

QuickTime™ and a
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are needed to see this picture.

Attach recent photo of applicant here:

Murphy & Dwyer Academy Inc.

29 Regina Drive, Chelmsford, MA 01824-4540

Telephone: (978) 256-3093 Fax: (978) 455-1726

E-mail: MDA@murphydwyer.org

APPLICATION INFORMATION

Date of Application: _____ Desired Date of Admission: _____ Date of Admission: _____

Full name of Applicant: _____
first middle last nickname if school should use

Address: _____
No./street City/town State Zip

Home telephone: _____ Fax: _____ E-mail: _____

Date of Birth: _____ Place/Country of Birth: _____ Citizenship: _____

Age: _____ Current Grade: _____ Primary Language if other than English: _____

Father			Mother		
Name: _____ <small>first middle last</small>			Name: _____ <small>first middle last</small>		
Address: _____ <small>No./street</small>			Address: _____ <small>No./street</small>		
<small>City/town State Zip</small>			<small>City/town State Zip</small>		
Home phone: _____		Cell Phone: _____	Home phone: _____		Cell Phone: _____
Fax:() - _____		E-mail: _____	Fax: _____		E-mail: _____
Date of Birth: _____		Age: _____	Date of Birth: _____		Age: _____
Education(School/College): _____			Education(School/College): _____		
Degree(s): _____			Degree(s): _____		
Employer: _____			Employer: _____		
Occupation and Position: _____			Occupation and Position: _____		
<small>City/town State Zip</small>			<small>City/town State Zip</small>		
Work phone: _____		Cell Phone: _____	Work phone: _____		Cell Phone: _____
Fax: _____		E-mail: _____	Fax: _____		E-mail: _____

I/We hereby certify that the information given in this application is complete and accurate. We have read and understood and accept the above Terms and Conditions.

Signature: _____ Date: _____

Student Application

IDENTIFYING INFORMATION

Male Female Social Security number: _____

Race: _____ Height: _____ Weight: _____ Color of eyes: _____ Color of Hair: _____

Any Identifying Marks: _____

FAMILY INFORMATION

Parents are: Married Divorced Separated Widowed

Father remarried Mother remarried

Name(s) of step-parent(s): _____

With whom does the applicant reside?: _____

Legal Guardianship: _____

Is applicant adopted? Yes No Is he/she aware of adoption? Yes No

Is applicant under guardianship? Yes No

Guardian: If you are the step/non-biological parents but have custody/guardianship, please complete the information as parent(s): _____

Name and address of applicant's legal guardian(s): _____

Parent(s) of guardian(s) to whom school correspondence should be sent: _____

Names of Siblings: Date of Birth: Age Resides in home?

Yes No

Yes No

Yes No

Yes No

Yes No

Indicate any family conditions (death, divorce or traumatic event) of which the school should be aware: _____

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Student Application

EMERGENCY INFORMATION

First person other than parents to be contacted in an emergency	Second person other than parents to be contacted in an emergency
Name: first middle Last	Name: first middle last
Address: No./street	Address: No./street
City/town State Zip Telephone:() - Cell Phone:	City/town State Zip Telephone:() - Cell Phone:
Fax:() - E-mail:	Fax:() - E-mail:
Relationship to Applicant:	Relationship to Applicant:

MEDICAL INFORMATION

Primary Physician: first middle Last	Specialist: first middle last
Address: No./street	Address: No./street
City/town State Zip Phone:() - Pager:() -	City/town State Zip Phone:() - Pager:() -
Fax:() - E-mail:	Fax:() - E-mail:
Date of most recent physical examination (attach):	
Most current immunization record available (attach):	

If the applicant is currently on a medication program, state the name(s) of the medication(s), & current dosage(s).

Prescription Medication:	Dosage:	Prescribing Physician

Prescribing Physician:

first Middle last		
Address: No./street City/town State Zip		
Telephone: - - Pager: - - Fax: - - E-mail:		

MEDICAL INFORMATION (Continued)

I/We hereby certify that the information given in this application is complete and accurate. We have read and understood and accept the above Terms and Conditions.

