

Landmark School



Application for Admission

Embracing Potential. Empowering Lives.
Educating students with language-based learning disabilities.

www.landmarkschool.org

Welcome to the Admission Process

Please read the following guidelines before filling out the application.

Applications will be reviewed by the Admission Committee when all required documentation has been received. You will be notified when documentation is outstanding and/or when the application is complete and has been submitted for review. The review process is typically completed within 4-6 weeks.

Applicants viewed as likely to benefit from Landmark School's programs are scheduled for a half-day of required testing, staff interview, and a campus tour (summer applicants may not be required to complete this portion of the process). The Admission Committee will typically provide a final decision regarding acceptance on the day of this appointment.

To visit the school prior to applying, please visit our online schedule of upcoming Informational Open House Visits at www.landmarkschool.org/admission/visit-landmark or call 978-236-3011 for dates and times.

When submitting application and documentation via mail:

All documentation must be collated and stapled. Please send copies only, not originals, to:

Landmark School
Office of Admission
PO Box 227
429 Hale Street
Prides Crossing, MA 01965-0227

When submitting application and documentation via email:

We are able to accept applications and supporting documentation by email only if they are sent to admission@landmarkschool.org with as few attachments as possible (ie: all items scanned as one single attachment, rather than multiple individual attachments).

Application Checklist:

- Complete and return Pages 1-14 along with \$150 Application Fee (\$175 for International students)
- Summer Program Selection form (if applicable), available on website or by request
- Provide all diagnostic testing completed within the past 3 years
(see Diagnostic Testing Requirements, Page 2)
- Provide copies of Official School Records from the past 2 years to include: report cards, transcript, IEP/504, and Progress Reports if applicable
- Give forms to service providers (ie: teachers, physicians), see section beginning on Page 15
- Please note: International students must have an F1/student visa

NOTE: Documents will be added to the application file upon receipt.

Diagnostic Testing Requirements

In order to consider your child's application, Landmark School requires a full narrative report that indicates the presence of a language-based learning disability. This evaluation must have been administered within the past three years. The following measures are required:

I. Cognitive Assessment: Wechsler IQ Scales

Full WISC-IV or WISC-V (Wechsler Intelligence Scale for Children) for students age 16 and under
or
Full WAIS-IV (Wechsler Adult Intelligence Scale) for students age 16 +

Please note that the WASI (Wechsler Abbreviated Scale of Intelligence) is not acceptable as a substitute for the WISC-V or WAIS-IV

To the Evaluator: All index scores as well as all subtest scaled scores are required. Landmark requests the Digit Span subtest to be reported as Digit Span *forward* and *backward*.

II. Academic Achievement Testing

WIAT III (Wechsler Individual Achievement Test)
or
Woodcock Johnson Tests of Achievement, version III or IV
or
other similar measures of academic achievement

III. Assessment of Psycho-Social Functioning

BASC-2 (Behavioral Assessment Scale for Children)
or
CBCL (Child Behavior Checklist)
or
other similar measures of psycho-social functioning

Please note:

Any additional testing that has been administered within the past three years (such as speech and language or occupational therapy evaluations) must be submitted along with your application.

Thank you.

Application for Admission Landmark School

Academic Year Application Yes No Starting Year of Interest: _____-_____

Summer Program Application Yes No Year of Interest: _____

Please circle one: Day / Boarding / Undecided
Boarding is available for students entering grade 9 or above.

Date of Application _____ Applying for Grade _____ Current Grade _____

Applicant's Legal Name _____ (_____)
First Middle Last Preferred Name

Address _____
No./Street City/Town State Zip

Primary Phone _____ Applicant's Gender _____ Current Age _____

Date of Birth _____ Country of Citizenship* _____ Country of Birth _____

Ethnicity (*optional*) _____ Primary language if other than English _____

*If Citizenship is other than U.S., does student have a Green Card? Yes No (check one)

*If Citizenship is other than U.S., does student have an F1/student visa? Yes No (check one)

To ensure that all documents relating to your student's application are paired with the correct file, please be sure that their full, proper name is written on each page of the enclosed forms.

