The Diener School

APPLICATION FOR ADMISSION

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11510 Falls Road

Potomac, MD 20854

www.thedienerschool.org

General Information

Name of Applicant: ____

Nickname: ____

Date of Birth: ______________________________ **Age:** __________________

General Admissions Policy

Thank you for taking the time to apply to The Diener School. The admissions process requires a great deal of open yet confidential communication between families, schools, professionals and Diener staff. In the interest of ensuring an optimal educational experience for our students, we require that all questions must be answered with complete honesty and all of the information required during the admissions process must be disclosed. This includes any significant change with the applicant's medical, social/emotional and/or educational status from the date your application is received until your child's first day of school at Diener. The Diener School reserves the right to deny admission or remove for expulsion if there are any material disclosures that were not made.

I have read the above admissions policy statement.

Print Name: ____

Signature: ______________________________ **Date:** __________________

School Information

Current School: ______________________________ Current Grade: ______________

Current School Address: ____

School Phone Number: ____________________**Dates of Attendance:** ______________

Homeroom Teachers name and contact information: ______________________________

____

Prior Schools: Please list all Schools/Date of Attendance/ Phone Numbers: ______________

____

____

Contact Information

Name of Parents: ____

Home Address: ____

Home Phone Number: ____

Cell Phone (M): ____________________ **Cell phone (F):** ____________________

Father's Occupation: ____________________ **Work Phone:** ____________________

Father's Employer: ____

Father's Email: ____

Mother's Occupation: ____________________**Work Phone:**____________________

Mother's Employer: ____

Mother's Email: ____

If applicable, please provide secondary residence with name of parent/guardian and contact info:

____

____

Please list the names and ages of all siblings that live in the home with the applicant as well as schools they presently attend:

____________________ ____________________

____________________ ____________________

____________________ ____________________

Therapeutic and Medical History

Does your child currently receive speech therapy? (please circle) **YES** **NO**

If yes, please provide the name, phone number and email of the current speech provider. Please indicate how long these services have been ongoing: ____

____

____

If yes, please list any speech diagnosis received: ____

____

Has your child received speech therapy in the past? (please circle) **YES** **NO**

If yes, please provide the name, phone number and email of the speech therapist. Please indicate when these services took place: ____

____

____

Does your child currently receive occupational therapy? (please circle) **YES** **NO**

If yes, please provide the name, phone number and email of the occupational therapist. Please indicate how long these services have been ongoing: ____

____

____

If yes, please list any OT diagnosis received: ____

____

Has your child received occupational therapy in the past? (please circle) **YES** **NO**

If yes, please provide the name, phone number and email of the occupational therapist. Please indicate when these services took place: ____

____

Is your child currently receiving or has received in the past any type of therapy that has not been mentioned above? (please circle) **YES** **NO**

If yes, please provide what type of therapy, dates of service as well as name and contact information for that provider(s): ____________________

____

____

Does your child currently see a mental health professional (including, but not limited to, a social worker, psychologist, psychiatrist)? (please circle) **YES** **NO**

If yes, please provide the name, phone number and email of the professional. Please indicate how long these services have been in place: ____________________

____

____

Has your child been seen by a mental health professional in the past? (please circle) **YES** **NO**

If yes, please provide the name, phone number and email of the professional who provided these services. Please indicate when these services took place: ____________________

____

____

Please list your child's pediatrician name and full contact information including address and phone number:

____

____

Were there any medical concerns at birth? ____________________

____

Was your child adopted? If so, from where?______________________________________

____

Have there been any hospitalization since birth?______________________________

____

____

Is your child under the care of a developmental pediatrician? **YES** **NO**

If so, please list that professional's name and contact information: ___________________

____

____

Is your child currently taking any medication? **YES** **NO**

If yes, for what condition? ____

If yes, please provide the type of medication, dosage, length of time on this medication and the name and contact information of the medicating doctor: ______________________________

____

____

Is your child currently under the care of a neurologist, psychologist, psychiatrist, neuropsychologist, behaviorial specialist? (or was in the care of such professional within the past 18 months): **YES** **NO**

If so, please list the doctors name, full contact information and length of time your child has been receiving services from this professional: ______________________________

____

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____

Has your child undergone an assessment by a neurologist, psychologist or psychiatrist?

____

____

If yes, please state the diagnosis received: ______________________________

____

____

If yes, please list the date of assessment as well as the full name contact information of the Doctor who completed this assessment: ______________________________

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Does your child have any medical diagnosis, health or allergy issues?

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When was your child's last vision exam and physician name?

___

___

Hearing exam and physician name?

___

___

Has your child undergone any type of educational testing within the past 2 years?

