CLINIC REGISTRATION/APPLICATION FORM

Student's name ______________________________ Date ______________

Age ______ Grade ______ Date of birth ______________ Gender ______ Current School ______________

Contact Information

Parent Name	Parent Name
Street	Street
City, State, Zip Code	City, State, Zip Code
Home Phone Cell Phone	Home Phone Cell Phone
Work Phone Employer	Work Phone Employer
email	email

With whom does the child reside? ______________________________

Please list siblings and ages: ______________________________

If divorced or separated, please share relevant details (custody and caretaking arrangements):

____

Reason for Referral to Raskob:

Has student attended the Raskob Clinic before? If so, when? ______________________________

Please describe in what subject areas the student has difficulty.

____

____

School History:

Please list all previous schools and grades attended:______________________________

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Please share student's special interests:______________________________

Has student repeated/skipped a grade? ______________ If so, when? ______________

Is student receiving special education? ___________

If so, how long has he/she received special education? ____
What is your student's eligibility category for special education? ____

What special education services is your student currently receiving (e.g. – resource room, special day class, nonpublic school, speech and language therapy, occupational therapy, etc.)? What services has he/she received in the past?

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If student is not currently receiving special education *but has received special education in the past*, when did he/she receive it and what were the identified areas of need? ____

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Please indicate if your child is receiving/ has received private educational services *(tutoring, educational therapy, speech and language therapy, occupational therapy, etc.)* or interventions *(counseling/psychotherapy)* and provide relevant details: e.g., dates, frequency, setting, areas or issues addressed.

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Please provide most recent report cards, IEPs and reports, and STAR testing results.
If psychological/neuropsychological testing and/or psychoeducational evaluations are available, please submit these, as well.

Health and Medical Information:

Please submit ***Emergency Contact*** *form.*

Student's general health (check one): ________ Good ________ Fair ________ Poor

Is your student currently taking any medications?____

Please list frequency and dosage____

Please list any special health issues or mental health diagnoses: ____

Describe the student's health and mental health issues with regard to learning difficulties. Are there any significant issues that will need to be attended to while student is receiving educational therapy? If so, what special interventions will be needed?

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Additional information you believe to be relevant____

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Application Procedures

- Complete and return this registration packet and forms, including IEP records, testing results, and recent evaluations. Once the file is complete, the Clinic will contact you to set up a therapy schedule.
- When the Clinic has matched your student with a learning specialist and a schedule has been discussed, a separate contract for services will be sent to you.
- Return this signed application and a $150, non-refundable deposit, which will go toward tuition.
- *Tuition payment in full is due by first session, or by arrangement with the Business Office, 510.436.1420*. Past that, educational therapy services will be suspended until the balance is paid in full, after which services will resume through the end of the semester.

Signature: ____ Relationship to student:___________________