Full-Time Academy
New Student Application

St. Lillian
ACADEMY

A Christian School for Children who have Communication and Learning Challenges

esp pediatric therapy services

St. Lillian Academy's therapy services partner,
excellence in speech pathology LLC

www.STLILLIAN.ORG

BATON ROUGE , LOUISIANA

NOTICE OF NONDISCRIMINATORY POLICY AS TO STUDENTS

St. Lillian Academy admits students of any race, color, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to the students at the school. It does not discriminate on the basis of race, color, national and ethnic origin in administration of its educational policies, admissions policies, and athletic and other school-administered programs.

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ST. LILLIAN ACADEMY MISSION AND VISION

TARGET POPULATION FOR FULL-TIME ACADEMY STUDENTS

Children with:

- Language Delays and/or Communication Disorders and other learning challenges
- Capacity to learn within our group setting
- Natural desire to interact with peers

The vision of St. Lillian Academy is to expand each year to accommodate our older student. Students will not "age out" of St. Lillian Academy if we are deemed the most appropriate placement by their evaluation team.

St. Lillian Academy enrolls students on a case-by-case basis using a multidisciplinary assessment team to determine appropriate placement.

WHAT MAKES ST. LILLIAN ACADEMY UNIQUE?

- Taking a holistic approach individualized for each child
- Providing all academic and therapeutic support services under one roof
- Integrating all of the child's needs into one seamless plan, creating an environment that will maximize achievement and active participation
- Small student/teacher ratios

SLA offers academic excellence allowing our children to reach their maximum learning potential with support from our multidisciplinary team of therapists and special education teachers.

MISSION

St. Lillian Academy educates children who have exceptionalities through the use of a unique team-method of teaching in an integrated, holistic environment involving teachers and therapists.

We achieve a high standard of excellence in the areas of curriculum design, instruction, and therapeutic support based primarily on the individualized needs, differences and learning abilities of each child.

Our innovative approach to learning encourages dignity, acceptance, trust, and love while preparing our students for a productive and interactive life.

VISION

St. Lillian Academy, a Christian school, exists to offer students with exceptionalities the opportunity to maximize their potential, lead rewarding and fulfilling lives, and to be independent, active members of our community.

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This form is being completed by	(relationship to child)	Today's date
CHILD'S FULL NAME	Sex	
Date of Birth	Place of Birth	

Child's Diagnosis

If not specified, please describe primary concern

Primary Language spoken at home(list if any additional)

MOTHER'S NAME	Birth date:

Address

Primary phone number	Secondary phone number

Other contact numbers (specify)

Email

Occupation

Business name/Address

FATHER'S NAME	Birth date:

Address

Primary phone number	Secondary phone number

Other contact numbers (specify)

Email Address

Occupation

Business name/Address

Parents are- Married ○ Separated ○ Divorced ○ Widowed ○ Single ○

List other members of the family living in the same house as the child and each member's relationship to the child

Name	Relationship	Age

Name of insurance carrier

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CHILDHOOD TO PRESENT **NOTE: use back of page if needed**

(a) COMMUNICATION

1. Describe your child's ability to speak, and/or other means of communication

2. What other means are used (sign, gesture, assistive device)?

3. Have you tried any assistive device or supportive communication, but discontinued? yes ◯ no ◯

4. Do people outside of your family have difficulty understanding your child's speech? yes ◯ no ◯

5. Can your child answer questions? yes ◯ no ◯

(b) BEHAVIOR

1. Has your child received special behavioral treatment or therapy? ◯ yes ◯ no If yes, give details below:

Dates Location Service/Program

Advice given to you, and your comments

2. Describe any self-stimulatory behaviors and/or aggressive behaviors, such as rocking, head banging, and/or verbal or physical aggression, etc.

3. Describe any behavior issues, e.g. running away, stealing, bad habits, obsessions and/or compulsions, destructiveness, self-abusive, inappropriate sexual behavior, aggression (verbally/physically, etc.)?

4. When does the inappropriate behavior(s) usually occur (what conditions/situations)?

5. What do you do to discipline your child?

6. How does she/he react to discipline?

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CHILDHOOD TO PRESENT (b) BEHAVIOR

7. Does your child have a "behavior plan?" If so, are you willing to work with the school staff to review and modify if necessary?

8. Describe your child's self care and toileting habits (teeth brushing, washing, toilet trained, etc.)

9. How many hours per day does your child watch TV, movies, or play computer/video games? Please specify.

(c) EATING HABITS

1. Describe eating habits (use of utensils, how your child relates to food/meal times)

2. What does your child usually eat for:

Breakfast

Lunch

Supper

Snacks

How many snacks a day?

3. Is your child on a special diet? Needs? What is the reason for the special diet. Give details.

(d) SLEEPING HABITS

1. Describe sleeping habits (bedtime, how long, how deeply).

2. What does your child do if your child awakens in the night (cry, make noise(s), wander, etc.)?

3. Does your child sleep in your child own bed?

4. Can your child fall asleep by him/herself?

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CHILDHOOD TO PRESENT (e) MEDICAL INFORMATION

1. Please list all current physicians

Name of Physician	Area of Practice	Location	Phone

2. Please indicate if your child has been evaluated or received the following, if yes when and where, and therapist's name

	Dates	Location	Therapist
Speech therapy			
Occupational therapy			
Physical therapy			
Nutritionist			
Other			

3. Has your child's hearing been tested? If yes, when | | where

Any concerns

4. Has your child's vision been tested? If yes, when | | where

Any concerns

5. What illnesses or childhood diseases has your child had, and at what age?

6. Describe any falls or accidents and at what age.

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V. CHILDHOOD TO PRESENT (e) MEDICAL INFORMATION

