Describe typical classroom behaviors: _____
_____

School: _____ Phone:_____

Address:_____

Date this questionnaire completed:_____

Signed:_____Title:_____

AGREEMENT

My signature below affirms that all of the information contained in this application is correct, complete and honestly presented. I understand that withholding or misrepresenting information in this application may jeopardize my child's admission. I agree to communicate in writing any changes to this application even if such changes occur after the student has been enrolled. I understand that upon discovery of any inaccuracy of information contained herein or omission of information requested herein, Cornerstone Preparatory School For Therapeutic Education reserves the right to revoke any admission to Cornerstone Preparatory School For Therapeutic Education. I understand that Cornerstone Preparatory School for Therapeutic Education is an LLC acting in a homeschool capacity and I will be required to sign an agreement to homeschool with Cornerstone Preparatory School for Therapeutic Education should my child be admitted. I also acknowledge that it is my responsibility to declare my intent to homeschool with the GaDOE and submit any testing required by the GaDOE.

_____ _____

Signature of First Parent or Guardian Date

_____ _____

Signature of Second Parent or Guardian Date