



ADMISSIONS TESTING FORM

Date _____

Child's Name _____

Date of Birth _____

Age _____ Grade _____

Parent Name (1) _____

Phone _____

Parent's Name (2) _____

Marital Status of Parents _____

Note: If parents are separated or have joint custody, *both* parents must consent to the evaluation and provide signatures below.

Mailing Address

Who referred you to our office?

Is there a language other than English spoken in your home?
If yes, please note language(s) here:

What would you consider your child's primary language?

Previous Testing Dates (if any)	WPPSI-III	_____
	WPPSI-IV	_____
	WISC-IV	_____
	WISC-V	_____

Note: Approximately one year should elapse before any of these tests are re-administered



Please list the schools you are applying to:

1. _____
2. _____
3. _____
4. _____
5. _____

Please sign below indicating that you have read the information provided above and that you consent to having your child tested by the staff at Old Town Cognitive Therapy for Kids.

Note: Parent (2) signature is only necessary when parents are separated or have joint custody

Parent (1) _____
Date

Parent (2) _____
Date

If you would like us to send the report to the school(s) listed above, please sign here. If not, we will hold the report until you contact us. At that time, you will need to provide written consent authorizing us to release the report.

Parent (1) _____
Date

Parent (2) _____
Date

If a school contacts us to discuss the test findings, we would like permission to do so. If you are agreeable, please sign below.

Parent (1) _____
Date

Parent (2) _____
Date



The fee is \$360 for the WPPSI-IV and \$380 for the WISC-V.
Checks should be made payable to the Old Town Cognitive Therapy for Kids.

Please sign here if you are requesting that your child's test results be emailed or faxed.

I understand that use of electronic transmission, such as email and fax, results in risks to privacy and confidentiality.

Printed Name

Email

Signature

Date