PARENT/GUARDIAN INFORMATION for _____ (full name of applicant)

Primary Parent/Guardian

Name _____
Mr./Mrs./Ms./Dr. First MI Last

Preferred Name _____

Relationship to Applicant _____

Check if deceased Date _____

Date of Birth _____

Home Address (if different from Applicant)

Primary Phone _____

Primary Email _____

School/College _____ Degree _____

Employer _____
Name of Company Type of Industry

Your Position/Title Business Phone

Business Address (Street, City, State, Zip, Country)

Name _____
Mr./Mrs./Ms./Dr. First MI Last

Preferred Name _____

Relationship to Applicant _____

Check if deceased Date _____

Date of Birth _____

Home Address (if different from Applicant)

Primary Phone _____

Primary Email _____

School/College _____ Degree _____

Employer _____
Name of Company Type of Industry

Your Position/Title Business Phone

Business Address (Street, City, State, Zip, Country)

Parent(s) are Single Married Life Partners Divorced Separated Father Remarried Mother Remarried

Name(s) of Step-parent(s) _____

With whom does the applicant reside? _____

Legal guardian(s) _____

If parent(s)/guardian(s) are not living at the same address do we have permission to communicate with both parents/guardians throughout the admission process? no yes

If no, all correspondence will be directed to the primary contact as noted above.

Is the applicant adopted? no yes Is the applicant aware of the adoption? no yes

Names and ages of siblings: _____, _____, _____

SCHOOL INFORMATION for _____ (full name of applicant)

Please check all applicable columns below

Grade	Year	Please list all schools that the applicant has attended from grade K to present:	Public	Private	Day	Boarding	IEP	Private Tutor
K	-							
1	-							
2	-							
3	-							
4	-							
5	-							
6	-							
7	-							
8	-							
9	-							
10	-							
11	-							
12	-							

If student is not in school, please state reason. _____

Has the applicant ever been suspended or expelled from school?
If so, include school reports documenting the date(s) and reason(s) for disciplinary action(s).

Who referred you to Landmark, or how did you hear about our programs?

Name _____ Organization _____

Profession (e.g. diagnostician, consultant, advocate, physician, educator) _____

Address _____

Phone _____ Email _____

MEDICAL INFORMATION for _____ (full name of applicant)

Physician's name _____ Phone _____

Please list all your child's diagnoses (educational, psychological, medical). By whom and when?

Please list medical conditions, if any.

Is your child currently receiving any medication(s)? No Yes

If yes, please list medication(s), start date(s), diagnoses, prescribing physicians, and describe condition(s) for which medication is being taken.

Has your child ever received psychological counseling or therapy, either in their school setting or privately? No Yes

If counseling services have been provided within the past two years, please have provider complete the Summary of Counseling form included in this packet.

Has your child ever been hospitalized for psychological reasons? No Yes

If you answered yes to either question, please complete the following:

Provider _____ Email _____

Phone _____ Date(s) _____

Reason(s) _____

TUITION PAYMENT INFORMATION for _____
(full name of applicant)

- Intend to pay tuition privately
- Intend to seek funding from our school district, but will pay privately if funding is not approved
- Intend to seek funding from our school district
- Intend to apply for financial aid

FINANCIAL AID

Landmark School utilizes the **School and Student Service by NAIS** to analyze applications for financial aid. While the Landmark School financial aid program is modest, it does provide some assistance to those parents/guardians who demonstrate clear financial need.

Families can apply for financial aid by visiting <http://www.landmarkschool.org/admission/affording-landmark>

Inquiries about financial aid should be directed to:

Jodi Bertolino
Landmark School
Business Office
978.236.3206
jbortolino@landmarkschool.org

RECORDS INFORMATION for _____ (full name of applicant)

In order to expedite the application process,
please list the names of service providers whose information will be part of this application.

Diagnostic Tester _____ Phone _____

Email _____

Diagnostic Tester _____ Phone _____

Email _____

English Teacher _____ Phone _____

Email _____

Math Teacher _____ Phone _____

Email _____

Principal *or* Guidance Counselor _____ Phone _____

Email _____

Tutor _____ Phone _____

Email _____

Specialist _____ Phone _____

Email _____

Residential Advisor _____ Phone _____

Email _____

Therapist/Counselor (psychological counseling) _____ Phone _____

Email _____

Psychopharmacologist (re: medications) _____ Phone _____

Email _____

PARENT/GUARDIAN STATEMENT

For _____ Completed by _____ Date _____
Full name of Applicant *Name of Parent/Guardian*

Please answer the following questions so that we may have a parent/guardian perspective on the strengths and needs of your child. Feel free to attach additional sheets.

