



CLINIC REGISTRATION/APPLICATION FORM

Student's name _____ Date _____

Age _____ Grade _____ Date of birth _____ Gender _____ Current School _____

Contact Information

Parent/Caregiver Name _____	Parent/Caregiver 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 (please feel free to use an additional page):

School History:

Please list all previous schools and grades attended: _____

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?

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? _____

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.

**Please provide most recent report cards, IEPs and reports, and SBAC 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? (Use an additional page, if needed.)

Additional information you believe to be relevant _____

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:** _____