



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
- Psychological / Psycho-educational testing
- Report Cards
- Individual Education Plans (IEPs)
- 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.



Turnpike



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

Priorities

In order for us to design the most effective individualized program for your child, it is important that we are aware of what you consider to be the main priorities we should work on with your child. This ensures that your child derives the maximum benefit from the program and that we have a common purpose. It is important that both parents (if applicable) read and prioritize this sheet together. **Please rank each of the items below in order of priority from 1 to 15, "1" being the most important and "15" the lowest priority.** Remember not to use any number more than once, and feel free to add comments after any of the items, or on the other side of this sheet.

Student Name _____

Date _____

	SOCIAL BEHAVIORS (Restaurants, supermarkets, visiting)
	EMOTIONAL ADJUSTMENTS (Teasing, bullying, fighting)
	PEER RELATIONSHIPS/FRIENDSHIPS
	LISTENING AND FOLLOWING DIRECTIONS
	FAMILY AND SIBLING RELATIONSHIPS
	POOR SELF CONTROL / TEMPER TANTRUMS / ANGER CONTROL
	ORGANIZATIONAL SKILLS
	CONFIDENCE
	LIFE SKILLS (Time/money management etc.)
	WRITING SKILLS (Neatness)
	TEST TAKING SKILLS
	HYGIENE
	READING
	WRITING SKILLS (Essays, papers)
	MATH

PARENT SIGNATURE

DATE



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

Presenting Problems
(Please print or type all information)

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: _____



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

Developmental History
 (Please print or type all information)

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 _____



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

General Information
 (Please print or type all information)

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



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

Emotional, Educational, and Social Adjustment of Child
(Please print or type all information)

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 _____



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

OTHER EVALUATIONS & TREATMENTS

(Please print or type all information)

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

Do we have your permission to contact any of the above-named specialists who have worked with your child to obtain further information when necessary? Yes No

If YES, please complete the next page. If NO, do not complete next page.

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:

**AEF Schools
4650 SW 61st Avenue
Davie, FL 33314**

**Tel (954) 581-8222
Fax (954)797-0700**