1. What are your child's chief strengths and interests? _____

2. What are your child's areas of greatest need? _____

3. How do you hope Landmark will help your child? _____

4. Please describe your child's level of independence in daily life with regard to personal hygiene, room maintenance, and household chores. _____

5. Are there additional areas of concern of which we should be aware?

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True, or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

Young person's name _____

Male / Female

Date of Birth _____

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other youth, for example book, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would rather be alone than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other youth or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees tasks through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ Date _____

Parent / Teacher / Other (Please specify) _____

STUDENT STATEMENT

To be completed by all students (grades 1 through 12), and should be completed by the student in their own handwriting and in their own words.

Your full name _____ Date completed _____

1. What subjects do you like best in school? Please tell us why.

2. What part of school do you like least? Please tell us why.

3. What do you do in your free time? What are your favorite activities or hobbies?

4. How would you like Landmark School to help you?

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True, or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

Your name _____

Male / Female

Date of Birth _____

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others, for example CD's, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would rather be alone than with people of my age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often volunteer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get along better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Signature _____

Today's Date _____



admission@landmarkschool.org

PERMISSION to RELEASE INFORMATION
PERMISSION TO CONTACT

I am the parent/guardian of a child applying for admission to Landmark School. I request that all pertinent information concerning my child's medical, psychological, and academic history be forwarded to the Landmark School Admission Office. These records include, but are not limited to, academic records, medical records, psychological evaluations, speech and language evaluations, and neuropsychological evaluations.

I give permission for Landmark School to contact all service providers for any additional information.

Landmark School
Office of Admission
PO Box 227
429 Hale Street
Prides Crossing, MA 01965-0227
admission@landmarkschool.org
Phone 978.236.3000 Fax 978.927.7268

Full Name of Applicant_____

Date of Birth_____

Street Address_____

City/State/Zip Code_____

Phone_____

Signature of Parent or Guardian_____

Date_____

This release shall remain effective from the date above until such time as I revoke consent in writing or my child's enrollment at Landmark School ceases.

The Landmark School (Landmark) does not discriminate on the basis of race, ethnicity, religion, sexual orientation, homelessness, color, national origin, gender, gender identity, genetic information, disability, sex, or age in treatment or employment at Landmark, admission or access to Landmark, or any other aspect of the educational programs and activities that Landmark operates.

Landmark is required by *Title VI of the Civil Rights Act of 1964 (Title VI)*, Section 504 of the Rehabilitation Act of 1973 (Section 504), Title IX of the Education Amendments of 1972 (Title IX), the Age Discrimination Act of 1975 (Age Act), and their respective implementing regulations at 34 C.F.R. Parts 100, 104, 106 and 110, not to discriminate in such a manner. Inquiries concerning the application of each of these statutes and their implementing regulations to Landmark may be referred to the U.S. Department of Education, Office for Civil Rights, at (617) 289-0111 or 5 Post Office Square, 8th Floor, Boston, MA 02109-3921, or to the applicable Landmark Coordinator:

Title VI Coordinator

Susan Tomases, 978-236-3369, 429 Hale Street, Prides Crossing MA 01965

Section 504 Coordinator

Susan Tomases, 978-236-3369, 429 Hale Street, Prides Crossing MA 01965

Title IX Coordinator(s)

Libby Parker, 978-236-3213, 429 Hale Street, Prides Crossing MA 01965

Age Act Coordinator(s)

Susan Tomases, 978-236-3369, 429 Hale Street, Prides Crossing MA 01965

If you have any questions or need more information please contact Dan Ahearn, Assistant Head of School, dahearn@landmarkschool.org.

ADMISSION POLICIES AGREEMENT

I hereby make application to Landmark School for the following student:

_____ (Full Name of Applicant)

Enclosed is a non-refundable application fee of \$150 (domestic), \$175 (international).
U.S. dollars only; checks made payable to LANDMARK SCHOOL.

