The Matthew Reardon Center for Autism

P.O. Box 14669 ● Savannah, GA 31416 ● (912) 355-9098 ● fax (912) 352-2460

Thank you for your interest in Advance Academy, Southeast Georgia's only year-round day school for children with autism operated by The Matthew Reardon Center for Autism and accredited by the Georgia Accrediting Commission. Attached is the requested application package. Please review and complete all forms. *The completed application packet should be submitted along with a non-refundable $50 application fee*. Please note the following:

- The Physician's Recommendation form must be completed by the diagnosing physician. This form does not have to reflect a brand new examination; simply if there are any abnormalities and if immunizations are up to date. The form can be faxed to the Center at (912) 352-2460.
- Teacher Questionnaires must be submitted separately by two (2) teachers or school personnel who work closely with your child.
- Advance Academy is a provider for the Georgia Special Needs Scholarship (SB10) program. Additional needs-based tuition assistance is available as well. MRCA's Board of Directors is determined that no child who will benefit from attending Advance Academy be denied access due to financial constraints.
- A copy of your child's most recent **IEP** and **psychological evaluation** must accompany your application.
- A copy of your child's most recent **BIP** (Behavior Intervention Plan), if applicable.

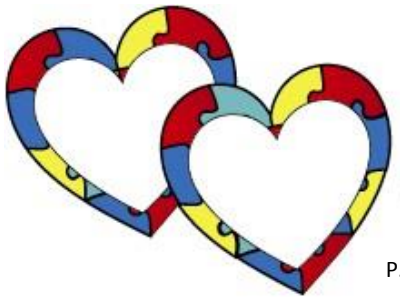
The admissions process typically includes an observation in the child's current classroom**.** If an observation is required, all parties involved must agree that the observation will take place under normal classroom conditions**. For more information, a copy of the admission guidelines and procedures is attached.**

Thank you for your interest in Advance Academy. Should you have any questions, please do not hesitate to contact one of us at (912) 355-9098.

Jack O'Connor
Advance Academy Director

Patti T. Victor,
MRCA President/CEO

Applicant Name:_____ DOB:_____



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info@matthewreardon.org ● ● ● www.matthewreardon.org

APPLICATION CHECKLIST

Child's name:_____ DOB: _____

Please submit all required documents together to ensure that the application is processed in a timely manner.

_____ Application fee ($50)
_____ Family Documentation
_____ Complete Copy of Most Current IEP
_____ Complete Copy of Most Current BIP, *if applicable (Behavior Intervention Plan)*
_____ Complete Copy of Most Recent Psychological Evaluation
_____ Quality of Life Indicator Index
_____ Physician Recommendation (may be submitted separately)
_____ Two (2) Teacher Questionnaires (to be submitted separately by teacher)

DATE RECEIVED:_____ Received by: _____

DATE REVIEW COMPLETED:_____ Completed by: _____

DATE REVIEWED BY ADMISSIONS COMMITTEE: _____

DATE/STATUS FINAL DETERMINATION:_____ ELIGIBLE INELGIBLE

_____
(initials)

Applicant Name:_____ DOB:_____

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Advance Academy
Application
Family Documentation

Applicant Name:_____

Mother's Name:_____Father's Name:_____

Address:_____
(Street, PO Box, City, State, Zip Code)

Home Phone:_____ email:_____

Cell Phones: _____ _____

How did you learn about MRCA? ( ) Friend ( ) Advocate ( ) Teacher/District ( ) Internet
( ) Clinical Referral – referring Provider's Name _____

****

Child's Current School/District: _____

School Address:_____
(Street, PO Box, City, State, Zip Code)

School Phone/fax:_____

Current Grade:_____ Start date of current IEP:_____

Date of most recent Re-evaluation: _____

Is your child currently enrolled in SSI? Yes No

Is your child currently enrolled in Medicaid? Yes No

Applicant Name:_____ DOB:_____

STUDENT'S BEHAVIORAL HISTORY

Has your child exhibited any of the following behaviors? If so, please indicate approximate date of last occurrence or, if the behavior is still a concern, how frequently the behavior occurs:

