



APPLICATION FOR ADMISSION

Date _____

Name of Applicant _____ Name that child prefers to be called in school _____

Gender M F Date of Birth _____ Place of Birth _____ SSN# _____

Home Address _____

Applying for Grade _____ Present Grade _____ Present School _____ Phone # _____

Teacher's Name _____ May we contact them for additional information? Yes No

ADMISSIONS POLICY

The Lab School mission is to accept students who will benefit from our specifically designed program. The Lab School's programs and policies are applied with equal consideration to all of its applicants and students. Candidates are not discriminated against on the grounds of race, ethnicity, gender, religion, nationality, disability or any other status protected by law. The Lab School is not able to accommodate the needs of students with autism, Pervasive Developmental Disorder, or learning disabled students with secondary conduct disorders or severe psychiatric problems.

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

Parent/Guardian

Name _____ Age _____
 Street _____
 City, State, Zip Code _____
 Home Phone# _____ Cell Phone# _____ H
 E-mail _____
 Profession _____
 Place of Employment _____
 Address _____
 Work Phone# _____ Ext. _____
 Educational Background _____

Parent/Guardian

Name _____ Age _____
 Street _____
 City, State, Zip Code _____
 Home Phone# _____ Cell Phone# _____ H
 E-mail _____
 Profession _____
 Place of Employment _____
 Address _____
 Work Phone# _____ Ext. _____
 Educational Background _____

From what source(s) have you heard of The Lab School of Washington? _____

Name of person who knows the whole family and serve as a reference _____

Address _____ Phone# _____

FAMILY INFORMATION

In family, child is # _____ of _____ children

Brothers and sisters (ages) _____

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

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?

- Constant colds
- Headaches
- Bladder problems
- Abdominal pains
- Asthma
- Migraines
- Bedwetting
- Seizures
- Respiratory infections
- Dizziness/fainting spells
- Accidents/broken bones
- Ear infections
- Surgery
- Adenoids
- Other
- Tonsils

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

Medication	Dosage	Times per day	Condition	Supervising physician
1 _____	_____	_____	_____	_____
2 _____	_____	_____	_____	_____
3 _____	_____	_____	_____	_____

CURRENT DEVELOPMENT

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

Address _____ Phone # _____

Date eyes last examined _____ By whom? _____

Vision problems? Yes No Glasses? Yes No

Date hearing last examined _____ By whom? _____

Hearing difficulties? Yes No Hearing aid? Yes No

Has your child had a neurological examination? Yes No If so, when? _____ Physician's name _____

Address _____ Phone # _____

SCHOOL HISTORY (Previous schools your child has attended)

_____ School _____ Address _____ Grades attended _____

_____ School _____ Address _____ Grades attended _____

_____ School _____ Address _____ Grades attended _____

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

Date of most recent psychoeducational testing _____ Examiner _____

Address _____ Phone# _____

Date(s) of previous psychoeducational testing _____

Date of most recent speech/language evaluation _____ Examiner _____

Address _____ Phone# _____

Is your child currently receiving speech/language therapy? Yes No If yes, please describe _____

Date of most recent occupational therapy evaluation _____ Examiner _____

Address _____ Phone# _____

Is your child currently receiving occupational therapy? Yes No If yes, please describe _____

Is your child being tutored? Yes No If yes, by whom? _____ How often? _____

Subject area(s) _____

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

Beginning date	Ending date	Frequency	Therapist(s)	Address(es)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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? _____

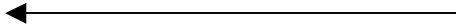
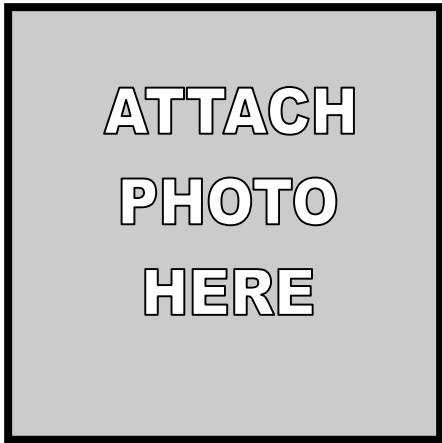
Does your child have difficulty in establishing and maintaining relationships? Yes No

If yes, please describe _____

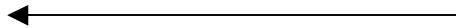
Please describe any concerns you may have about your child's social, emotional, or behavioral functioning:

Please state briefly why you think **The Lab School of Washington** might be a good school for your child

Application completed and signed by _____
Parent/Guardian Date



Please attach a small photograph
(staple or paper clip) 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 Lab School of Washington.

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 Lab School.

The Lab School of Washington 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.