Orion College
Grade R – 12 and Vocational

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EMIS No: 700400026
Exam No: 8400026

Name of applicant:

Application Form and Intake Questionnaire

Thank you for considering Orion College for your child's learning needs. We are committed to providing our learners the best possible service and access to education. It is also our mission to ensure that learners are correctly placed and receive individualized support interventions, based on their needs. As such, it is important that we have all the information that you could possibly provide about your child, as a prospective learner. This information will be carefully considered by the relevant parties to, firstly, ensure that Orion is the best fit for your child, secondly, that he/she is placed in the correct stream, and thirdly, to make the appropriate recommendations, in terms of additional support.

Please ensure that you fill this form in as accurately as you can. When answering the questions consider your child's development carefully and describe any unusual occurrences and behaviours. This questionnaire is designed to assist in understanding your child's development and his/her needs. Some of the questions may not apply to your child but, if they do, please answer fully. Withholding important information could affect your child's possible placement.

The following should accompany this form:

- A Psycho-Educational report, not older than two years
- Medical reports (if applicable)
- Copy of both parents/guardian's identity documents
- Learner's birth certificate
- Study permit (if foreign learner)
- Latest school report
- R250 non-refundable application fee

Banking Details:
Standard Bank Clearwater
Account no. 021208883
Branch code: 001206
Ref: Learners name and surname

Once all the relevant documentation has been submitted, the following will take place:

1. We will review your application and the documentation submitted.
2. Based on the information provided, we will contact you to either schedule an intake meeting with the Principal and Educational Psychologist or refer you to a more appropriate school for your child. The purpose of the intake meeting is to discuss your child's needs further and explain how the school operates. You will also be offered a tour of the school.
3. If agreed on, your child will be invited to visit our school for 5 days. This visit will help Orion determine whether he/she is a good fit for the school, which stream he/she should be placed in, and whether the school can meet his/her needs.
4. After this you will be provided with feedback and the school's decision regarding your child's placement.
5. Your child will either be offered a place at Orion, placed on the waiting list (if the class is full), or referred to a school that may be able to cater to his/her needs better.

PART A – APPLICATION FORM
BIOGRAPHICAL DETAILS

Details of Child/Prospective Learner

Full Name				Gender	
D.O.B			ID Number		
Age		Grade		Religion	
Nationality			Home Language		
Current School			Other Languages		
Current medication and Dosage			Reason for medication and/or diagnosis		
Does your child have any allergies?	Yes	No	If yes, please specify:		
Dexterity	Right-handed		Left-handed		
Street Address					
Postal Address					
Why are you applying to Orion College?					
How did you find out about us?					
How do you think your child will benefit at Orion College?					

Medical Details

Medical Aid			
Name		Main member	
Contact number		Membership no.	
Medical aid Package		Dependent code	
General Practitioner			
Doctor's name		Tel.	
Next of Kin/Emergency contact			
Name		Tel.	
Relationship to child			

Transport Company

Name	
Contact details	

Current School

Name of School		
Contact details	Tel no.	
	Email address	
Name of Principal		
Name of Class Teacher		

Parent/Guardian Information

Parent/Guardian 1	
Full name	
Relationship to child	
ID/Passport no.	
Race	
Occupation	
Highest qualification	
Employer	
Does your work necessitate long absences from home?	
Nationality	
Cell Phone number	
Work Telephone number	
Email address	
Street address	
Postal address	
Parent/Guardian 2	
Full name	
Relationship to child	
ID/Passport no.	
Race	
Occupation	
Highest qualification	
Employer	
Does your work necessitate long absences from home?	
Nationality	
Cell Phone number	
Work Telephone number	
Email address	
Street address	
Postal Address	

Other Relevant Caregiver/Guardian	
Full name	
Relationship to child	
ID number	
Race	

Occupation	
Employer	
Does your work necessitate long absences from home?	
Nationality	
Cell Phone number	
Work Telephone number	
Email address	
Street address	
Postal Address	

Marital Status

Single		Married		Divorced		Separated		Widowed		Remarried		Other									
How old was the child at the time of divorce/separation?																					
If divorced/separated, with whom is primary residence?																					
Does the other parent have visiting rights?																					
Is this child:		Biological					Fostered					Adopted									

Person Responsible for Account

Name		**Tel.**	
ID/Passport no.		**Occupation**	
Email		**Employer**	

FOR OFFICE USE ONLY:

