AEF Schools
"Success is measured one child at a time."
4650 SW 61st Ave
Davie, FL 33314

P (954)581-8222
F (954)797-0700
W: http://www.aefschools.com
E: info@aefschools.com

Thank you for your interest in AEF Schools.

Your appointment is scheduled for:

Date: _____

Time: _____

Please bring your child to our Main Broward Campus for an interview and assessment. You will meet with a member of our administration to discuss our program and to address any questions you may have. Enclosed you will find a Parent Priority Sheet as well as a Preliminary Diagnostic Information Sheet. Please complete both forms prior to your appointment. This will greatly assist us in determining whether your child will excel in our program.

In order to truly assess your child for our program, please bring the following items:

- School Records
- Report Cards
- Psychological / Psycho-educational testing (If applicable)
- Individual Education Plans (IEPs) (If applicable)
- Any information that would tell us more about your child

Failure to bring in available requested documentation may affect your child's admission into the program.

You may visit our website at www.aefschools.com to get more information and to see an introductory slideshow

Once again, thank you for your interest in AEF Preparatory School where our mission is to prepare our students for life and develop in students the necessary academic, social, emotional, physical and problem solving skills that will enable them to live successful lives in a rapidly changing society. We look forward to meeting you and your family.

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Preliminary Information - Section 1

(Please complete fields below - enter N/A for all required fields that do not apply to or that you want to leave blank)

Child's Name_____ Birth Date _____
(Last) (First) (Middle)

Home Address_____

_____

Father's Occupation_____ Bus. Phone _____ Email: _____

Father's Business Address _____ Cell Phone: _____

Mother's Occupation _____ Bus. Phone _____ Email: _____

Mother's Business Address _____ Cell Phone: _____

_____

Marital Status of Parents (Check appropriate box)	Married	Separated	Divorced	Widowed	Remarried
Date:					

Member of Family (Give full name and indicate remarriage name when applicable)	Age	Birth Date	Adopted (Yes or No)	Education (Level and/or Degree)
Father				
Mother				
Siblings				
1				
2				
3				
4				
5				
6				
Others in Household	Age	Relationship to Child		
A				
B				
C				

Student Name:_____

Preliminary Information – Section 1 Continued

Where did you find AEF Schools / Who referred you?

- ☐ On line – Search Engine
- ☐ FDOE Website – McKay, Step Up, Gardiner
- ☐ Drove by / saw bus / saw advertisement
- ☐ Referred by professional
- ☐ Word of mouth
- ☐ Other

Why are you looking for a new school?

- ☐ Not happy with current school
- ☐ Moving
- ☐ Aging out
- ☐ Want a different environment

What qualities are MOST important for you in a school (Rank in order by placing numbers 1 to 6 in box)

1 Being the most important, 6 being not as important. If Safety is your most important factor in choosing a school, put a 1 next to safety. If safety is your least important factor put a 6 next to safety

- ☐ Safety
- ☐ Cleanliness
- ☐ Academics
- ☐ Social Life
- ☐ Structure
- ☐ Enjoyment of School

Name of Current School:

Current Grade:

Name of Previous School:

Grades Attended:

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Priorities

Please rank each of the items below in order of what is most important to you "1" being the most important and "15" less important. You can only use each number 1-15 once.
If Reading Comprehension is the most important thing to you - put a 1 next to reading comprehension

Student Name_____ **Date**_____

	Social skills - navigating the world / making friends
	Emotional Growth (Maturity, self-confidenc, discipline)
	Focus / Attention / Auditory and Visual Memory
	Listening and following directions
	Family and Sibling relationships
	Self control / Controlling anxiety / Coping with change
	Organization, study skills, and time management
	Accepting Responsibility
	Life Skills (Time/money management etc.)
	Diet, Hygiene, Cleanliness
	Test Taking Skills
	Peer Pressure
	Reading Comprehension
	Writing Skills (Essays, papers)
	Math, logic, and resoning TH

PARENT SIGNATURE **DATE**

Please leave the area after “Specialist’s Name” blank.

AEF Schools
INFORMATION RELEASE AUTHORIZATION

PARENT NAME: _____

CHILD’S NAME: _____

SPECIALIST’S NAME: _____

I hereby authorize the above-mentioned specialist to communicate with a representative of AEF Schools regarding psychological, educational, tutoring services, etc. that were provided to my child (referenced above).

_____ _____

Parent Signature **Date**

Reports may be sent to:

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Section 2

ONLY Complete this section if your child has:

An IEP
504 Plan
Gardiner Scholarship
Diagnosis from Licenses Practitioner
Special Medical Needs

If your child does NOT meet any of the criteria listed above YOU DO NOT NEED TO COMPLETE THE SECTION BELOW

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Section 2

Only complete this section if your child has an IEP, 504 Plan or has been diagnosed by a licensed practitioner. If NOT, please leave BLANK

1. Who referred you to us? _____

   Title or profession _____

   Address _____

2. Specifically, what are the problems presented by your child? _____

   _____

   _____

   _____

   _____

   _____

3. Which of these concerns you the most? _____

   _____

4. When were these problems first noted? _____

5. Does your child demonstrate any awareness of these problems? _____

   _____

6. Which problems seem to concern your child the most? _____

   _____

Comments: _____

_____

_____

_____

_____

_____

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Section 2 (contd)

