



MILL SPRINGS ACADEMY

13660 NEW PROVIDENCE ROAD, ALPHARETTA, GA 30004-3413
TEL: (770) 360-1336 FAX: (770) 360-1341 www.millsprings.org

A non-refundable fee of \$100.00 must accompany this application

APPLICATION FOR ADMISSION

Date _____ Academic Year _____
Current Grade _____

First Name _____ Middle Name _____ Last Name _____

Nickname _____

Birthdate _____ Age _____ Sex _____ Social Security # _____

Parent/Guardian _____ Phone _____

Address _____

Street City County State Zip

Parent Email Addresses: _____

Marital Status _____ If divorced, who has custody? _____

Georgia Law currently states that we must provide non-custodial parents regardless of whether they participate in payment of fees with information re school program provided no court injunctions exist should the parent so request in an interview

Custodial parent please check if you wish:

- _____ Weekly reports sent to non-custodial parent
- _____ Quarterly reports sent to non-custodial parent
- _____ Any other written communication
- _____ Any other verbal communication
- _____ Student to be transported by non-custodial parent
- _____ Information sent re school functions
- _____ Information sent re Parent Volunteer Association functions

Name, address and phone number of parent not living in the home _____

Name

Street City State Zip Phone Number

Person financially responsible for fees _____

Who referred you to Mill Springs Academy? _____

Name

Street City State Zip Phone Number

Name of School presently attending _____

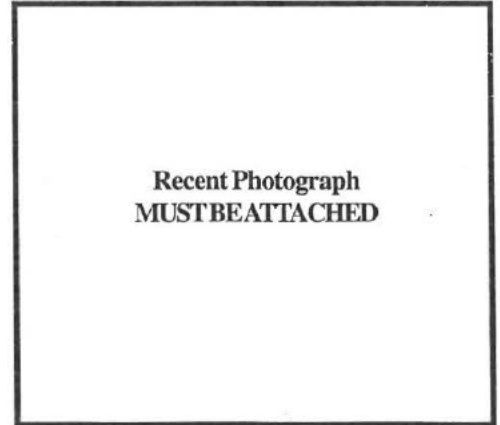
Address _____

Street City State Zip Phone Number

PARENT QUESTIONNAIRE

INSTRUCTIONS: Please print. If you need additional space for your answers, please use additional sheets of paper.
Please answer all questions.

Date _____
Phone Number _____ email _____
Student's Name _____
Age _____ Date of Birth _____ SS# _____
Address _____ County _____
City _____ State _____ Zip _____
Current School _____ Grade _____



FAMILY INFORMATION

Name _____ Birth Date _____ Education _____
(Father)
Name _____ Birth Date _____ Education _____
(Mother)
Name _____ Birth Date _____ Education _____
(Stepfather)
Name _____ Birth Date _____ Education _____
(Stepmother)

Place of Employment

Occupation

Address

Phone Number

Father _____
Mother _____
Stepfather _____
Stepmother _____

Marital Status _____ If divorced, who has custody? _____

Please provide us with a copy of the custody agreement.

Person(s) responsible for program fee: _____

List in chronological order the names of all siblings.

Name	Date of Birth	Education and/or Occupation	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

If a member has experienced any of the following please check who the family member is/was:

(i.e. maternal, paternal) f m gm gf a u s br

_____	ADHD	_____	Diabetes	_____	Seizure Disorder
_____	Alcoholism	_____	Drug Addiction	_____	Speech Problems
_____	Allergies	_____	Dysgraphia	_____	Suicide
_____	Asthma	_____	Dyslexia	_____	Suicide Attempt
_____	Bi-polar	_____	Learning Disability	_____	Tuberculosis
_____	Cancer	_____	Mental Illness		
_____	Depression	_____	OCD		

Was this child born to you? _____ Adopted? _____ If so, at what age? _____

What kind of adoption agency: Private - Public. If private, through physician or attorney? _____

If born to you, length of pregnancy? _____ Order of pregnancy _____

Delivery	Normal	_____	Labor:	Prolonged	_____
	Breech	_____		Very Brief	_____
	Caesarean	_____		Induced	_____
	Forceps	_____			

MEDICAL HISTORY

List doctors and other professional people who have examined, tested, or treated your student.
(Please give full address including zip code and phone numbers.)

Pediatrician _____

Psychiatrist _____

Psychologist _____

Neurologist _____

Other _____

Is your student presently seeing a psychiatrist, psychologist, or neurologist or therapist? Please provide name and address:

Does your student have specific physical handicaps that require special attention? _____

If yes, please describe _____

List any major illnesses, accidents or surgery _____

Is your student right or left handed? _____

Does your student take any medication routinely? _____

If yes, give name of medication, dosage given, prescribing physician and what condition the medications treats. _____

Does your child have seasonal allergies, food, or other allergies? _____

If so, what kind of allergies? _____

Does your student have asthma? _____

Does your student have diabetes? _____

Does your student have a seizure disorder? _____

SCHOOL HISTORY

Please list names and locations of previous schools and programs attended.

School	Address	Phone	Describe Special Services?
--------	---------	-------	----------------------------

Has your student been tested? If so, by whom, when and kind of testing? _____

Have there been behavior problems at school? _____ If yes, please describe _____

Problems with truancy? _____ If yes, explain _____

State in your own words, the nature of your student's needs.

When were the difficulties first noticed and by whom?