If the applicant has experienced physical or mental health issues which have necessitated the use of medication or therapeutic intervention, it is of utmost importance that this be indicated and described at the time of application. This information will allow us to determine the applicant's needs more effectively. Withholding such information can only jeopardize the applicant's well-being and deter from the school's ability to handle any problems that may arise.

If it is determined that any critical information has been either intentionally or inadvertently withheld, Landmark School reserves the right to withdraw a student's acceptance or terminate placement. Information pertinent to the student's application will be held in strictest confidence and will be destroyed in five years from its receipt if the child does not attend. Please note that the *Landmark Policy and Procedure Manual* is available for public review at www.landmarkschool.org.

Parent or Guardian's Signature

Date

Parent or Guardian's Signature

Date

Attach
recent
photo
of
applicant
here.

When submitting application and documentation via mail:

All documentation must be collated and stapled.

Please send copies only, not originals.

Application fee should be mailed along with your application to:

Landmark School
Office of Admission
PO Box 227
429 Hale Street
Prides Crossing, MA 01965-0227

When submitting application and documentation via email:

We are able to accept applications and supporting documentation by email only if they are sent to admission@landmarkschool.org with as few attachments as possible (ie: all items scanned as one single attachment, rather than multiple individual attachments).

NOTE: Application fee must be sent via mail to the above address.



The following application forms are to be completed by people who provide services directly to the applicant (ie: teacher(s), counselor, primary care physician).

Choose the forms that are applicable to your child.

If your child is Elementary grade level, please have both English and Math reference forms completed, even if your child has the same teacher for both subjects. Each reference contains important information.

Please write the applicant's name on the top of each form and distribute them to the appropriate individuals for completion along with a stamped envelope addressed to:

Landmark School
Office of Admission
PO Box 227
429 Hale Street
Prides Crossing, MA 01965-0227

Or completed forms can be returned via email: admission@landmarkschool.org
Or via fax: 978-927-7268

For questions regarding these forms, please contact an Admission Counselor at (978) 236-3407 or (978) 236-3204 or admission@landmarkschool.org



PRINCIPAL or SCHOOL GUIDANCE COUNSELOR REFERENCE

Full Name of Student/Applicant _____ Date of Birth _____

The student named above has made application to Landmark, a school for students with language-based learning disabilities. You have been chosen by the parent/guardian/student to provide a reference for this student. Your comments will remain confidential and will not become part of the student record. Completion of this form does not sanction the student's application to Landmark School.

1. How long have you known this student? _____

2. Is this student a positive and productive member of the school community? Yes No
Please describe

3. Does this student engage in appropriate social interactions with peers and teachers? Yes No
Please describe

4. Has this student had any problems with discipline, or been suspended? Yes No
If yes, please describe

5. Additional comments _____

ACADEMIC TRAITS	Good	Average	Poor
Academic Motivation			
Study Habits			
Response to Constructive Criticism			
Homework Completion			
Responsibility			
Organization/Time Mgmt.			
Self-Confidence			

Name of person completing this form _____

Your position _____

School _____

Phone _____

Email _____

Date completed _____

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True, or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

Young person's name _____

Male / Female

Date of Birth _____

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other youth, for example book, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would rather be alone than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other youth or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees tasks through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ Date _____

Parent / Teacher / Other (Please specify) _____

Thank you very much for your help

© Robert Goodman, 2005



ENGLISH TEACHER REFERENCE

Full Name of Student _____ Date of Birth _____

The student named above has made application to Landmark, a school for students with language-based learning disabilities. You have been chosen by the parent/guardian/student to provide a reference for this student. Your comments will remain confidential and will not become part of the student record. Completion of this form does not sanction the student's application to Landmark School.