1. Aggression? DATE_____ Frequency_____
2. Self-injury? DATE_____ Frequency_____
3. Destructive behavior? DATE_____ Frequency_____
4. Verbal outburst? DATE_____ Frequency_____
5. Elopement/Running? DATE_____ Frequency_____
6. Other_____? DATE_____ Frequency_____

Has your child ever had a behavioral crisis resulting in hospitalization? Yes No

If Yes, please provide date(s) and details?_____

_____

_____

Further Comments/Concerns about Behavior:_____

_____

_____

Please complete the following statements:

My priority for the curriculum areas I want my child to master are: (please indicate using numbers; *example* – (1)_Speaking/Listening, (2)_Life Skills, (3)_Reading, etc.)

( )_Reading	( )_Writing	( )_Social Skills	( )_Art
( )_Social Studies	( )_Mathematics	( )_Communication	( )_Music
( )_Life Skills	( )_Science	( )_Technology	( )_Phys. Ed.
( )_Vocational Skills	( )_Other_____		

Please describe your long-term goals for your child:

_____

_____

_____

_____

Applicant Name:_____ DOB:_____

As a parent/guardian, I especially appreciate it when (include aspects of your relationship with school staff that are important to you and your child)…

_____

_____

_____

What specific skills would you like to see your child *master* this year?

_____

_____

_____

Describe the social, academic, and familial skills you want your child to master across the next 5 years.

_____

_____

_____

_____

Is your child toilet trained? _____ Age training completed: _____

HOUSEHOLD INFORMATION

Please list the members of your household:

NAME	AGE	RELATIONSHIP TO STUDENT

Applicant Name:_____ DOB:_____

FAMILY STATISTICS

Please complete the following section. The information you provide will be kept confidential and will be released in summary form only for Federal statistical reporting.

MARITAL STATUS (parents)

Check One

_____ Single (never married)
_____ Married
_____ Divorced
_____ Widowed

ANNUAL INCOME

Check for family total

_____ $ 0 – 9,999
_____ $ 10,000 – 19,999
_____ $ 20,000 – 39,999
_____ $ 40,000 – 59,999
_____ $ 60,000 – 89,999
_____ $ 90,000 – 119,999
_____ $ 120,000 – 199,999
_____ $ 200,000 +

EDUCATION (Check highest *COMPLETED*)

	MOM	DAD
Kindergarten - 6th Grade	( )	( )
7th – 9th Grade	( )	( )
10th – 12th Grade	( )	( )
High School Diploma/GED	( )	( )
Some College	( )	( )
Associate's Degree	( )	( )
Bachelor's Degree	( )	( )
Master's Degree	( )	( )
Doctoral Degree	( )	( )
Unknown	( )	( )

PARENTS' OCCUPATION(S):

- Mother_____ Employer:_____
- Father _____ Employer:_____

Additional Comments:

Applicant Name:_____ DOB:_____

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Advance Academy Application **Communication and Observation Consent Form**

Parents: Please complete this form and return it to Advance Academy as part of your child's application packet:

I, _____ (parent name), give consent for staff from the Matthew Reardon Center for Autism's Advance Academy to communicate with staff from _____ _____ (current school), regarding an admission application for my child, _____(child name), as outlined below:

- Staff from Advance Academy may communicate with my child's current teacher and classroom staff regarding this application and his/her current performance in school.
- Staff from Advance Academy may enter my child's classroom for an observation. (The admissions process typically includes an observation in the child's current classroom**.** If an observation is required, all parties involved understand that the observation will take place under normal classroom conditions**.**)

This consent will be effective for six (6) months from the signature date below.

