



Dr. Linda J. Jacobs, Executive Director

Application for Admission

The Harbour School at Annapolis
1277 Green Holly Drive
Annapolis, MD 21409
Tel: 410-974-4248
Fax: 410-757-3722
Email: admissions@harbourschool.org

Noël Butler, Program Director
Taylor Wheelock, Curriculum Coordinator

The Harbour School at Baltimore
11251 Dolfeld Blvd
Owings Mills, MD 21117
Tel: 443-394-3760
Fax: 443-394-3765
Email: admissions@harbourschool.org

Martha Schneider, Program Director
Kim Harrison, Curriculum Coordinator



Visit our website: www.harbourschool.org

Applying for:

Annapolis _____ School Year July _____
Baltimore Co. _____ to June _____
Either _____

Full Given name of Student _____

Nicknames (if any) _____ Grade: _____ Date of Birth ____/____/____ Age _____ Gender _____

Student's Home Address _____

_____ Zip _____ Telephone () _____

Student's Social Security # _____ Student's Medical Assistance # _____

Full Name of child's Father _____

Home Address _____ Zip _____

Cell () _____ Home () _____ Email: _____

Position & Occupation _____

Employed by _____

Business Address _____

_____ Zip _____ Telephone () _____

Full Name of child's Mother _____

Home Address _____ Zip _____

Cell () _____ Home () _____ Email: _____

Position & Occupation _____

Employed by _____

Business Address _____

_____ Zip _____ Telephone () _____

Names and Ages of Brothers and Sisters _____

Name of Applicant's Current School: _____ Principal: _____

Telephone () _____ School System: _____

Is your child currently receiving special education services? _____

Describe your child's educational problems: _____

Had your child had any evaluations: Include copies

☐ educational ☐ psychological ☐ medical ☐ other Explain (what, when, by whom)

Name of Step Parent (if any) residing with Child _____

Child's Height _____ Child's Weight _____ (A picture of your youngster would also help us to get a "feel for your child")

Child's Attending Physician _____

Address _____

_____ Zip _____ Telephone () _____

Is your child receiving medication? _____ If yes, please indicate the medication _____

Dosage _____, and the reason for the medication _____

Describe any allergies or special diets which may apply to your child: _____

Describe any physical problems your child may have: _____

Describe any serious concerns you may have about your child: _____

Describe any school related problems other family members have experienced: _____

Describe any difficulties your child had in learning to eat, sleep, sit, walk or talk: _____

Briefly describe any traumatic events which the child has experienced, for example, death of a close relative,
divorce, family crisis _____

Is English the usual language spoken at home? Yes ____ No ____ Other Language _____

What does your child do well? _____

What do you like best about your child? _____

Is there anything else we should know about your child? _____

How did you hear about us? _____

Who referred you to The Harbour School? _____

Why do you want The Harbour School for your child? _____

All information on this form will be strictly confidential and will be used to help us in developing the best education program for your child. This form will be kept in your child's confidential folder.

If you have any questions, please call Noël Butler, Program Director (Annapolis Campus), 410-974-4248
or Martha Schneider, Program Director (Baltimore County Campus) 443-394-3760.

Parent's Signature _____ Today's Date _____

Please check any of the following which describe your child:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Physical challenge | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Nailbiting | <input type="checkbox"/> Lacks self control |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Daydreams | <input type="checkbox"/> Mechanical | <input type="checkbox"/> Frequent sudden changes in mood |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Overactive | <input type="checkbox"/> Excessive inconsistency in behavior |
| <input type="checkbox"/> Temperatures above 104° | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Athletic | <input type="checkbox"/> Needs constant approval or reassurance |
| <input type="checkbox"/> Frequent colds or sore throats | <input type="checkbox"/> Unreasonable fears | <input type="checkbox"/> Musical | <input type="checkbox"/> Unusually shy or withdrawn |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Gets idea quickly | <input type="checkbox"/> Rocking | <input type="checkbox"/> Difficulty completing jobs and activities |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Fantasies | <input type="checkbox"/> Difficulty with organization | <input type="checkbox"/> Difficulty with change in routine |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Artistic | <input type="checkbox"/> Frequently does not tell the truth | <input type="checkbox"/> Self confident |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Outgoing | <input type="checkbox"/> Enjoys reading | <input type="checkbox"/> Avoids reading |
| <input type="checkbox"/> Underactive | <input type="checkbox"/> Avoids homework | <input type="checkbox"/> Doesn't seem to understand questions or directions | <input type="checkbox"/> Difficulty telling time |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Dietary problems | <input type="checkbox"/> Difficulty making and keeping friends |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Frequently talks to self | <input type="checkbox"/> Creative | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Resists going to school | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Easily influenced by others | |
| <input type="checkbox"/> Flexible | <input type="checkbox"/> Lacks motivation | <input type="checkbox"/> Difficulty using numbers | |
| <input type="checkbox"/> Consistently short attention span | <input type="checkbox"/> Bedwetting | | |
| | <input type="checkbox"/> Thumb sucking | | |

Comments on any problems or behaviors above _____