7. Has your child had any seizures? If so, describe type, duration, and frequency. Do they recur at particular times?

8. Does your child have any allergies or sensitivities?

9. Has your child had any surgeries? If yes, please explain

10. ALL CURRENT MEDICATIONS AND PURPOSES (SEIZURES, ANXIETY, BEHAVIOR, ETC.), DOSAGES AND WHEN STARTED (APPROXIMATELY).

Drug	Dosage	Date Started
Purpose		
Drug	Dosage	Date Started
Purpose		
Drug	Dosage	Date Started
Purpose		

11. LIST ALL PREVIOUS MEDICATIONS AND PURPOSES (SEIZURES, ANXIETY, BEHAVIOR, ETC.), DOSAGES AND WHEN STARTED AND STOPPED (APPROXIMATELY).

Drug	Dosage	Date Started	Stopped
Why was it discontinued?			
Drug	Dosage	Date Started	Stopped
Why was it discontinued?			

12. Has your child been prescribed or given any unconventional treatments—special diets, supplements, vitamins, homeopathy, etc.?

Have they been effective?

13. Has your child had any hospitalizations? yes ◯ no ◯ If yes, date(s) and reasons for admission:

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CHILDHOOD TO PRESENT (f) SOCIAL

1. How would you describe the child as a person?

Strengths and Needs

2. What does your child like to do? (hobbies/interests)

3. What kinds of things scare or worry your child?

4. What are some of the things your child does which please you or make you proud?

5. Put a check on any of the following things which concern you about the child.

- ○ 1. Bed wetting
- ○ 2. Wetting during the day
- ○ 3. Thumb sucking
- ○ 4. Stammering or stuttering
- ○ 5. High strung or easily upset
- ○ 6. Too restless
- ○ 7. Shy
- ○ 8. Sad or sulky
- ○ 9. Feelings easily hurt
- ○ 10. Wanting too much attention
- ○ 11. Wanting too much comfort/ support from parent
- ○ 12. Day dreaming
- ○ 13. Sleep issues
- ○ 14. Nightmares
- ○ 15. Temper Tantrums
- ○ 16. Contrary or stubborn
- ○ 17. Disobedient
- ○ 18. Lying
- ○ 19. Selfish in sharing
- ○ 20. Jealous of brothers & sisters
- ○ 21. Fighting with other children
- ○ 22. Purposely destroys things
- ○ 23. Feeding
- ○ 24. Toilet issues
- ○ 25. Any other problems? Or comments:

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CHILDHOOD TO PRESENT (continued) (f) SOCIAL

If needed, elaborate further on behaviors that concern you about your child:

6. How does your child get along with mother, father, and other children/family members? Does your child show normal affection?

7. Who looks after the child most of the time?

Day? Night?

8. Please describe any other incidents or facts which might help understand your child's difficulties which might help us understand.

9. Does your child enjoy interaction with peers? (other than family members)

10. Does your child engage in conversation/seek interaction with peers?

11. Does your child prefer to interact with adults?

(f) MOTOR SKILLS

1. Does your child sit in a chair without needing support or a lap belt?

2. Does your child walk independently?

3. Does your child use adapted equipment?

walker ◯ wheelchair ◯ orthotics ◯ standing frame ◯ other ◯

4. Can your child hold a crayon or pencil? yes ◯ no ◯

5. Does your child like to color, paint or draw? yes ◯ no ◯

6. Can your child isolate keys on a computer keyboard? yes ◯ no ◯

7. Can your child hold eating utensils? yes ◯ no ◯

(g) SELF HELP/INDEPENDENCE

1. Is your child toilet trained? yes ◯ no ◯

2. Does your child dress independently? yes ◯ no ◯

3. Does your child feed him/herself? yes ◯ no ◯

4. Does your child help with household chores? yes ◯ no ◯

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CHILDHOOD TO PRESENT (h) EDUCATION | **CURRENT School** grade

1. Why are you considering St.Lillian Academy for your child at this time?

2. Are you presently considering any other school(s)?

3. What is the current ratio of staff/child at your child's current/previous school?

4. Has your child used a classroom aide? yes ◯ no ◯ If yes, was it a positive experience?

5. How does your child relate to going to school?

6. Describe your child's academic abilities.

7. What does you child like best about school?

8. What does your child like least about school?

9. Has your child undergone any intelligence tests? yes ◯ no ◯

If yes, when and where was your child tested?

Result of Test (IQ)

10. Has your child had any private tutoring? yes ◯ no ◯ When Where

Reason for tutoring

11. Has your child had any other academic testing? yes ◯ no ◯

12. If any unusual progress or regression took place during school attendance and/or transitions, please describe.

13. St. Lillian Academy will offer a full educational program and therapeutic services. If your child is accepted, would you plan to continue or seek therapy services through another provider? If so, please explain/describe.

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CHILDHOOD TO PRESENT (h) EDUCATION

Please list school/daycare history

Name of Facility	Dates Enrolled.	Reason for leaving

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CONCLUSION

Do you know of others who might wish to receive information about St. Lillian Academy?

If so, please list there names below and direct them to our website to access this application.

Name/Address

Relationship to you

Name/Address

Relationship to you

Name/Address

Relationship to you

Please return the application and intake fee of $50 to: (Checks made payable to St. Lillian Academy)

St.Lillian Academy
Elissa McKenzie, Head of School
8130 Kelwood Avenue
Baton Rouge, LA 70806

www.StLillian.org

Parent/Guardian Signature | DATE

Thank you.