



CROSSROADS SCHOOL
ADMISSION / ENROLMENT FORM

Name of Learner: _____

Grade applying for: _____ Starting Date: _____

Learner's Date of Birth: _____ Date of submission: _____

Please take time to consider these questions carefully. They help us to gain a picture of your child and his/her developmental history.

REASON FOR APPLICATION:

Describe the nature of your child's presenting problem/s and how you hope Crossroads will be able to assist with these challenges.

Please briefly explain the history of the presenting problem/s, such as the emergence, development, and contributing factors that have led to this point.

Please provide details of the person who recommended Crossroads, e.g. family member, friend, teacher, school or medical professional:

Permission to contact the school / Professionals: yes ☐ no ☐
Information gained will be used for the admission process and guides us in acceptance or suggesting suitable schools.

Principal: Y. Roux | Business Manager: N. Brown



Member of Independent Schools Association of Southern Africa (ISASA)

DETAILS OF APPLICANT:

BASIC INFORMATION:	
Age:	Gender:
Nationality:	
Learner's Home address:	
Home Language:	Second Language:

DEVELOPMENT HISTORY
<i>Please indicate if there were any concerns/ delays/adverse experiences:</i>
Pregnancy and birth:
Early attachment and bonding with caregivers:
Delays in motor milestones: i.e. sitting/crawling/walking:
Speech delays:

SCHOOL HISTORY
CURRENT SCHOOL
Name:
Current Grade:
Language of instruction:
SCHOOLS ATTENDED: <i>Indicate school and grades attended.</i>
Name of Creché/Nursery School:
Name of Primary School 1:
Name of Primary School 2:
Other:

ACADEMIC HISTORY		
At which grade/age were challenges first noted?		
Has your child ever repeated a grade?	yes ☐ no ☐	If yes, which grade?
Does your child have a facilitator?	yes ☐ no ☐	If yes, why?
Does your child receive concessions?		
Does your child use Assistive Technology to support learning?		

MEDICAL INFORMATION	
GENERAL HEALTH	
Medical Conditions/ Childhood illness:	
Allergies:	
Operations:	
DIAGNOSIS / MEDICATION	
FORMAL DIAGNOSIS yes ☐ no ☐	
Diagnosis:	
Name of diagnosing practitioner/s:	
Current Medication:	
History of medication:	
Date of diagnosis:	
Date last seen:	
Psychiatrist:	
Medication:	
Date of diagnosis:	
Date seen:	
Neurologist:	
Date seen:	
EEG conducted:	
Findings:	

Pediatrician:	
Medication:	
Date seen:	
Findings:	
GP:	
Medication:	
Findings:	
Other Medical Professionals:	
Name and Surname	
Reason	
Findings	
Medication	

HEARING AND VISION SCREENINGS / TESTS		
	Date of Tests	Results
Hearing Test/Screening		
Eye Test		
Does your child wear glasses?		
Does your child wear a hearing aid?		
Is your child diagnosed with Auditory Processing Disorder? yes ☐ no ☐		
If yes, by whom and when:		
Does your child use an FM device?		
Notes:		

THERAPEUTIC HISTORY / ASSESSMENTS

PSYCHOLOGICAL INTERVENTION / PLAY THERAPY	
Name and Surname of therapist	
Start date of therapy	
Termination of therapy	
Therapy addressed:	
Recommendations:	

OCCUPATIONAL THERAPY	
Name and Surname of therapist	
Findings	
Start date of therapy	
Termination of therapy	
Therapy addressed:	
Recommendations:	

SPEECH AND LANGUAGE THERAPY	
Name and Surname of therapist	
Findings	
Start date of therapy	
Termination of therapy	
Therapy addressed:	
Recommendations:	

LEARNER SUPPORT OR REMEDIAL THERAPY

Name and Surname of therapist

Findings

Start date of therapy

Termination of therapy

Therapy addressed:

Recommendations:

OTHER THERAPIES/ INTERVENTIONS / ASSESSMENTS

PERSONAL PROFILE

GENERAL: Please share the information below

Self-esteem: *Please comment on your child's self-esteem.*

Emotional and Behaviour concerns: *Please describe your child's general mood, level of anxiety, coping skills, any aggressive behaviour and related triggers or fluctuations.*

Social Interactions: *Please describe your child's social engagement with peers, adults, ability to form and maintain friendships/relationships, role in group dynamics, management of conflict etc.*

Discipline: *Please indicate your child's typical response to discipline, boundaries and authority figures.*

Trauma: *Please provide information on any adverse childhood experiences or relevant family trauma/ events.*

FAMILY INFORMATION

PARENT / GUARDIAN INFORMATION		
	Parent / Guardian 1	Parent / Guardian 2
Name and Surname:		
Relationship to Child:		
Contact Details:		
Occupation:		
Level of Education:		
Significant others in child's life:		

FAMILY SET-UP
Married/ Partners/ Divorced/ Separated/Widow/ Widower:
If divorced/separated, who has legal custody or what are the custody arrangements?
Is the child: Biological ☐ Fostered ☐ Adopted ☐
Marital / Partners relationship?
Child's relationship with parents/guardians/ significant others?
How is discipline enforced in the child's home environment/s? What are the roles that each caregiver takes in engaging with discipline? ?
Family History of physical health conditions, learning and/or psychiatric difficulties?

SIBLINGS:	
Name:	Age:
School:	Grade:
Relationship:	
Name:	Age:
School:	Grade:
Relationship:	
Name:	Age:
School:	Grade:
Relationship:	
Name:	Age:
School:	Grade:
Relationship:	
Other:	

Is there any other information that you would like to share with the school?

Thank you for taking the time to complete the information