STEPPING STONES
EDUCATIONAL THERAPY CENTER
EST. 1990

Phone: 770-229-5511
Fax: 770-233-0995
Email: info@steppingstonesschool.org

PRESCHOOL NEW STUDENT APPLICATION

Date of Application: _____ Social Security Number: _____

Name of Applicant: _____
(Last) (First) (Middle) (Preferred)

Date of Birth: _____ Current Age: _____

Gender: _____ Ethnicity: _____

Child's Primary Language: _____ Is student Hispanic/Latino? YES NO

Current Class: _____

Has the applicant been diagnosed with a learning difference or impairment? _____

If yes, BRIEFLY please list diagnosis(es): _____

_____

Application Checklist

Please remit all requested items with the application form

_____ Application form **completed in full** _____ Recent picture of child _____ Immunization Records

_____ Copy of Insurance Card _____ Birth Certificate _____ Social Security Card

_____ **Application fee:** $150 for new students, $50 for each additional student in one family

If Applicable:

_____ School Transcripts _____ Most Recent Behavioral Assessment _____ Current IEP

_____ Records Release Authorization Form _____ Copy of Psychological, Neurological, Speech, and Language Reports

_____ Current Feeding Plans, Medical Plans, Seizure Plans ____ Copy of Form 3300 (Ear, Eye and Dental)

_____ Two recommendation forms from previous schools/institutions

Household Information

Parent/Guardian:

Full Name: _____

Relationship to Student: _____

Address: _____

_____

Cell Phone: _____

Email: _____

Occupation: _____

Employer: _____

Employer Address: _____

_____

Employer Phone: _____

Parent/Guardian:

Full Name: _____

Relationship to Student: _____

Address: _____

_____

Cell Phone: _____

Email: _____

Occupation: _____

Employer: _____

Employer Address: _____

_____

Employer Phone: _____

Student resides with (please circle all that apply): Mother Father Guardian Grandparent Stepparent

Name and ages of siblings, if applicable: _____

_____

Emergency Contact, other than custodial guardian/parent: _____

Cell Phone: _____ Email: _____

Address: _____

_____

Optional Additional Emergency Contact, other than custodial guardian/parent: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Address: _____

_____

Optional Additional Emergency Contact, other than custodial guardian/parent: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Address: _____

_____

Optional Additional Emergency Contact, other than custodial guardian/parent: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Address: _____

_____

In the event of an emergency, I give Stepping Stones Educational Therapy Center permission to share the applicant's information with the aforementioned person(s) listed under parent/guardian and emergency contact.

*Signature:*_____ *Date:* _____

Authorized Pick Up

In addition to parents/guardians, please list all people who are authorized to pick up student(s). Please note that the school reserves the right to confirm the identity of authorized persons by requesting photo identification at the time of pick up.

Name: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Name: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Name: _____

Relationship to Applicant: _____

Cell Phone: _____ Email: _____

Photo Release Consent

Use of Photographs – **Please select ONE:**

☐ I give consent to the use, publication, and copyright by Stepping Stones Educational Therapy Center in school publications, website, school and classroom social media platforms, and other promotional materials, artwork, written work, videos or photographs in which the above student may appear in any programs or activities of Stepping Stones Educational Therapy Center. This consent includes the use of photographs of student(s) in the local newspaper, and authorizes the student 's name to appear in the paper with press releases of activities at Stepping Stones Educational Therapy Center. The foregoing consent shall extend beyond the student's enrollment and shall survive the termination of this contract.

☐ I **DO NOT** give consent to the use, publication, and copyright by Stepping Stones Educational Therapy Center in any school publications, website, school and social media platforms, and other promotional materials, artwork, written work, videos or photographs in which the above student may appear in any programs or activities of Stepping Stones Educational Therapy Center. The foregoing consent shall extend beyond the student's enrollment and shall survive the termination of this contract.