Have the following documents been submitted (please tick):

A Psycho-Educational report, not older than two years	
Medical reports (if applicable)	
Copy of both parents/guardian's identity documents	
Learner's birth certificate	
Study permit (if foreign learner)	
Latest school report	
R250 non-refundable application fee	

Signature: _____ (Shelley Lubbe)

Notes:

PART B – INTAKE QUESTIONNAIRE
DEVELOPMENTAL HISTORY AND CURRENT FUNCTIONING

Family Structure

Siblings				
Name	**Age**	**School**	**Class**	**Academic Progress**

Who resides with the child (other family members/household members):
Is there a family history of hereditary illnesses? If yes, please specify**.**
Is there a family history of learning difficulties? If yes, please specify.
Has the learner or the family experienced a trauma, e.g. death of a family member, hijacking, robbery etc.? Please provide details.
Family Relationships Describe your child's relationships and interactions with various family members, e.g. often have a difference of opinion and argue a lot.
Marital relationship (between parents - if divorced/separated describe coparenting arrangements)
Relationship of child with mother:
Relationship of child with Father:
Relationship of child with siblings:
Relationship of child with other significant role players:

School History

Grade's repeated	
Language of teaching and learning	

Previous Schools

Phase	School Attended	Year & Age	Duration	Progress Made
Nursery School				
Primary School				
High School				

School Readiness

Was your child considered ready for Primary School at Grade R age?			
Was a school Readiness assessment conducted?		Date	

If your child was not considered ready, please provide the reasons:

When were the difficulties first observed:

Describe your child's learning difficulties:

Describe your child's relationship with his/her peers:

Describe your child's relationship with his/her teachers:

Describe your child's current school and class. How many learners in a class? Do you feel your child receives enough attention?

Learner's current functioning

Sleep Tick √ what is relevant										
Regular		Restless		Nightmares		Bedwetting		Sleepwalking		

Eating Tick √ what is relevant					
Good appetite		Fussy/picky eater		Other	

Habits Tick √ what is relevant							
Thumb sucking		Nail biting		Twitching		Other	

Attention and Concentration Tick √ what is relevant		
Is your child able to concentrate for extended periods of time, e.g. playing Play Station, watching TV?	Yes	No
Does your child get easily distracted?	Yes	No
Do you have to continuously repeat instructions?	Yes	No

Rate the following:			
Concentration	Good	Average	Poor
Activity level	Overactive	Normal	Poor
Talks	Too much	Average	Too little
Fidgets	A lot	A little	Not at all

Socially				
Does your child prefer to be alone?			Yes	No
Does he/she like to have the company of friends?			Yes	No
Does he/she interact well with friends?			Yes	No
What age group does he/she prefer to spend time with?	Older	Younger	Both	Same age
How does he/she interact with other adults?				

Discipline
When does your child need disciplinary measures, if at all?

Which disciplinary measures do you use?

Ignore behavior/remove attention	Time out/naughty corner
Redirect child's interests	Send child to his/her room
Scold child	Take away toys/activities
Spank child	Other:
Reason with child	

Medical History					
How is your child's current health?	Excellent	Very good	Good	Poor	Very poor
Significant medical events	**Details**				
Illnesses:					
Accidents:					
Hospitalizations/surgeries:					
Fevers/seizures:					
Any other medical conditions we should be aware of?					

Previous Assessments

Assessment Done	Doctor/therapist	Contact details	Date	Report attached?
		Tel: **Email:**		
		Tel: **Email:**		
		Tel: **Email:**		
		Tel: **Email:**		
		Tel: **Email:**		
		Tel: **Email:**		

Do you give consent for us to contact therapists, teachers, doctors, or other professionals who have worked with your child, should we need more information?	Yes	No

If yes, please sign:

We, _____ (names of parents/guardians), parents of _____ (learner's name), hereby consent for the relevant staff members at Orion College to contact therapists, teachers, doctors, or other professionals that have worked with my child should they require further information.

_____ (signature parent/guardian 1) Date: _____

_____ (signature parent/guardian 2) Date: _____

Auditory system – Hearing Assessment Please attach any assessment reports available	
Who did the assessment?	
Date	
Results/recommendations	
Does your child currently have or ever had grommets? If yes, please provide details.	

