

Children's Dyslexia Centers, Inc. Child Application		
Date: Rev. 1/11/2024	Policy #5 General Clinical	Owner: Clinical

*The Children's Dyslexia Centers, Inc. provides the highest quality, state-of-the-art, multisensory tutorial reading and written language instruction to children with a primary diagnosis of dyslexia. We reserve the right not to treat a child who has another diagnosis when, in our sole discretion, we determine that it will hinder the child's ability to benefit from our services.*

Center: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Information: Please complete the items below.**

Parent/Guardian 1: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Telephone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Parent/Guardian 2: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Telephone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

**Child Information: Children must have a psychoeducational evaluation completed by a qualified professional to be eligible for the program. Please complete the items below.**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Child's Gender:  Male  Female  Other Grade: \_\_\_\_\_

Name of School: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Evaluator's Name: \_\_\_\_\_ Date of Evaluation: \_\_\_\_\_

Does your child know the alphabet?  Yes  No

Can your child write his/her name?  Yes  No

Child writes with:  Left hand  Right hand  Both

Does your child understand words?  Yes  No

Does your child understand questions?  Yes  No

Does your child understand directions?  Yes  No

How well do other people understand your child's speech? \_\_\_\_\_

Describe your child's learning difficulties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there a history of learning problems in the family?  Yes  No

If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

Does the child have any other diagnosed learning, attention, emotional, behavior or medical problems?  Yes  No

If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

Most recent eye exam date: \_\_\_\_\_ Results: \_\_\_\_\_

Most recent hearing exam date: \_\_\_\_\_ Results: \_\_\_\_\_

Is English the child's primary language?  Yes  No If no, what is? \_\_\_\_\_

Has your child applied to or received services at any other Children's Dyslexia Center?

Yes  No If yes, please list center location and attendance dates. \_\_\_\_\_

\_\_\_\_\_

How did you hear about the Center? \_\_\_\_\_

\_\_\_\_\_

Child's Siblings/Ages: \_\_\_\_\_

\_\_\_\_\_

Please list your child's Interests and hobbies. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent/Guardian Printed Name: \_\_\_\_\_

\_\_\_\_\_

Parent/Guardian Signature

Date