

POST Academy

Application for Enrollment

Student Name: _____
Date of Birth: _____ Age: _____ Gender: _____

Parent/Guardian: _____
(Circle one) Biological Adoptive Foster Grandparent Other: _____
Address: _____
Phone: home: _____ work: _____ cell: _____

Legal Guardian (if different from above): _____
Social worker: _____ phone: _____

Referring Agency: _____
Contact Person: _____ Title: _____
Phone: office: _____ cell: _____ fax: _____

Reasons for Referral: _____

Current School District (City): _____
Current School Attending: _____ Grade: _____
Special Education Classification: _____
Related Services, if applicable: _____

Mental Health Diagnosis: _____
Outpatient Services: _____
Physician: _____ phone: _____
Therapist: _____ phone: _____

Current Medications: _____

Medical Concerns: _____
Allergies: _____
Physical Activity Restrictions: _____

Signature/Title

Date