If your child has an IEP, 504 Plan or has been diagnosed by a licensed practitioner, please complete below. If NOT, please leave BLANK

1. Is your child adopted? Yes _____ No _____ Private Matter _____

   a. Is your child aware that they are adopted? _____

   b. If yes, what is your explanation of adoption to your child? _____

   _____

   _____

2. Was any information made available to you regarding your child's birth mother (health, prenatal care, etc).

_____

_____

Daily Living Skills – Please indicate your child's level of assistance needed on the daily living skills chart below by putting an X in the appropriate box

Level of Assistance	No Assistance	Some Assistance	Dependent - Describe
Reading			
Bathing			
Dressing			
Toileting			
Sleep Routines			
Cooking			
Eating			
Money Skills			

Other Limitations/Comments: _____

_____

_____

Bed Time _____ Wake Time _____ Favorite routines for going to sleep and/or waking up _____

_____

_____

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Section 2 Continued

If your child has an IEP, 504 Plan or has been diagnosed by a licensed practitioner, please complete below. If NOT, please leave BLANK

1. Name of child's physician _____ Phone #_____

Date of Last Physical _____

2. Is your child receiving any medication at present? _____

Drug	Dosage	Date Started	Purpose	Reaction

3. Has your child received any other medication in the past? _____

(If so, list type of drug, dosage if known, date started, date discontinued, purpose, reason for discontinuing.)

Drug	Dosage	Duration Dates (From/To)	Purpose	Reaction

4. Has your child had any adverse reaction to any drugs taken in past? _____

_____

5. Asthma, eczema or allergies? _____

If so, describe frequency, severity, treatment: _____

6. Food allergies/restrictions _____

7. Outcome if restricted foods are consumed: _____

_____

Previous Illnesses	Age	Hospitalized (Y/N)	Time in Hospital

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Section 2 - Continued

If your child has an IEP, 504 Plan or has been diagnosed by a licensed practitioner, please complete below. If NOT, please leave BLANK

1. How would you describe your child's personality? _____

_____

2. What, if anything, about his/ her behavior is troublesome for family, friends, and community?

_____

_____

When first noted? _____

How has it been handled successfully? _____

_____

What methods have been unsuccessful for handling this behavior? _____

_____

3. Describe your child's relationship with the immediate family (parents and siblings):

_____

_____

4. Describe your child's relationship with other adults (including teachers): _____

_____

5. Describe your child's relationship with peers (at school and play): _____

_____

6. How do you think your child views or feels about himself/herself? _____

_____

7. What are your child's self-care skills and responsibilities at home? _____

_____

8. What are usual play activities? _____

_____

9. What are your child's special interests, skills, hobbies? _____

_____

10. What are your child's dislikes? _____

11. Are there any specific traditions, beliefs, or core values you carry in your house? _____

_____

12. What are your educational goals for your child? _____

13. What professional career, if any, does your child wish to pursue? _____

14. What is your child's current school? _____ Grade: _____

15. Has your child had any suspensions/expulsions? Please fill in the chart below

School	Reason	Suspension	Expulsion	Length of Time/Dates

16. Does your child demonstrate any specific classroom behaviors? _____

_____

17. Do you see the same behaviors demonstrated at home? _____

_____

18. What are your child's behavioral triggers, challenges, and interventions? _____

_____

_____

_____

19. Potential emergency situations and instructions: _____

_____

20. Other relevant personal history _____

_____

_____

_____

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Section 2 - Continued - Other Evaluations

If your child has an IEP, 504 Plan or has been diagnosed by a licensed practitioner, please complete below. If NOT, please leave BLANK

1. Has your child ever had a visual examination? _____ When? _____

By whom? Name: _____ Ophthalmologist □ Optometrist □

Phone: _____

Does your child wear prescriptive lenses? _____ If yes, when are glasses worn? _____

2. Has your child had a hearing examination? _____ When? _____

By whom? Name: _____

Phone: _____

Is there any hearing loss? _____ If so, how severe (mild/ moderate/ severe)? Right ear □ Left ear □

3. Has your child had a neurological exam? _____ When? _____

By whom? Name: _____

Phone: _____

4. Has your child had a psychological examination? _____ When? _____

By Whom? Name: _____

Phone: _____

5. Has your child had psychotherapy? _____ Inclusive dates: _____

Frequency of therapy session: _____

With Whom? Name: _____

Phone: _____

6. Have you ever received professional counseling about your child? _____

With whom? Name: _____

Phone: _____

7. Has your child had any tutoring or remedial work? _____

For what? _____ How often? _____ Inclusive dates: _____

By whom? Name: _____

Phone: _____

8. Has your child received any speech therapy? _____ Inclusive dates: _____

By whom? Name: _____

Phone: _____

9. Has your child had any perceptual motor or visual motor- training? _____

Inclusive dates: _____ Frequency of counseling sessions: _____

With whom? Name: _____

Phone: _____

10. Other doctors, hospitals, clinics, etc. where your child has been examined?

Name	Phone	Purpose	Date

11. Other comments concerning evaluations/treatment:

_____

_____

_____

_____ _____

Signature of provider of information Date