_____ _____

Signature Date

Applicant Name:_____ DOB:_____

Family Stress/Quality of Life Index

Please rate how stressful you currently find each of the following aspects of your child's life	Not stressful	Somewhat stressful at times	Often stressful	Very stressful most of the time	Always extremely stressful- often have difficulty coping
1. Disruptions to your child's typical daily schedule or routine	0	1	2	3	4
2. Extended school vacations or breaks	0	1	2	3	4
3. Child's ability to participate in family functions or holidays	0	1	2	3	4
4. Ability to eat out at a restaurant as a family	0	1	2	3	4
5. Ability to go to a store with your child (walking down aisles, waiting in line, etc.)	0	1	2	3	4
6. Child's behavior during routine medical appointments (waiting room, exam, etc.)	0	1	2	3	4
7. Your child's current sleep patterns	0	1	2	3	4
8. Your child's eating habits	0	1	2	3	4
9. Your child's ability to complete self-care routines (toileting, dress independently, etc.)	0	1	2	3	4
10. Your child's needs and their impact on other members of the family (e.g. siblings)	0	1	2	3	4
11. Your child's needs effect on relationship between parents	0	1	2	3	4
12. Child's current performance and progress in school	0	1	2	3	4
13. Thoughts of your child's life after they finish school	0	1	2	3	4

Applicant Name:_____ DOB:_____

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Advance Academy Application

Physician Recommendation

Child's name:_____ DOB: _____

Parent's Name:_____

Parent's Address:_____

_____

Parent's Phone:_____ email:_____

****

Patient Information: Date of Latest Evaluation:_____

Weight _____ Height: _____

Child is diagnosed with a congenital, traumatic, or acquired neurological disorder Y N
Diagnosis:_____

Child has a related communication/speech and language deficit Y N
Specify: _____

Child exhibits delays in the following areas (Please describe delays) Y N
Behavioral:_____
Social:_____
Motor (fine and gross):_____
Cognitive:_____

Based on degree of delay, this child requires systematic instruction in a 1:1 setting Y N

*Child demonstrates ability to learn but requires an individualized ed. setting Y N

*Child is at risk for regression without a structured year-round program Y N

*Child requires an educational program that is predictable and routine Y N

*A functional approach is needed to address problem behaviors Y N

Applicant Name:_____ DOB:_____

STUDENT'S HEALTH HISTORY

Special Diet Requirements? ____YES ____NO

If yes, please describe:_____

Please list Allergies:_____

Other current/previous health conditions (Seizures, migraines, etc.):_____

_____

_____

Has this child ever been hospitalized following a behavioral crisis?_____

_____

_____

Please list ALL medications that the child takes regularly:

Medication:_____ Dose: _____mg TIME: AM/PM ___
Medication:_____ Dose: _____mg TIME: AM/PM ___
Medication:_____ Dose: _____mg TIME: AM/PM ___
Medication:_____ Dose: _____mg TIME: AM/PM ___
Medication:_____ Dose: _____mg TIME: AM/PM ___

Immunizations (information can be provided by attaching immunization record):

Current:	YES	NO	Date
Diptheria	☐	☐	_____
Hep A	☐	☐	_____
Hep B	☐	☐	_____
MMR	☐	☐	_____
Meningitis	☐	☐	_____
Pertussis	☐	☐	_____
Poliomyelitis	☐	☐	_____
Varicella	☐	☐	_____
Tdap (DOB>2001)	☐	☐	_____
Tetanus	☐	☐	_____

Applicant Name:_____ DOB:_____

Are there any specific health issues that need to be monitored while this child is under our care? (weight, vital signs, etc.)_____

_____

In keeping with our policy and procedure regarding safeguard of infectious disease, each child must be screened for proper immunizations and other precautions.

IF THE CHILD HAS BEEN EXEMPTED FROM IMMUNIZATION IN ACCORDANCE WITH THE GEORGIA RULES OF THE DEPARTMENT OF PUBLIC HEALTH, CHAPTER 511-2-2-.05, THE FOLLOWING INFORMATION IS REQUIRED AS EVIDENCE OF IMMUNITY:

The following has been performed within 6 months of admission: **Result**

_____Hepatitis B surface Antigen (HbsAg) _____

_____Hepatitis C antibody _____

_____HIV I antibody _____

_____Tuberculosis (TB) – Mantoux method only _____

The following should be obtained on patients who have completed Hepatitis B vaccinations to confirm immunity.