___

___

If yes, please indicate name and contact information of tester as well as date of evaluation: ___

___

___

Has your child received a diagnosis of some type as a result of any educational testing/neurological testing:

___

___

If yes, please describe who performed testing (including both names and contact information) concluded diagnosis and approximate date of diagnosis: ___

___

___

___

___

Please list any other therapeutic or medical resources your child maybe receiving or has previously received not already described above:

____

____

____

Please list any other professional your child currently sees or has been seen by over the past 18 months that was not listed in the previous questions. Please include their contact information, dates of service and type of service provided:

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____

____

____

____

Attention Challenges

Does your child have difficulty focusing on schoolwork?

____

____

Does your child sustain attention appropriate to his/her peer group?

____

____

____

____

Rate your attentional concerns: (1 very concerned, 2 somewhat concerned, 3 no attentional concerns).
Specify if necessary:

____

____

____

____

Does your child sustain attention appropriate to his/her peer group? ____________________

____

____

Social/Emotional

Please describe any social, emotional, and/or behavioral concerns that affect your child:

In school: ____

____

____

____

Outside of School: ____

____

____

____

Please describe your child's social/emotional strengths: ______________________

____

____

____

Is your child anxious or depressed? Please describe: ______________________________

____

____

____

What is your child's favorite family activity: ______________________________

____

____

Does your child take part in a social pragmatics group? If so with whom? ______________

____

____

____

Does your child have difficulty making friends? ______________________________

____

____

____

Does your child have trouble maintaining friendships? ______________________________

____

____

____

How would you rate their self-esteem? ______________________________

____

____

____

Does your child have meltdowns in school? ____

____

____

____

Does your child have meltdowns at home? ____

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____

____

Does your child seem generally happy? ____

____

____

____

Does your child enjoy play-dates? ____

____

____

____

How do you think his/her social skills compare to their peers/siblings? __________________

____

____

____

____

How does your child relate to adults? ______________________________

____

____

____

How does your child relate to peers? ______________________________

____

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____

In what way do you hope that the Diener School can help your child grow social/emotionally?

____

____

____

____

Sensory Checklist

Has your child ever been diagnosed or treated for sensory integration/sensory processing disorder? ______________________________

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Does your child have tactile defensiveness? ______________________________

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____

Does your child crave sensory input? ______________________________

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____

Does your child have any eating/feeding concerns? ______________________________

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____

Does your child crave movement? ______________________________

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Does your child shy away from loud noises, crowded rooms, etc.? ______________________________

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____

Please comment on your concerns regarding your child's sensory issues: ______________________________

____

____

____

____

Academic Questions

Does your child have a 504 Plan or IEP at their current school? **YES** **NO**

Does your child receive any types of services at school? **YES** **NO**

If yes, what type of services and list names and contact information of providers:

____

____

____

Has your child been subject to any type of disciplinary action at school? **YES** **NO**

If yes, please describe including dates:

____

____

____

Does your child like school? ____

____

What type of teacher does your child best relate to? ____

____

____

What is your child biggest challenge in school? ____

____

____

What is your child's greatest academic strength? ____

____

____

Was your child's entrance into kindergarten delayed? **YES** **NO**

If yes, please describe: ______________________________

____

____

General Questions

Does your child have any special interests?

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____

____

What is your child's area of strength?

____

____

____

____

____

What is your child's area of challenge?

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____

What organized activities (sports, clubs etc.) does your child participate in (both in school and outside of the school setting):

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____

____

What are your child's hobbies?

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____

What are your child's playtime activities?

____

____

What are your child's favorite TV shows/movie/books?

____

____

____

Does he /she get along with siblings?

____

____

Things child dislikes:

____

____

The Diener School

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Please make any other comments you feel would be helpful to us in knowing and working with your child. Feel free to attach a separate sheet for this answer.

____

____

____

____

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____

____

Please circle the words below that best describe your child:

❑ Happy	❑ Kind	❑ Sense of Humor	❑ Creative
❑ Compassionate	❑ Outgoing	❑ Anxious	❑ Shy
❑ Passive	❑ Organized	❑ Disorganized	❑ Introvert
❑ Calm	❑ Energetic	❑ Irritable	❑ Empathetic
❑ Curious	❑ Independent	❑ Social	❑ Imaginative
❑ Easily Frustrated	❑ Quirky	❑ Easily Distracted	❑ Sensitive to Noise
❑ Sensitive to Texture	❑ Under-reactive	❑ Physical	❑ Attention Seeking
❑ Impulsive	❑ Careless	❑ Sad	❑ Withdrawn
❑ Loses focus	❑ Obsessive	❑ Quiet	❑ Immature
❑ Bright	❑ Self Starter	❑ Loves school	❑ Hates school
❑ Plays alone	❑ Athletic	❑ Clumsy	❑ Self confidence