



Atlanta Youth Academy

2020-2021 ACADEMIC YEAR

Direct Admissions documentation to:
Atlanta Youth Academy
2120 Forrest Park Rd SE
Atlanta, Georgia 30115
OR
mainoffice@atlantayouthacademy.com

ADMISSIONS APPLICATION

A **non-refundable application fee of \$30.00** must accompany this application. Money Order and Checks should be made payable to **Atlanta Youth Academy**. A copy of the following documents must also accompany this application: *Student's Birth Certificate, and a signed Records Release.*

Student Information

Entering Grade: _____ How did you learn of Atlanta Youth Academy? _____

Full Name:

Last *First* *M.I.*

Address _____

Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Phone: _____ Family Email: _____

Date of Birth (Month/Day/Year) _____ Gender Male Female

Place of Birth (City, State, Country) _____

Country of Citizenship _____

Parent/Guardian Information #1

Parents' Marital Status: Single Married Separated Widowed Divorced

Last *First* *M.I.*

Check here if address is same as student's.

Address: _____

Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Work #: _____ Cell #: _____ Home #: _____

Email: _____



Atlanta Youth Academy

Occupation: _____ Employer: _____

Student's Full Name:

Entering Grade:

Parent/Guardian Information #2

_____ *Last*

_____ *First*

_____ *M.I.*

Check here if address is same as student's

Address: _____

Street Address

Apartment/Unit #

_____ *City*

_____ *State*

_____ *ZIP Code*

Work #: _____

Cell #: _____ Home #: _____

Email: _____

Occupation: _____ Employer: _____

Other Members of the Household

Please list all other people living in the same house as the student, including ALL siblings.

FULL NAME	RELATION TO STUDENT	GENDER (M/F)	APPROVED PICK-UP?	EMERGENCY CONTACT	CELL #	WORK #
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Emergency Contacts and Approved Pick-Ups

Please list additional emergency contacts (at least one) and all people approved to pick-up the student from school.

*Authorized pick-ups must be at least **18 years of age, and photo ID will be required.***

Please check this box if only the parents/guardians listed on the previous page are allowed to pick-up the student.

FULL NAME	RELATION TO STUDENT	GENDER (M/F)	APPROVED PICK-UP?	EMERGENCY CONTACT	CELL #	WORK #
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Student Health History

Name of student's primary physician: _____

Physician's phone number: _____

Physician's address: _____

Please list any health issues or concerns you would like the school nurse to be aware of (i.e. allergies, problems with vision, hearing or speech, hospitalizations, medications, chronic diseases, disorders or illnesses).

Student's Full Name: _____

Entering Grade: _____

Academic Experience / Background

What is the name of the student's current school? _____

City/State: _____

Current School Phone: _____

How many times has the student entered this grade level? Check one option ONLY.

- First Time
- Second Time
- Third Time

Has your child ever been expelled or refused admissions or readmission by any school? Yes No

Has your child ever received or been evaluated for Special Education Services? Yes No

Only complete following section if you replied "Yes" to the proceeding question regarding your child.

Special Education Services

Please check any statement (#1-4) that applies to your child:

1. My child has never received any special education services
2. My child has an **Individualized Education Program (IEP)** or **Section 504 Accommodation Plan**

If you checked #2, please indicate the following as applicable.

(a) Do you have a copy of your child's **IEP or 504 Plan**? Yes No

(b) If your child has an **IEP or 504 Plan**, with which of the following disabilities have they been classified?

- | | | |
|---|---|--|
| <input type="checkbox"/> Autistic/Autism | <input type="checkbox"/> Deaf-blindness | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Multiple disabilities | <input type="checkbox"/> Orthopedic impairment |
| <input type="checkbox"/> Emotional disturbance | <input type="checkbox"/> Specific learning disability | <input type="checkbox"/> Speech or language impairment |
| <input type="checkbox"/> Traumatic brain injury | <input type="checkbox"/> Visual impairment (i.e. blindness) | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Other health impairment | <input type="checkbox"/> Deafness | |
| <input type="checkbox"/> Infants and toddlers with disabilities | <input type="checkbox"/> None | |

3. My child does not have an **IEP or 504 Plan**, but has undergone some evaluations.
4. I requested that my child be evaluated for special education or related services, but the evaluations have not yet been done. If yes, when did you request the evaluation? _____ What was the reason for the evaluation? (please check all that apply)

<input type="checkbox"/> Could use extra help in reading	<input type="checkbox"/> Feels frustrated in school
<input type="checkbox"/> Could use extra help in writing	<input type="checkbox"/> Has a hard time following directions
<input type="checkbox"/> Could use extra help in math	<input type="checkbox"/> Has a hard time relating with peers
<input type="checkbox"/> Has a hard time concentrating on his/her work	<input type="checkbox"/> Has a hard time understanding what people are saying
<input type="checkbox"/> Has a hard time sitting still for an extended periods of time	<input type="checkbox"/> Other

Please specify: _____

After Care Information

Will your child need before and/or after care? Yes No

After Care: **Mon. – Fri. 2:30pm – 6:00pm**

Religious Affiliation

Student Religion: _____

Father's Religion: _____

Mother's Religion: _____

Race/Ethnicity

Is the child Hispanic/Latino? (A person of Central or South America, or other Spanish culture or origin, regardless of race)

- Yes No

Is the child from one or more races? (*Please check all that apply*)

- American Indian or Alaska Native
- Asian
- White
- Black or African American
- Native Hawaiian or Other Pacific Islander

Preliminary Assessment of Native Language

What is the primary language spoken in the home, regardless of the language spoken by the student? _____

What is the language most often spoken by the student? _____

Student's Full Name: _____

Entering Grade: _____

What is the language the student first acquired? _____

Disclaimer and Signature

- I understand that **Atlanta Youth Academy** is a Christian Institution.
- I hereby give **Atlanta Youth Academy** the right to contact any previously attended schools in regards to this enrollment of my child.
- I hereby certify that the information submitted in the application process, including this admissions form is true.
- I understand that if it is determined that any information, I have provided is false, the admissions of my child may be revoked, or if my child is already in attendance, he/she may be subject to immediate expulsion.

Signature: _____

Date: _____

Printed Name: _____

FOR SCHOOL USE ONLY	
	Date/Initials
App Rec'd	_____
App Fee	_____
Enrollment Deposit	_____

Student's Full Name: _____

Entering Grade: _____