

# APPLICATION FOR LEARNING PARTNERS

\_\_\_\_ Month \_\_\_\_ Day \_\_\_\_ Year

Please Print ALL Items in Your Own Handwriting. I am applying for the term of: Spring  Summer  Fall

YOUR NAME \_\_\_\_\_ Date of birth \_\_\_\_ \_\_\_\_ \_\_\_\_ Age \_\_\_\_ Male  Female

Month Day Year

Address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Home Fax (\_\_\_\_) \_\_\_\_ - \_\_\_\_

E-mail \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Mother's Name** \_\_\_\_\_

Home Address \_\_\_\_\_ Home Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

E-mail \_\_\_\_\_ Email \_\_\_\_\_

## DIAGNOSTIC INFORMATION

Please fill out this section of the application as fully as possible..... DO NOT LEAVE ANY SECTION BLANK.

Do you currently receive support services? (For example, tutoring, special services for learning disabilities or ADHD, speech and language therapy.)

Yes  No  If yes, please describe the nature of the support and how often you receive it. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In your own words, describe what you understand about how you learn. \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any diagnoses you have received including the name of the professional and the date of the diagnosis.

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medication you take related to your learning or attentional difficulties. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