1. How long have you known this student? _____

2. What is this student's attitude towards learning and responsiveness to instruction?

3. Does this student engage in appropriate social interactions with peers? Yes No Please describe

4. Does this student have difficulty paying attention to academic work or sitting through class?
Yes No If yes, please describe

5. Additional comments _____

ACADEMIC TRAITS	Good	Average	Poor
Academic Motivation			
Study Habits			
Response to Constructive Criticism			
Homework Completion			
Responsibility			
Organization/Time Mgmt.			
Self-Confidence			

Name of person completing this form _____
Your position _____
School _____
Phone _____
Email _____
Date completed _____

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True, or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

Young person's name _____

Male / Female

Date of Birth _____

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other youth, for example book, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would rather be alone than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other youth or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees tasks through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ Date _____

Parent / Teacher / Other (Please specify) _____

Thank you very much for your help

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MATH TEACHER REFERENCE

Full Name of Student _____ Date of Birth _____

The student named above has made application to Landmark, a school for students with language-based learning disabilities. You have been chosen by the parent/guardian/student to provide a reference for this student. Your comments will remain confidential and will not become part of the student record. Completion of this form does not sanction the student's application to Landmark School.

1. How long have you known this student? _____

2. What is this student's attitude towards learning and responsiveness to instruction?

3. Does this student engage in appropriate social interactions with peers? Yes No Please describe

4. Does this student have difficulty paying attention to academic work or sitting through class?
Yes No If yes, please describe

5. Has this student been working through grade level material or a modified program? Please describe

6. Additional comments _____

ACADEMIC TRAITS	Good	Average	Poor	Name of person completing this form _____
Academic Motivation				Your position _____
Study Habits				School _____
Response to Constructive Criticism				Phone _____
Homework Completion				Email _____
Responsibility				Date completed _____
Organization/Time Mgmt.				
Self-Confidence				

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True, or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

Young person's name _____

Male / Female

Date of Birth _____

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other youth, for example book, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would rather be alone than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other youth or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees tasks through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ Date _____

Parent / Teacher / Other (Please specify) _____

Thank you very much for your help

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TUTOR and/or SPECIALIST REFERENCE

Full Name of Student/Applicant _____ Date of Birth _____

The student named above has made application to Landmark, a school for students with language-based learning disabilities. You have been chosen by the parent/guardian/student to provide a reference for this student. Your comments will remain confidential and will not become part of the student record. Completion of this form does not sanction the student's application to Landmark School.

1. How long have you known this student? _____

2. What skills are you working on with this student?

3. What is this student's attitude towards learning and responsiveness to instruction?

4. Does this student have difficulty paying attention to academic work or sitting through tutorial session?
 Yes No Please describe _____

5. Additional comments _____

ACADEMIC TRAITS	Good	Average	Poor
Academic Motivation			
Study Habits			
Response to Constructive Criticism			
Homework Completion			
Responsibility			
Organization/Time Mgmt.			
Self-Confidence			

Name of person completing this form _____
Your position _____
School _____
Phone _____
Email _____
Date completed _____

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True, or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

Young person's name _____

Male / Female

Date of Birth _____

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other youth, for example book, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would rather be alone than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other youth or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees tasks through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ Date _____

Parent / Teacher / Other (Please specify) _____

Thank you very much for your help

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RESIDENTIAL ADVISOR REFERENCE

(to be completed for applicants who are currently attending a boarding school)

Full Name of Student _____ Date of Birth _____

The student named above has made application to Landmark, a school for students with language-based learning disabilities. You have been chosen by the parent/guardian/student to provide a reference for this student. Your comments will remain confidential and will not become part of the student record. Completion of this form does not sanction the student's application to Landmark School.

1. How long have you known this student? _____

2. How does this student interact with peers? _____

3. How does this student interact with adults? _____

4. How does this student respond to authority and constructive criticism? _____

5. Please describe this student's level of independence in daily life with regard to personal hygiene, room maintenance, and household chores. _____

ACADEMIC TRAITS	Good	Average	Poor
Academic Motivation			
Study Habits			
Response to Constructive Criticism			
Homework Completion			
Responsibility			
Organization/Time Mgmt.			
Self-Confidence			

Name of person completing this form _____
Your position _____
School _____
Phone _____
Email _____
Date completed _____

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True, or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

Young person's name _____

Male / Female

Date of Birth _____

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other youth, for example book, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would rather be alone than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other youth or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees tasks through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ Date _____

Parent / Teacher / Other (Please specify) _____

Thank you very much for your help

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PRIMARY CARE PHYSICIAN REPORT

(Parent/Guardian: please note that this form is required as part of your Application for Admission, but it does not replace the Physical Exam & Immunization Form that you would receive along with required Registration Forms if your child is accepted to Landmark School.)

