

# The Little Tree Learning Center Student Application

## Student Information

Child's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Student Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

How did you hear about The Little Tree Learning Center?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent(s) or Guardian(s) Signature

Date

\_\_\_\_\_

**The Little Tree Learning Center**  
**Consent for Evaluation/Assessments, Behavioral Intervention, Photographs/Video**

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Parent(s) or Legal Guardian(s): \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

I hereby give my permission and consent to The Little Tree Learning Center to conduct psychological and educational evaluations and assessments on my child and to perform or secure any additional studies associated with, or required for these evaluations. **INITIAL here if you give consent** \_\_\_\_\_

Based on the results of the evaluations, appropriate behavioral interventions and teaching programs will be developed and implemented while my child is enrolled at The Little Tree Learning Center based on the assessment results. I have full access to view these programs at any time. **INITIAL here if you give consent** \_\_\_\_\_

I authorize the staff of The Little Tree Learning Center to take still photographs and video of my child. The videotape footage will be viewed by staff, graduate students, and practicum students at The Little Tree and will be retained in the student's records. **INITIAL here if you give consent** \_\_\_\_\_

I authorize the staff of The Little Tree Learning Center to present data collected for my child's programming at national, national and state conferences as long as the information contained within presentations remains anonymous. **INITIAL here is you give consent** \_\_\_\_\_  
**(The Little Tree staff will additionally obtain your verbal consent prior to the presentation.)**

At all times, I retain the right to revoke this authorization. Such revocation must be submitted to The Little Tree Learning Center in writing. The revocation shall be effective except to the extent that The Learning Tree has already used or disclosed information in reliance on the Authorization.

I acknowledge this authorization is effective until written notification of revocation is supplied by me.

\_\_\_\_\_  
Mother's Signature Date

\_\_\_\_\_  
Father's Signature Date

\_\_\_\_\_  
Legal Guardian's Signature if different Date

**The Little Tree Learning Center  
Lunch Waiver**

**I will be providing lunch daily for my child \_\_\_\_\_.**  
**The Food and Nutrition Service of the USDA suggests that preschoolers have a lunch consisting of a meat or meat alternative, two vegetables or fruits, a bread or bread product, and milk. However, I understand that I may send whatever items I wish for my child's lunch. I also understand that The Little Tree Learning Center will not be held responsible for the content or nutritional value of this meal in accordance with the Food and Nutrition Service, USDA.**

**I also agree to bring foods in accordance with the Department of Human Resources safety guidelines for serving food to preschoolers as follows:**

- 1. I will not bring small hard candies or nuts to give my child if he/she is younger than 4 years of age.**
- 2. I will cut grapes in half.**
- 3. I will cut hot dogs and sausages lengthwise and then chop them into small pieces.**
- 4. All meats that I send to preschool with my child will be lean meats with no bones.**

**If your child's food does not follow the above DHR guidelines, the Little Tree staff will NOT serve the food to your child, and will provide an alternative food.**

**Parent Signature \_\_\_\_\_ Date \_\_\_\_\_**

## Medical History

Has your child been hospitalized for any reason? If yes, please explain.

Does your child have normal hearing? If not, please list the tests conducted to evaluate your child's hearing and who conducted them.

Has your child had any surgeries? If yes, what type and when?

If your child has been given a diagnosis by a medical doctor, psychologist, or psychiatrist, please list the diagnosis and the clinic or doctor that diagnosed your child.

Is your child taking any medications? If yes, please list the name of the medications and the frequency.

|    | Medication | Dosage | Administered when? |
|----|------------|--------|--------------------|
| 1. |            |        |                    |
| 2. |            |        |                    |
| 3. |            |        |                    |

Is your child allergic to any medications?

Besides medication is your child allergic to anything? If yes, what?

## Developmental History

Please provide approximate ages at which your child began to do the following activities: (You can use **early, late, or on-time** if age is unknown)

|              |  |                       |  |
|--------------|--|-----------------------|--|
| Smile        |  | Crawl                 |  |
| Coo/Babble   |  | Stand Alone           |  |
| Roll Over    |  | Walk Alone            |  |
| Sit Alone    |  | Feeds Self            |  |
| Single Words |  | Dresses Self          |  |
| Phrases      |  | Toilet Trained/ Bowel |  |

How does your child communicate? Please circle all that apply (Words, Sign language, Picture Exchange, Sentences, Crying, and Sounds)

How much of your child's speech is understandable to you? Some \_\_\_\_\_ Most \_\_\_\_\_ All \_\_\_\_\_

How much of your child's speech is understandable to others? Some \_\_\_\_\_ Most \_\_\_\_\_ All \_\_\_\_\_

What foods does your child enjoy eating?

What foods does your child not enjoy eating?

Is your child a picky eater?

Is your child on or ever been on any special diets? If yes, please describe and how long ago.

Does your child take any nutritional supplements?

Describe your child's response to sound (e.g. does he/she cover ears when noises occur, does he/she respond to all sounds, some sounds, or just seem to tune you out)

Do you experience any behavior problems with your child? If yes, please describe the problem behavior and how you deal with it.

Has your child ever attended or been a part of a school or program that used an ABA (Applied Behavior Analysis) approach?

Please describe your child's play/social skills?

What does your child enjoy doing in his/her spare time?

What are your child's special interests, likes, dislikes? What rewards or motivates your child?

### Family History

Are there any of the following medical conditions among any immediate family members?

|                            |  |                       |  |
|----------------------------|--|-----------------------|--|
| Speech Language Impairment |  | Drug or Alcohol Abuse |  |
| Hearing Impairment         |  | Seizure Disorders     |  |
| Learning Disabilities      |  | Chronic Illness       |  |
| Behavior Problems          |  | ADHD/ADD              |  |
| Emotional Difficulties     |  | Diabetes              |  |
| Mental Retardation         |  | Visual Impairment     |  |
| Depression                 |  | Schizophrenia         |  |

Other:

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