*Signature:*_____ *Date:* _____

Medical History and Information

Name of Pediatrician: _____ Phone Number: _____

Address: _____

Student Insurance Company: _____ Phone Number: _____

Policy Number: _____ Group Number: _____

Does student have any medical conditions? YES NO

If yes, please list: _____

_____

_____

Please list all medications:
Medication #1: _____ Dosage: _____

Frequency: _____ Subscribing Physician: _____

Medication #2: _____ Dosage: _____

Frequency: _____ Subscribing Physician: _____

Medication #3: _____ Dosage: _____

Frequency: _____ Subscribing Physician: _____

Medication #4: _____ Dosage: _____

Frequency: _____ Subscribing Physician: _____

Medication #5: _____ Dosage: _____

Frequency: _____ Subscribing Physician: _____

Permission for Nurse to Administer Over-the-Counter medications as needed (dosage will be administered based on child's weight and age):

☐ Tylenol/Acetaminophen ☐ Advil/Ibuprofen

☐ Tums ☐ Cough Drops

Please list any allergies:

_____

_____

_____

Has your child been seen by an Occupational, Speech/Language, Physical, or ABA Therapist(s): YES NO
If yes, please list the name of therapist, type of therapy, and phone number of provider:

_____

_____

_____

Medical Authorization and Parental Consent: In the event the above named child becomes ill or sustains injury while at school or any other school related trip or event at Stepping Stones Educational Therapy Center, I, the undersigned, give my permission to those in charge to take whatever steps are necessary to stop any bleeding and to administer first aid. I also consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the above-named minor under the general or special supervision and on the advice of any duly licensed physician, surgeon, and/or dentist, whether such diagnosis or treatment is rendered at the office of said physician, surgeon, or dentist or at a licensed hospital. The undersigned shall be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization. Should it be necessary for the aforementioned child to return home due to medical reasons, behavioral problems or otherwise, the undersigned agrees to assume all transportation costs. The undersigned does also, hereby, give permission for the above named child to ride in any vehicle designated by the adult in whose care the minor has been entrusted, provided the child is in a safety belt and, if available, a shoulder strap while attending and participating in the activities sponsored by Stepping Stones Educational Therapy Center.

*Signature:*_____ *Date:*_____

Parent/Student Handbook Acknowledgement

I acknowledge that Student/Parent Handbook has been made available to me on the school website (www.steppingstonesschool.org) and in paper format: I will review it with my student.

*Signature:*_____ *Date:*_____

Acknowledgement of School Operating Hours

I acknowledge that Stepping Stones Educational Therapy Center school hours are 8:05 am to 3:05 pm, Monday through Friday, as indicated by the school calendar. Before and after care is available to me as needed.

*Signature:*_____ *Date:*_____

Notice of Nondiscrimination Policy

Stepping Stones Educational Therapy Center admits students of any race, color, national or ethnic origin, to all rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate based on color, race, national or ethnic origin in the administration of its educational policies, admission policies, athletics and other school-administered programs.

Tuition and Fees:

Note: All families are eligible to apply for financial assistance.

Preschool: $7,700, to be paid in full or in ten installments. Tuition is due on the first of the month beginning in August and ending in May.

Afterschool Fees: Afterschool is billed as needed at a flat rate of $50 per week, per child.

Meals: Meals are $50 per month: this includes breakfast, lunch and snacks. Free and reduced meal applications are available.

Contract for Enrollment Terms and Conditions

The information provided in this application is to the best of my knowledge complete, accurate, and true. I understand that the application fee must be paid before a child is enrolled and that it is non-refundable. I understand that before my child can attend the first day of school all fees and the first month's tuition must be paid. I understand that all required documents must be turned into the school office before my child can attend school. I understand that in signing this Contract for the coming school year, I am agreeing to accept the policies and procedures of Stepping Stones Educational Therapy Center as established by the Board of Directors and/or the Administration of the school, the policies and procedures as outlined in the school's handbook(s), and the financial terms and conditions described to me in the financial portion of the enrollment process.

I acknowledge that the receipt of a signed contract by the school does not constitute a definitive guarantee of enrollment for the academic year 2024-2025. It is understood that each application shall undergo a thorough review by the admissions team before enrollment confirmation is granted.

This Contract should be signed by both Parents (or guardians/conservators) and returned along with the one-time enrollment fee of $150 for new students, and $50 for each additional student in a family.

*Signature:*_____ *Date:*_____

*Printed Name:*_____ *Relationship to Student:*_____

*Signature:*_____ *Date:*_____

*Printed Name:*_____ *Relationship to Student:*_____

Additional Information

The following is only to be completed if applicant has a suspected or diagnosed learning difference or disability.