Part A

Parent or Guardian: Please complete the following information in this box. **Then forward this form to the Applicant's primary care physician or pediatrician (they will complete Part B of this form).**

I hereby give permission for Dr. _____ to release
please print name of physician
medical information for my child/ward to Landmark School for Landmark's professional use.

Full, Legal Name of Applicant/Student _____ Date of Birth _____

Parent/Guardian signature _____ Date _____

Part B

Physician: The parent/guardian of the above-named child has applied for admission to Landmark School. We would appreciate any information about the child that you may be able to share with us. Please complete both sides of this form and return it via email, mail, or fax (see top of form). Questions? (978) 236-3000

- 1. Is the child in general good health? Yes No
- 2. Are immunizations up-to-date? Yes No
- 3. Is there history of any physical or mental illness in this child? Yes No

If yes, please be specific _____

4. Medication History:

Name of Medication	Target Symptom(s)	Current or D/C
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

**Please attach copies of medical evaluations or pertinent records.
Please complete other side of this form.**

5. Please describe any hospitalizations for this child.

6. Please describe any family history of learning disabilities.

7. Please provide any pertinent medical information about this child.

Signature of Physician_____

Full Name of Applicant/Patient_____

Date_____

Your candid comments are greatly appreciated in helping us obtain a clear understanding of this child.



PSYCHOPHARMACOLOGIST REPORT

(NOTE: to be completed only for applicants currently being seen regarding medications)

Part A

Parent or Guardian: Please complete the following information in this box. **Then forward this form to the applicant's Psychopharmacologist (they will complete Part B of this form).**

I hereby give permission for Dr. _____ to release
please print name of physician
information for my child/ward to Landmark School for Landmark's professional use.

Full, Legal Name of Applicant/Student _____ Date of Birth _____

Parent/Guardian signature _____ Date _____

Part B

Physician: The parent/guardian of the above-named child has applied for admission to Landmark School. We would appreciate any information about the child that you may be able to share with us. Please complete both sides of this form and return it via email, mail, or fax (see top of form). Questions? (978) 236-3000

Medication History:

Name of Medication	Target Symptom(s)	Current or D/C
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

**Please attach copies of medical evaluations or pertinent records.
Please complete other side of this form.**

1. Has this child ever been hospitalized for psychological reasons?

2. Please provide any additional pertinent information about this child.

Signature of Physician _____

Full Name of Applicant/Patient _____

Date _____

Your candid comments are greatly appreciated in helping us obtain a clear understanding of this child.



**LANDMARK
SCHOOL**
OFFICE OF ADMISSION

admission@landmarkschool.org

Fax 978.927.7268

P.O. BOX 227 • PRIDES CROSSING, MASSACHUSETTS • 01965 • 978-236-3010 • LANDMARKSCHOOL.ORG

SUMMARY of COUNSELING SERVICES

(This information will remain confidential and will not become part of the student record.)

Full Name of Applicant _____ Date of Birth _____

To the Therapist: The parent/guardian of the above-named child has applied for admission to Landmark School. Your candid comments are greatly appreciated in helping us obtain a clear understanding of this child. Please complete both sides of this form (in legible print) and return it by email, mail, or fax (see above).

If you have any questions or concerns, please call Landmark at 978.236.3000

1. Duration, modality, and frequency of contact

2. Presenting problem, and relevant issues addressed in treatment

3. How have this child's learning disabilities affected your treatment of this patient?

4. History of any inpatient or residential experiences in either psychiatric or substance abuse facilities

Please continue on reverse side.

5. Medication history – current and past

6. How would you rate your patient’s functioning in the following areas?

a. Ability to separate in an age-appropriate manner

b. Ability to make and maintain friends

c. Involvement in recreational and leisure activities

d. Ability to follow rules and adjust to institutional expectations

e. Social skills

7. Current DSM-V diagnosis:

(NOTE: Please include disorder subtypes and/or specifiers as appropriate)

8. Will you remain involved in a counseling relationship with the student?

9. Would you recommend further counseling or other services that would help support this student?

Therapist Name (*please print*) _____ Date _____

Therapist Signature _____

Phone _____ Email _____

Full Name of Applicant/Patient _____