



building a foundation for success

5439 Glen Lakes • Dallas, TX 75231 • 214-205-1433
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Student Enrollment Application and Social History Form

Cornerstone admits students of any race, color, and national or ethnic origin.

Date _____ Requesting Enrollment for (date) _____

Child's Name _____
(First) (Middle) (Last)

Date of Birth _____ Age _____ Sex _____

Birth Place _____ Language spoken at home _____

FAMILY INFORMATION

MOTHER/GUARDIAN

Name _____ Home Phone _____

Address _____
(Street Address) (Apartment Number)

City _____ State _____ Zip Code _____

Highest Grade Completed in School _____

Occupation _____

Business Name & Address _____

Business Phone _____ Cellular Phone _____

Fax _____ email _____

Marital Status (circle one) Single Married Separated Divorced Widow

Religious Preference (optional) _____

FATHER/GUARDIAN

Name _____ Home Phone _____

Address _____

City _____ (Street Address) _____ (Apartment Number) _____
State _____ Zip Code _____

Highest Grade Completed in School _____

Occupation _____

Business Name & Address _____

Business Phone _____ Cellular Phone _____

Fax _____ email _____

Marital Status (circle one) Single Married Separated Divorced Widow

Religious Preference (optional) _____

List the names and ages of your other children:

In addition to those above, list others living in the home:

Legal Alert

Is anyone legally restricted from contact with Student: Yes No

If "yes", then copies of the appropriate documents (e.g. court order, etc.) must be on file with the School.

MEDICAL INFORMATION

What is your child's current diagnosis? _____

Does your child have a G tube for feeding? Yes _____ No _____

Does your child have any existing illness, previous serious illness or injury, hospitalizations during the past 12 months or any other problems that currently affect their health (e.g. asthma, seizures)?

Explain _____

If your child receives routine medication, please list the medication(s) and condition(s) being treated:

Describe all allergies and allergic reactions:

Please list the information about your child's physicians and medical specialists:

Name

Specialty

Address

Hearing/Speech/Vision

- Uses Signs Uses Signs/Words Uses Few Words Sometimes Uses Sentences
 Talks in Sentences No Problem with Speech Some Trouble with Hearing
 Wears Hearing Aid No Problem with Hearing Legally Blind Partially Blind
 Wears Glasses Wears Contact Lenses No Problems with Vision

Other comments pertaining to hearing, speech, or vision:

Physical Limitations

Does your child use or wear any special appliance (e.g., leg brace, colostomy bag, etc.)? _____

Does your child need support to walk? _____ Comments _____

Are there any limitations regarding your child's physical participation in the program? _____

Personal Care

Is your child toilet-trained? _____ If not, describe any assistance needed.

Are there any feeding problems? _____ If so, describe any assistance needed.

Girls-Does your daughter menstruate? ____ If so, describe any assistance needed.

Behavior

Does your child have any known troubles, fears, disinterests, or group problems? If yes, describe.

Describe any behavior problems and/or other behavior related concerns, as well as how you handle or address them:

Developmental

Does your child have any developmental delays? Yes ____ No ____

If yes, please describe: _____

Date and place of the most recent developmental evaluation:

Test results: _____

Academic skills (if applicable): Reading _____ Math _____

Social Information

Does your child currently attend a school? Yes _____ No _____

If yes, where and how often? _____

What are your child's most enjoyable activities?

What do you do to comfort your child? _____

List any food dislikes: _____

Describe any sleep problems: _____

What are your child's favorite toys? _____

List the places your child frequently visits: _____

List the significant people in your child's life: _____

EDUCATION AND THERAPY SERVICES

Current or most recent school _____

Placement: Self-Contained Resource Regular

Current grade in school _____

List the education and therapy services your child is **currently receiving**:

Type of Service _____ Provider _____

Address _____ Phone _____

Type of Service _____ Provider _____

Address _____ Phone _____

Type of Service _____ Provider _____

Address _____

Phone _____

Type of Service _____

Provider _____

Address _____

Phone _____

List **previous** education and therapy services your child received:

Has your child ever been enrolled or have you applied to any other learning different schools in the area? ____ Schools: _____

Type of Service _____

Provider _____

Address _____

Dates of service _____

Type of Service _____

Provider _____

Address _____

Dates of service _____

Type of Service _____

Provider _____

Address _____

Dates of service _____

Type of Service _____

Provider _____

Address _____

Dates of service _____

Type of Service _____

Provider _____

Address _____

Dates of service _____

Is there anything else about your child that you feel we should know, additional concerns, or pertinent information?

Signature of Person Completing this form: _____