



Student Application – Fall 2009

Charles Armstrong School, Belmont, CA

Student Information

Last Name: _____ First Name: _____ MI: _____ Gender: M ___ F ___

Street Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: ____ / ____ / ____ City / Country of Birth: _____ U.S. Citizen: Yes ___ No ___

Primary language spoken at home: _____ Ethnicity: _____ Adopted: Yes ___ No ___ Does child know: Yes ___ No ___

Current Grade: _____ School Year: _____ Grade (s) Repeated: _____

Present School: _____ City / State: _____ Public: ___ Private: ___

Name (s) and age (s) of siblings: _____

Does child live with both parents: Yes ___ No ___ If no, please indicate who child lives with _____

Parent Information

Title: ___ Last Name: _____ First Name: _____ MI: _____

Mailing Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Day Phone: (_____) _____ Cell Phone: (_____) _____

Employer: _____ Position: _____ E-Mail: _____

Parent Information

Title: ___ Last Name: _____ First Name: _____ MI: _____

Mailing Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Day Phone: (_____) _____ Cell Phone: (_____) _____

Employer: _____ Position: _____ E-Mail: _____

Step Parent / Guardian Information (please circle)

Spouse of:

Title: ___ Last Name: _____ First Name: _____ MI: _____

Mailing Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Day Phone: (_____) _____ Cell Phone: (_____) _____

Employer: _____ Position: _____ E-Mail: _____

Step Parent / Guardian Information (please circle)

Spouse of:

Title: ___ Last Name: _____ First Name: _____ MI: _____

Mailing Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Day Phone: (_____) _____ Cell Phone: (_____) _____

Employer: _____ Position: _____ E-Mail: _____

Student Background Information

1. Has your child ever received or been evaluated for pharmaceutical therapy for: Attention Deficit Disorder (ADD): _____ or Hyperactivity (ADHD): _____
 Currently: _____ Type of therapy: _____ Pharmacological Intervention: Type: _____ Dosage: _____
2. Does your child receive treatment for allergies: _____ Type of Allergies: _____
3. Please list any outstanding medical conditions that warrant our attention (i.e. allergies, diabetes, asthma, epilepsy): _____

4. Does your child currently receive special education services? _____ Description: _____
5. Does your child have a current Individual Education Plan? _____ District of IEP: _____ Triennial Due: _____
6. Has your child received any of the following?

Type	Date Rec'd From – To-	Name of Clinician/Therapist, etc.	How frequently?
Lindamood Bell			
Slingerland			
Fast ForWord			
Speech and Language			
Bright Stars			
Occupational Therapy			
Psychological Counseling			
Private Tutoring			
Auditory Integration Training (AIT)			
Vision Therapy			
Other			

7. How did you hear about CAS?

<p>Please indicate your interest for enrollment:</p> <p style="text-align: center;">_____ Fall Enrollment (Includes Summer School and Camp)</p> <p style="text-align: center;"><i>2009 Summer Registrations available in the spring at</i></p> <p style="text-align: center;"><i>charlesarmstrong.org</i></p>	<p>Please attach a current photograph of your child:</p> <div style="border: 1px dashed black; width: 150px; height: 100px; margin: 20px auto;"></div>
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Parent's Signature

Date

Parent's Signature

Date