Signature: _____ Date: _____

Student Application

Describe the purpose for which each medication is being taken:

Prescription Medication: Reason

Please list the names and locations of any hospitals, clinics, social agencies, private physician or psychologist to whom the applicant is known. Whenever possible, please include the division of the clinic you visited (i.e. Pediatric, Psychiatry, etc.):

Name:

first middle Last

Address:

No./street City/town State Zip

Telephone:() - Pager: Fax: E-mail:

Name:

first middle Last

Address:

No./street City/town State Zip

Telephone:() - Pager: Fax: E-mail:

If the applicant has been given a diagnosis or DSM-IVTR classification, please list:

Diagnosis: By Whom: When:

If your son/daughter has ever been under the care of a psychologist, psychiatrist, or therapist, please provide the reason, the name of the provider(s) and the date of service.

Provider Name:

first Middle last

Dates: Reason:

Provider Name:

first Middle last

Dates: Reason:

Has the applicant had Neuropsychological testing? Yes No

If yes, please provide MDA with a copy of the report.

Has your son/daughter been in group therapy or a pragmatic group? Yes No

If yes, please describe:

MEDICAL INFORMATION (Continued)

I/We hereby certify that the information given in this application is complete and accurate. We have read and understood and accept the above Terms and Conditions.

Signature: _____ Date: _____

Student Application

Has your son/daughter ever been hospitalized? Yes No

Provider Name: _____ Telephone: () -

first middle Last

Dates: _____ Reason Medical or psychological: _____

Provider Name: _____ Telephone: () -

first middle Last

Dates: _____ Reason Medical or psychological: _____

Are you currently or have you ever participated in family counseling? Yes No

If yes, has this been helpful to you?

Is there any history of behavioral difficulty in relationship to family or peers? Please describe:

If the applicant is affected by any allergies, indicate to what and describe the reaction, and any medication you have used in the past.

Allergy	Reaction	Action taken or medication used
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Please list and briefly describe any diseases, illnesses, accidents or other health difficulties which this applicant has had or experiences currently, that could affect his/her school life or performance:

Please identify and briefly describe any difficulties during pregnancy, labor or the birth of the applicant.

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Student Application

MEDICAL INFORMATION (Continued)

Please identify and briefly describe any areas of developmental delay, such as gross motor development, language acquisition, etc., or any information that pertains to or may affect the applicant's learning:

Please describe any physical restrictions about which the MDA staff should have knowledge of:

Parents are requested to fill out the checklist below:

Trait	Exc.	Very	Good	Fair	Poor
Mood Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relation with Adults in Authority	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Discipline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acceptance of Limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Response to Limit Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulse Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dentist's Name:

first middle last

Address:

No./street City/town State Zip

Telephone:() - Pager:() - Fax:() - E-mail:

Date of most recent dental examination:

I/We hereby certify that the information given in this application is complete and accurate. We have read and understood and accept the above Terms and Conditions.

Signature: _____ Date: _____

Student Application

SCHOOL INFORMATION

Name of School the student is currently attending: _____

Name: _____

Address: _____

No./street

City/town

State

Zip

School Liaison: _____

Telephone:() - _____

Does the student have an IEP?:

Yes

No

If yes, please send MDA a copy of the current IEP.

Please list what you consider to be your son/daughter's strengths, outstanding abilities, talents, and interests (use additional pages if necessary.):

How have your son/daughter's strengths been addressed in previous school settings?

Please list what you consider to be your son/daughter's areas of need?

How have your son/daughter's areas of need been addressed in previous school settings?

Please describe your immediate and long range goals and how you expect MDA help to meet them.

I/We are interested in an alternative educational programs for student's with Non-verbal learning disabilities and Asperger Disorder at Murphy and Dwyer Academy at this time:

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Signature: _____ Date: _____

Student Application

SCHOOL INFORMATION

Check all that apply

- Student is not currently in any school program.
- Tutored at home.
- I/We have rejected our son/daughter's current IEP or current school placement.
- Our son/daughter's school team or Special Educational Dept. has recommended outside placement.
- I/We are seeking another educational program: immediately next school year.

Who referred you to Murphy and Dwyer Academy or how did you learn about our program?

