



**Reading Clinic
Application for Enrollment**

Name: _____ Birthdate: _____ Age: _____

Parent / Guardian Name _____

Address: _____

City: _____ State: _____ Zip: _____

Has your child repeated a grade? Yes No If yes, which grade? _____

Has your child ever received a psychological evaluation? (i.e. reading disability) Yes No

If the above response is yes, please attach a copy of the most up-to-date testing.

Has your child been diagnosed as having a reading disability? Yes No

If yes, was your child referred for special services such as

Special instruction in the classroom

Special Education services

Tutoring provided in school

Tutoring by a private tutor or reading clinic

Does your child have an IEP? Yes No

If yes, what was recommended? _____

Approximately, how many hours does your child spend on homework each night? _____

Does your child require you to sit with them to complete their work? Yes No

Does your child read for pleasure? Yes No

Does your child enjoy listening to stories read by others (parents, relatives, siblings, etc.)? Yes No

How does your child learn best? _____

What do you see as your child's strengths in school? _____

What do you see as your child's greatest struggle in school? _____

Do you agree to allow agents of the STAR Center Inc. to administer a reading achievement test to your child to properly determine the strengths and weakness of your child's reading skills?

Yes No SIGNATURE OF PARENT OR GUARDIAN _____