Have you observed the following?	Yes	No	Comment
Your child appears to hear sounds other children don't			
Your child appears to be sensitive to sounds, e.g. fridge, heater etc.			
Your child appears to struggle to identify the direction from which a sound comes			
Visual System – Eye Test Please attach any assessment reports available.			
Who did the assessment?			
Date			
Results/recommendations			
Please provide details on the following:	Yes	No	Comment
Does your child have a diagnosed visual defect?			
Does he/she wear glasses?			
Is or has he/she received visual therapy?			
Does your child make reversals when writing?			
Does your child experience difficulty following a moving object?			
Is your child sensitive to light?			
Does your child blink continuously?			
Does your child work with head close to the paper?			
Does your child become excited or confused when exposed to a variety of visual stimuli?			

Developmental History

Pregnancy			
	Yes	**No**	**Comment**
1. Previous miscarriages or stillbirths?			
2. Was the pregnancy planned?			
3. Medication during pregnancy?			
4. Smoking during pregnancy?			
5. Drinking during pregnancy?			
6. Any significant events during pregnancy? E.g. trauma			
7. Any other complications during pregnancy?			
Birth			
8. Normal, c-section, forceps delivery?	/	/	
9. Was labour induced?			
10. Duration of labour?	/	/	
11. How many weeks at birth?			
12. Birth weight?	/	/	
13. Apgar score?	/	/	
14. Any complications at or after birth?			
15. Incubator used? If yes, how long?			
16. Any feeding problems?			
17. Breast or bottle-fed?	/	/	

18. Jaundice? If yes, for how long?			
19. Post Natal despression? If yes, please provide details on duration, treatment, and bonding?			

Motor Milestones	
Milestone	**Age/Comment** If you cannot remember the exact age then comment on whether it was age appropriate or not
Smile	
Hold head up	
Roll over	
Sit on his/her own	
Crawl	
Walk	
Ride a tricycle	
Ride a bicycle	
Dress him/herself	
Feed him/herself	
Sleep in own room	
Toilet train	

Occupational Therapy History and Milestones

Has your child ever received Occupational Therapy?	**Yes**	**No**	
If yes, please provide details. E.g. duration, goals etc.			
Functional Tasks	**Yes**	**No**	**Comment**
Can your child perform everyday functional tasks independently? E.g. getting dressed/undressed, bathing/showering, using the toilet?			
Sensorimotor			
Tactile sensation	**Yes**	**No**	
Does your child dislike being touched?			
Prefers to touch rather than be touched?			
Dislikes being hugged/cuddled?			
Have a strong need to touch people, objects or animals?			
Seem easily irritated or angered when touched by siblings or peers?			
Frequently pushes/bumps other children?			
Appears to pick fights in school?			
Isolates him/herself from other children?			
Vestibular	**Yes**	**No**	
Appears fearful of space, e.g. going up and down escalator, stairs, lifts, etc.?			
Appears clumsy and often bumps into things or falls easily?			
Enjoys moving fast, rolling, spinning movements and/or rides?			
Gets car sick?			

Are your child's movements slow, plodding and/or deliberate?			
Co-ordination	**Yes**	**No**	
Does your child appear to be accident prone?			
Does he/she eat in a sloppy manner?			
Appear to tire easily?			
Appears to ignore one side of the body? If yes, which side?			
Appears to experience difficulties with sequencing of movements, e.g. dressing?			

Speech and Language History and Milestones

Has your child ever received Speech and Language Therapy?	**Yes**	**No**
If yes, please provide details. E.g. duration, goals etc.		

Ear infections?	**Never**	**Seldom**	**Frequently**
0 - 3 years old			
3 – 6 years old			
Over 6 years old			
When was the last ear infection?			
Who treated it and what treatment was given?			
Is there a family history of speech difficulties?			

Milestones	**Yes**	**No**
Did your child cry at birth?		
Was your child an abnormally quiet baby?		
Did your child respond to sounds as a baby?		
Was he/she able to imitate sounds?		
Approximate age at which your child babbled?		
Age at which first words were said?		
Age at which child was able to say sentences?		

Currently	**Yes**	**No**	**Sometimes**
Does your child show understanding when spoken to?			
Are strangers able to understand your child when he/she speaks?			
Does your child express him/herself fluently?			
Does your child use long sentences?			
Do you think your child's vocabulary is on par for his/her age?			
If not, please provide details.			

Thank you for taking the time to fill this questionnaire in ☺