Name:

first middle last

Address:

No./street City/town State Zip

Profession: (e.g. Physician, Psychologist, Social Worker, Occupational Therapist, Educator, Advocate):

If Applicable:

Educational Advocate: Telephone:() -

Lawyer: Telephone:() -

School District's Special Education Director: Telephone:() -

School District's Liaison: Telephone:() -

TUITION INFORMATION

If tuition will be privately funded, financial correspondence should be sent to:

Name:

first middle last

Address:

No./street City/town State Zip

If tuition will be publicly funded, or you are seeking public funds, please complete the following:

Name:

first middle last

Address:

No./street City/town State Zip

School Liaison: Telephone:() -

Funding Status: In-Place Pending Not In-Place

Intent to seek funding, have not yet contacted the school district: Yes No

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Student Application

TUITION INFORMATION

Negotiating with school district: Yes No

Have retained legal counsel: Yes No

Rejected IEP, have mediation date: Yes No Date/Time: _____

Rejected IEP, have hearing date: Yes No Date/Time: _____

School District has agreed to fund Murphy & Dwyer Academy, Inc. placement. Bills should be sent to:

School/Agency: _____

Contact Person: _____

Address: first middle last

Address: _____

No./street City/town State Zip

Telephone:() - Fax:() - E-mail: _____

PICTURES:

It is understood that MDA and has the right to use any pictures or videos taken at school or clinic (Center for Neurointegrative Services, Inc, CNS) for the purpose of promoting school enrollment and/or marketing the school. Dr. McPhee does staff training for school departments and agencies. The videos may be used to educate staff and programs on pragmatic and social skills programs. This use includes: Oral/Video presentations by Dr. McPhee, Web pages(MDA/CNS), School promotional literature, and newsletters provided to parents/professional colleagues.

HEALTH/MEDICAL:

We acknowledge that the school does not maintain any student health or medical insurance, which would cover the students while attending the school. Each student will need to have medical insurance. A copy of the policy and a medical release for emergency needs to be submitted. The parent or legal guardian shall be responsible for the cost of all medical treatment. The health form will need to be submitted prior to the beginning of school.

The school shall not be responsible for any injuries that may be sustained by your child while participating in any activity at school unless such injury is directly caused by the gross negligence of willful acts of the school.

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Signature: _____ Date: _____

Student Application

APPLICATION STATEMENT

Please read the following information carefully before signing, acknowledging and accepting the contents of this application and Murphy & Dwyer Academy, Inc.'s Admission policies.

I hereby make application to Murphy & Dwyer Academy, Inc. for my son/daughter. Enclosed is a non-refundable application fee for \$85.00 made payable to Murphy & Dwyer Academy.

IF YOUR SON/DAUGHTER HAS EXPERIENCE NEUROLOGICAL, PSYCHOLOGICAL OR BEHAVIORAL BASED DIFFICULTIES WHICH HAVE NECESSITATED THE USE OF MEDICATION AND OR THERAPEUTIC INTERVENTION(S), IT IS IMPERATIVE THAT THIS INFORMATION BE DISCLOSED AND DESCRIBED IN THIS APPLICATION. THIS INFORMATION WILL ALLOW MURPHY & DWYER ACADEMY, INC. TO APPROPRIATELY ADDRESS YOUR SON/DAUGHTER'S OVERALL NEEDS.

IF IT IS DETERMINED THAT CRITICAL INFORMATION HAS BEEN INADVERTENTLY OR INTENTIONALLY WITHHELD, MURPHY & DWYER ACADEMY, INC. RESERVES THE RIGHT TO WITHDRAW A STUDENT'S ACCEPTANCE OR TERMINATE THE CONTRACT AND TERMINATE THE PLACEMENT. INFORMATION PERTINENT TO YOUR SON/DAUGHTER'S APPLICATION WILL BE HELD IN STRICTEST CONFIDENCE. IF YOUR SON/DAUGHTER IS NOT ACCEPTED OR DOES NOT ATTEND MURPHY & DWYER ACADEMY, INC., THE APPLICATION AND RECORDS WILL BE DESTROYED IN THREE MONTHS FROM CONFIRMATION THAT THE APPLICANT WILL NOT ATTEND.

I/We hereby certify that the information given in this application is complete and accurate. We have read and understood and accept the above Terms and Conditions.

Signature: _____ Date: _____