



ST. JOSEPH SCHOOL
Living THE Truth IN Love



St. Joseph Preschool Educational Needs Form 2018-2019

To be completed by parent/guardian at time of registration

Please complete this two-sided form for *each child* attending St. Joseph Preschool for the 2018-2019 school year.

Student Name: _____ Date: _____

Session applying for: _____

Does your child require any special arrangements resulting from physical conditions such as visual impairments, hearing impairments, medical conditions (e.g., asthma, allergies, diabetes), or other physical disabilities?

- No, my child does not require any special arrangements.
- Yes, my child requires special arrangements.

Please describe the condition and the arrangements needed:

In order to understand and provide for your child's educational needs, we need to know if your child has ever been evaluated for learning difficulties or concerns in the areas of behavior, attention, or social/emotional issues. This evaluation may have been provided by a public school district, a private agency, or a private practice professional.

- No, my child has never been evaluated.
- Yes, my child has been evaluated.

If yes, please provide the following information:

Name of evaluating agency or professional

_____ Date of evaluation: _____

The evaluation determined my child has:

- a learning disability in _____ (specify the area) an emotional disorder
- a speech impairment anxiety
- a language impairment sensory processing disorder
- attention deficit/hyperactivity disorder Autism spectrum disorder
- other (please describe) _____

We require a copy of the evaluation report that includes the existing diagnosis, as well as a current IEP if possible. Please provide those reports with this form, as a decision about acceptance cannot be made without them.

Does your child receive services from the public school district as a result of the evaluation described above?

- No, my child has never received services.
- Yes, my child receives services at a public school, and will continue to do so as a student at St. Joseph.

If yes, please check the school where your child will be receiving services and list a contact person/phone number

- | | |
|--|-----------------------------|
| <input type="checkbox"/> Castlio Elementary | Contact person/number _____ |
| <input type="checkbox"/> Independence Elementary | Contact person/number _____ |
| <input type="checkbox"/> John Weldon Elementary | Contact person/number _____ |
| <input type="checkbox"/> Central Elementary | Contact person/number _____ |
| <input type="checkbox"/> Warren Elementary | Contact person/number _____ |
| <input type="checkbox"/> Other _____ | Contact person/number _____ |

Days/times of services: _____

If services are provided during our school day, please provide the following information:

Time picked up from St. Joseph Preschool _____

Person(s) picking up _____

Is your child currently on any medication that may impact their performance in the school setting?

- Yes
- No

If yes, please provide the following information:

Name of medication(s)

_____	prescribed for _____
_____	prescribed for _____
_____	prescribed for _____