Developmental History

Name of Student: _____ Birthdate: _____

Age when student:
Sat: _____ Crawled: _____ Walked: _____ Talked: _____ Used Full Words: _____ Used Full Phrases: _____

Academic Skills: The following questions are related to pre/academic information. For each item below, please write "I" if the students can complete the task independently, or, "A" if the student can complete the task with assistance (verbal or otherwise). If student cannot complete the task as of yet, please leave blank.

_____ Complete simple interlocking puzzles _____ Complete basic patterns _____ Match photos

_____ Identify colors _____Identify shapes _____Identify letters _____ Spell first name ____ Spell last name

_____ Rote count 1-10 _____ Rote count 1-20 _____ Rote higher than 20 _____ Identify numbers 1-10

_____ Identify numbers higher than 11-20 _____ Identify numbers higher than 20 _____ Write name

_____ Write words _____ Reads sight words _____ Reads phonetically _____ Comprehends what is read

_____ Complete basic math functions with single digits _____ Complete basic math functions with two digits

_____ Write in phrases _____ Write in complete sentences

If academic skills exceed those listed above, please describe: _____

_____

Student's favorite subjects, interests, or topics: _____

_____

Student's strengths both in and outside the classroom: _____

_____

_____

_____

Functional Skills: The following questions are related to daily functioning, fine and gross motor skills. For each item below, please write "I" if the students can complete the task independently, or, "A" if the student can complete the task with assistance (verbal or otherwise). If the student cannot complete the task as of yet, please leave the item blank.

_____ Pick up small items with fingers _____ Manipulate objects with both hands _____ Throw a ball

_____ Use stairs _____ Run _____ Jump _____ Use slide _____ Put on most items of clothing

_____Take off most clothing _____ Use buttons _____ Use zippers _____ Tie laces _____ Wash Hands

_____ Brush teeth _____ Comb/brush hair _____ Bathe or shower _____ Eat with fork and/or spoon

_____ Drink from a regular cup _____ Use computer _____ Use writing utensil _____ Draw

_____ Play appropriately with toys _____ Play appropriately with others _____ Shows interest in others actions

Is student toilet trained? YES NO

If no, has student begun toilet training? YES NO If yes, please give date started: _____

Can student indicate when they need to use the restroom? YES NO

Social/Emotional History

Please describe how student interacts with parents/guardians and siblings:

_____

_____

_____

_____

Please describe how student interacts with peers:

_____

_____

_____

_____

Has the student ever exhibited impulsive and/or aggressive behavior? YES NO If yes, please describe:

_____

_____

_____

Does student exhibit anxiety? YES NO If yes, please describe how the school can best help student feel more comfortable in the educational setting:

_____

_____

_____

_____

Diagnosis: Please list all student's diagnoses, and dates made. Please be sure to include any cognitive, physical, mental, social/emotional, and/or medical diagnoses. Please attach supporting documents, if available.

Diagnosis: _____ Date: _____ Diagnostician: _____

Diagnosis: _____ Date: _____ Diagnostician: _____

Diagnosis: _____ Date: _____ Diagnostician: _____

Diagnosis: _____ Date: _____ Diagnostician: _____

Diagnosis: _____ Date: _____ Diagnostician: _____

Diagnosis: _____ Date: _____ Diagnostician: _____

Injuries/Illness: Please list any significant past injuries, surgeries, or extended illnesses.

Event: _____ Date: _____

Event: _____ Date: _____

Event: _____ Date: _____

Event: _____ Date: _____

Event: _____ Date: _____

Is student currently medically stable: YES NO

If no, please explain: _____

Has your child ever had a seizure? YES NO If yes, please explain: _____

_____

If yes, does student have a current seizure plan: YES NO
If yes, date of last review of plan: _____
If yes, please attach copy of plan to packet.

Has the student ever been seen by a Psychiatrist, Psychologist, or Counselor? YES NO

Date of most recent psychological: _____

Has the student ever been seen by a developmental pediatrician or neurologist? YES NO

Has child ever been seen by a specialist other than those mentioned above? YES NO

If yes to any of the aforementioned questions, please explain reasons for visit and diagnosis (if applicable):
_____

_____

Dietary Concerns: Please list any dietary needs (diet, allergies, aversions, chewing/swallowing concerns, etc.) of which our staff needs to be aware:

_____

_____