

GATELY ACADEMY

205 NE 50th
Portland, Oregon 97213
503-215-2672
Fax 503-215-2688

FAMILY ADMISSION APPLICATION

Name of Student _____

Last First Middle

Address _____

Street City State ZIP

Phone _____ Social Security Number _____

Nickname _____ Birthdate _____ Age _____ Sex _____

Most Recent School Attended _____ Grade _____

Applying for School Year/Grade _____

Full Name and Address of Parent(s) or Guardian(s):

Last First Middle Relationship to Child

Street City State ZIP Phone

Last First Middle Relationship to Child

Street City State ZIP Phone

E-mail address

Father/Guardian: Occupation _____ Education _____

Employer _____

Name Address Phone

Mother/Guardian: Occupation _____ Education _____

Employer _____

Name Address Phone

If parents are divorced, with whom does this child live? _____

Who guarantees payment of expenses? _____

**Note—If you intend to ask your school district to pay to send your child to Gately Academy, either now or in the future, please contact them before proceeding with your application.*

Any school district placements must be initiated by the school district.

Give names and ages of all children in the family, beginning with the oldest:

Please indicate who supervises your child/children (name, address, phone number):

Before school _____

After school _____

Evenings/Nights _____

Student is: (circle one) Natural Adopted Foster

If adopted, at what age? _____ Does student know s/he is adopted? _____

How was s/he told, and what was the reaction?

What schools has your child attended? Please list, beginning with the present school.

(Continue on back if necessary)

School	Grade	Special Placement
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Has your child ever repeated a grade? _____ If so, which one(s)? _____

If your child has Attention Deficit problems, at what age did you first notice them? _____

At what age was your child first diagnosed as having ADD? _____

By whom? _____

What specific educational concerns are you seeking help with? When did the educational problems begin?

Please describe things you have tried to do to help.

Does your child have any social skills or behavioral concerns that you think s/he needs help with?

If yes, please specifically describe your concern(s), when they began, and things you have tried to do to help.

Does your child have any problems with the following?

	In the past	In the present	Describe
Academic achievement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discouraged about learning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavior in school	<input type="checkbox"/>	<input type="checkbox"/>	_____
Disorganization	<input type="checkbox"/>	<input type="checkbox"/>	_____
Timely completion of work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Power struggles with parents	<input type="checkbox"/>	<input type="checkbox"/>	
Irritating/disruptive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	
Excessively agitated behaviors	<input type="checkbox"/>	<input type="checkbox"/>	
Impulsive behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Teased by others	<input type="checkbox"/>	<input type="checkbox"/>	
Trying to control others	<input type="checkbox"/>	<input type="checkbox"/>	
Most friends younger	<input type="checkbox"/>	<input type="checkbox"/>	
Most friends older	<input type="checkbox"/>	<input type="checkbox"/>	
Often loses friends	<input type="checkbox"/>	<input type="checkbox"/>	
Uses rude/offensive language	<input type="checkbox"/>	<input type="checkbox"/>	
Bullying and/or aggressive posturing	<input type="checkbox"/>	<input type="checkbox"/>	
Avoids taking ownership/responsibility for negative behaviors	<input type="checkbox"/>	<input type="checkbox"/>	
Destroys property	<input type="checkbox"/>	<input type="checkbox"/>	

What kinds of things does your child like to do?

Does your child participate in after-school sports, activities, special interest lessons? _____

If yes, please list:

What are your child's strengths/assets?

What are your ideas about the ideal classroom for your child?

Please write a paragraph indicating why you want your child to attend Gately Academy, and your hopes/goals for him/her:

Previous Evaluations and Special Academic and/or Counseling Help:

Has your child ever had a psychiatric evaluation? _____

If yes, list name, address and phone number and **include a copy of the report**, or have one sent to us.

Name	Address	Phone
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Has your child ever been given a psychological evaluation? _____

If yes, list name, address and phone number of school/private psychologist who administered the testing and **include a copy of the report**, or have one sent to us.

Name	Address	Phone
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Has your child ever had counseling and/or extra academic help (including school programs, tutoring, etc)? _____ If yes, please list.

Type of help	By whom (person/agency)	When
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Are you presently in contact with **any** helping professionals? _____ If yes, please list.

Name	Address	Phone
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Name	Address	Phone
------	---------	-------

How would you evaluate your child's general health status? (circle one) Good Fair Poor

List any current physical disabilities or medical problems.

Please check those items that seem to be a problem for your child:

- | | |
|--|---|
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Weight loss or gain (circle one) |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Muscular weakness |
| <input type="checkbox"/> Hard of hearing | <input type="checkbox"/> Excessive clumsiness |
| <input type="checkbox"/> Persistent headaches | <input type="checkbox"/> Poor coordination |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Frequent complaints of illness |
| <input type="checkbox"/> Frequent colds | |

List any current medications, medical treatments, special diets, therapy, restrictions, or aids to physical functioning, and name of the prescribing physician or other health professional.

Has your child had all the immunizations required by the Oregon Dept. of Education? _____

Do you have a record of your child's immunizations? _____

What physical or emotional traumatic events might have upset your child and at what age (car accident, divorce, death of parent or sibling, etc.)? Please describe:

Is your child presently under the care of a doctor and/or dentist? _____

If yes, please give name, address and phone number of each.

_____	_____	_____
Name	Address	Phone

_____	_____	_____
Name	Address	Phone

Has your child had a recent physical and/or dental exam? _____ Date _____

Does your child have any allergies? _____

If yes, please describe what they are, and any treatment or medication prescribed:

Please list any *significant* childhood illnesses or diseases your child has had, and at what age.

Were there complications (high fever, convulsions, coma, etc.)? _____

If yes, please describe.

Are there any unusual family stressors at this time? _____

If yes, please explain.

Is there anything else you feel we need to know about your child or the family in order to be most helpful to your child?

Do you have any concerns about sending your child to Gately?

Who referred you to our program? _____

Signature of person completing application _____

Print Name

Date

Relationship to child