_____Hepatitis B surface Antibody (HbsAb) _____

_____Tuberculosis (TB) – Mantoux method only _____

(*TB testing should be performed within one year of admission)*

Common Childhood Illnesses:

_____Measles-Mumps-Rubella (MMR) _____

_____Diptheria-Tetanus-Pertusis (Tdap) _____

_____Hemophilus Influenza type b (HIB) _____

****

Physician's Name: _____

Provider Address: _____

_____

Phone: _____ email:_____

Physician's Signature:_____ Date:_____

Additional Comments:

Applicant Name:_____ DOB:_____

Applicant Name:_____ DOB:_____

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Advance Academy Application
Teacher Questionnaire

PARENTS: Please submit this form to two (**2**) teachers or school personnel who work closely with your child along with a stamped envelope addressed to:

Advance Academy Admissions
c/o MRCA
P.O. Box 14669
Savannah, GA 31416

Child's name:_____ DOB: _____

Current School:_____

Teacher Completing Form:_____

Teacher Phone:_____ email:_____

****

TEACHERS: Please take a few minutes to complete this form and return it in the envelope provided. Please contact the Advance Academy Director at (912) 355-9098 with any questions or concerns

Student Information: Date of Enrollment at Current School:_____

Average number of hours you work with the student (per week):_____

Please rate each of the following categories:

	Excellent	**Good**	**Fair**	**Poor**
Overall Attendance	☐	☐	☐	☐
Relationships with Classmates	☐	☐	☐	☐
Relationships with School Staff	☐	☐	☐	☐
Classroom Behavior	☐	☐	☐	☐
Classroom Participation	☐	☐	☐	☐
General Attitude in Classroom	☐	☐	☐	☐
Communication Skills	☐	☐	☐	☐
Social Skills	☐	☐	☐	☐
Parent Involvement	☐	☐	☐	☐
Communication between Parents and School	☐	☐	☐	☐

(continued on next page)

Applicant Name:_____ DOB:_____

What are this child's STRENGTHS?_____

_____

_____

What are this child's NEEDS?_____

_____

_____

Please list at least three items/activities this child enjoys._____

_____

Please provide details about anything rated <u>POOR</u> or <u>FAIR</u> on the previous page._____

_____

_____

_____

Please describe any factors (e.g. Diagnosis, family situation, diet, attendance) which have impacted the applicant's performance in school._____

_____

_____

_____

Please describe the current reinforcement/discipline procedure used for this student_____

_____

_____

Additional Comments:_____

_____

_____

_____ _____

Signature Date

Thank you for taking the time to complete this form.

Applicant Name:_____ DOB:_____

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Teacher Completing Form:_____

Teacher Phone:_____ email:_____

****

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Student Information: Date of Enrollment at Current School:_____

Average number of hours you work with the student (per week):_____

Please rate each of the following categories:

	Excellent	Good	Fair	Poor
Overall Attendance	☐	☐	☐	☐
Relationships with Classmates	☐	☐	☐	☐
Relationships with School Staff	☐	☐	☐	☐
Classroom Behavior	☐	☐	☐	☐
Classroom Participation	☐	☐	☐	☐
General Attitude in Classroom	☐	☐	☐	☐
Communication Skills	☐	☐	☐	☐
Social Skills	☐	☐	☐	☐
Parent Involvement	☐	☐	☐	☐
Communication between Parents and School	☐	☐	☐	☐

(continued on next page)

Applicant Name:_____ DOB:_____

What are this child's STRENGTHS?_____

_____

_____

What are this child's NEEDS?_____

_____

_____

Please list at least three items/activities this child enjoys._____

_____

Please provide details about anything rated <u>POOR</u> or <u>FAIR</u> on the previous page._____

_____

_____

_____

Please describe any factors (e.g. Diagnosis, family situation, diet, attendance) which have impacted the applicant's performance in school._____

_____

_____

_____

Please describe the current reinforcement/discipline procedure used for this student._____

_____

_____

Additional Comments:_____

_____

_____

_____ _____

Signature Date

Thank you for taking the time to complete this form.