Thank you for your interest in applying to have your child participate in ______________________. The following application must be completed before we can determine the suitability of your child for these programs. The child’s primary caretaker should complete all questions. Only a parent or legal guardian can apply for services for their child through The Children and Family Programs.

Please note: Submission of materials does not guarantee acceptance into our programs. Our goal is to ensure that we can meet your child’s needs. In some cases, we may request additional information about your child or request that your family participate in an interview to gather additional information.

You will be contacted when all the information in the application has been received and advised as to the status of your child’s application. If you have any questions regarding the application process, please contact me at (470) 578-2233

Thank you again for your interest in The Children and Family Programs.

Sincerely,

Allison Garefino, Ph.D.

Documents can be mailed to:

School of Conflict Management, Peacebuilding and Development
Attn: Children and Family Programs
Center for Conflict Management
MD 1604
365 Cobb Avenue
Kennesaw, GA 30144
Applicant Information

Child’s Name: First____________________ Last____________________

Child’s Date of Birth (MM/DD/YY): ______________________

Child’s Age:____________ Child’s Gender: ______________________
Guardian Information

Parent/Guardian (1) Name:  First ______________________________  Last ______________________________

Parent/Guardian (1) Relationship to Child:

Mother    Father    Step-parent    Adoptive parent

Grandparent    Guardian    Other ______________________________

Parent/Guardian (1) Marital Status:

Married    Separated    Divorced    Widowed    Never Married

Parent/Guardian (1) Currently (or during the last 12 months) employed full-time or part-time outside of the home

Yes    No

Parent/Guardian (1) Please circle highest grade completed on scale

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<th>Undergraduate/College</th>
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Parent/Guardian (2) Name:  First ______________________________  Last ______________________________

Parent/Guardian (2) Relationship to Child:

Mother    Father    Step-parent    Adoptive parent

Grandparent    Guardian    Other ______________________________

Parent/Guardian (2) Marital Status:

Married    Separated    Divorced    Widowed    Never Married

Parent/Guardian (2) Currently (or during the last 12 months) employed full-time or part-time outside of the home

Yes    No

Parent/Guardian (2) Please circle highest grade completed on scale

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Verification of Legal Custody of Child (please check one)

☐ I have legal authority to enroll the above named applicant in The Children and Family Programs

☐ I do not have legal authority to enroll the above named applicant in The Children and Family Programs

Additional Family Information (please provide additional family information you feel would be helpful with the application process, such as information regarding custody):

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Contact Information

Home Address: ____________________________________________

Street Address__________________________________________

Address Line 2__________________________________________

City __________________________________________ State __________ __________ Zip Code

Country________________________________________________

Primary Phone Number: __________ - __________ - __________

Secondary Phone Number: __________ - __________ - __________

Email: ________________________________________________

Would you like to be added to the CFP’s mailing list? Yes No
School Information

Child’s Grade in School: ____________

School District: ____________________________________________________________

School Name (Name of Building): ____________________________________________

Teacher’s Title: Mrs. Ms. Miss Mr.

Teacher’s Name: First ___________________________ Last _______________________

Teacher’s Email Address: ____________________________________________________

May we contact your child’s teacher in order to complete a rating scale to describe your child’s functioning at school? Yes No

Has your child ever been retained/held back? Yes No

Has your child ever been suspended from school? Yes No

Does your child have a history of running/bolting from a group? Yes No

Does your child have a history of physical aggression towards self or others? Yes No

Is this student classified through the CSE? Yes No

If yes, please indicate classification (circle):

Autism (AUT) Emotional Disturbance (ED)
Hearing Impairment (HI) Learning Disabled (LD)
Intellectually Disabled (ID) Multiple Disabilities (MD)
Orthopedic Impairment (OI) Other Health Impairment (OHI)
Speech/Language Impaired (SI/LI) Traumatic Brain Injury (TBI)
Visual Impairment (VI)

Does the student have a(n): □ IEP □ 504 Accommodation Plan If so, please include a copy.
Class Size (number of students in class): __________

Does the student have a 1:1 aide or require individualized adult support?    Yes    No

If yes, please describe the frequency and reasons for this level of support. (Please specify why additional adult support is needed for your child, e.g., feeding, injurious behaviors, running away, behavioral intervention plan, verbal/physical prompting to stay on task, direct instruction, transitions, supervising social interactions, etc.)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Have you ever been concerned about your child’s speech or language development?    Yes    No

If yes, at what age(s) were you concerned and what made you concerned about his/her speech and/or language development? (Please describe [e.g., not talking by age 2 years, had trouble pronouncing words, did not appear to understand simple directions at age 3 years, etc.])

______________________________________________________________________________

______________________________________________________________________________

Did your child previously receive speech/language therapy?    Yes    No

If yes, at what age? __________

Does your child currently receive speech/language therapy?    Yes    No

If yes, approximately how many minutes per week? __________

If yes, what speech or language areas are the focus of therapy? (Check all that apply)

____ Articulation (i.e., pronunciation)
____ Pragmatic Language (i.e., using vocal tone, volume, pitch, or intensity to convey meaning to others; understanding implied, not explicit, information)
____ Expressive Language (i.e., what the child can say)
____ Receptive Language (i.e., what the child can understand)
____ Other (Explain) ___________________________
Medical Information

Does the applicant currently have a mental health/developmental disability diagnosis?  Yes  No

*If yes, please indicate the applicant's diagnosis:*

Please include a copy of your child’s diagnostic report, if applicable.

Does your child/family presently see a community mental health professional (e.g., psychologist, counselor)?  Yes  No

*If yes, please indicate for what reasons or the treatment goals that are being addressed.*

Does your child take medication?  Yes  No

*If yes, please describe type of medication(s), dose and reason.*

Do you plan to have your child take his/her medication during the summer program?  Yes  No

Does your child have any physical health conditions that would prevent or limit his/her ability to participate in recreational/camp activities?  Yes  No

*If yes, please describe:*

Does your child have any known allergies?  Yes  No

*If yes, please describe:*

Does your child have a history of seizures?  Yes  No

*If yes, indicate which type:*

Please indicate any additional health information you feel would be helpful with the application process.
Social/Behavioral Information

Please complete the following information to identify your child’s main difficulties or areas of concern that you would like to see improve over the summer. This list of concerns may be turned into treatment targets.

**Concern #1**

Describe the concern

________________________________________________________________________

________________________________________________________________________

Indicate the severity of the concern

Not a concern at all - 1 2 3 4 5 6 7 8 9 10 - Huge concern

**Concern #2**

Describe the concern

________________________________________________________________________

________________________________________________________________________

Indicate the severity of the concern

Not a concern at all - 1 2 3 4 5 6 7 8 9 10 - Huge concern

**Concern #3**

Describe the concern

________________________________________________________________________

________________________________________________________________________

Indicate the severity of the concern

Not a concern at all - 1 2 3 4 5 6 7 8 9 10 - Huge concern
How did you hear about the Children and Family Programs at KSU? Please select any that apply.

- My child is a returning child
- My child’s school/teacher
- Pediatrician/psychologist
- Kennesaw State University’s website
- Online search
- Facebook
- Radio
- Publications
- Cobb in Focus Magazine
- Health expo or community event
- Other ________________________________

I hereby certify that the information contained on this application is true and correct to the best of my knowledge.

Signature________________________________________ Date
_________________________________________________