

# OROT Admissions Application

Date \_\_\_\_\_

## HOST SCHOOL

Please check one.

- Caskey Torah Academy
- Perelman Jewish Day School—Forman Campus
- Perelman Jewish Day School—Stern Campus
- Politz Hebrew Academy

## CONTACT INFORMATION

Student's Name \_\_\_\_\_

Student's Date of Birth \_\_\_\_\_

Grade Student Will be Entering \_\_\_\_\_

Parent's Name \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Email Address \_\_\_\_\_

In the case of divorce or separation, please indicate the custodial parent by placing an asterisk (\*) next to the name.



# Background

Please provide below (or attach) any information the OROT teaching staff should know about your child, so we can better understand your child's learning profile. If your child has an existing evaluation, please share this with OROT during the admissions process to help us build your child's education plan.

What specific instructional (or other) areas would you like your child's OROT program to cover?

## OUTSIDE SUPPORT SERVICES

Please complete this section if your child is receiving extra support or outside services in any of the areas listed below, including private therapy. You will need to sign the relevant release forms that follow in this application, thereby giving OROT permission to contact therapists and other service providers directly.

### Occupational Therapy

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Name of Therapist

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Contact Information

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Number of Visits Per Week

### Speech Therapy

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Name of Therapist

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Contact Information

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Number of Visits Per Week

### Physical Therapy

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Name of Therapist

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Contact Information

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Number of Visits Per Week

## Behavioral Support

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Name of Therapist

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Contact Information

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Number of Visits Per Week

**Other** (Psychologist, Tutoring, Social Skills, Art Therapy, Music Therapy, Etc.)

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Name of Therapist

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Contact Information

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Number of Visits Per Week

## MEDICATIONS

If your child is taking medication, please list the name of the medication, the dosage and the frequency the medication is given.

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Name of Medication

Dosage

Frequency Given

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Name of Medication

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Name of Medication

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Name of Medication

## Signature Page and Information Release Form to Allow Host School to Share Information

Student's Name \_\_\_\_\_

I verify that all of the information provided in this application is true and correct to the best of my knowledge.

By signing below, I/we hereby give the host school listed on the first page of this application the permission to release and share with OROT all information and documents regarding medical information, psychological evaluations and reports, therapy services, and other information and documents regarding my/our child named above.

The information obtained to provide your child with an education plan will never be shared outside of the OROT/host school relationship.

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Parent/Guardian Signature Date

- Please upload a current photo of your child.
- Please upload your child's assessment. Each child must have a current assessment or be in the process of an assessment to enter the OROT program.

Every application must be accompanied by a \$100 non-refundable processing fee. Please click on the link below to submit this fee via Google Pay or credit card.

**Payment (<https://buy.stripe.com/5kA3eV2Rh6iy7C0144>)**

If you have any questions or concerns, please contact Hilary Cummings, Office Manager, at [info@orotkids.org](mailto:info@orotkids.org) or 215.935.0020.



# Information Release Form to Contact Therapists/Doctors/Service Providers

Date \_\_\_\_\_

Student's Name \_\_\_\_\_

School \_\_\_\_\_

Grade \_\_\_\_\_

Please List Names of All Therapists/Doctors/ Service Providers

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By signing below, I/we hereby give the above therapists, doctors, or providers of extra services to my/our child the permission to release the information requested by OROT regarding my/our child, named above.

The information obtained to provide your child with an education plan will never be shared outside of the OROT/therapist/doctor relationship.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# OROT Financial Aid Form

## Consent to Communicate with Host School

### HOST SCHOOL

Please check one.

- Caskey Torah Academy
- Perelman Jewish Day School—Forman Campus
- Perelman Jewish Day School—Stern Campus
- Politz Hebrew Academy

Dear Parents:

If you are applying for financial aid for the OROT program, the OROT Financial Aid Committee must be able to discuss your aid application with the Financial Aid Committee of your host school. The sharing of information is necessary for OROT to provide a tuition financial aid package that is equitable and meets the needs of our families.

All inquiries regarding your financial aid application will remain confidential.

By signing this document, you agree and consent to the OROT Financial Aid Committee communicating with your host school regarding your application for financial aid and sharing the information given to the host school.

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Print Name

Print Name

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Parent/Guardian Signature

Parent/Guardian Signature

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Date

Date



# OROT Photo/Video Permission Form

We request permission to take photographs and record video your child in the OROT classroom. The areas of use for these photographs and videos may include, but are not limited to:

- OROT Website
- OROT Chronicle
- OROT Publicity Materials
- OROT Event Materials (including but not limited to invitations, ad journals, programs)

Under NO circumstances will identification of any kind be used in conjunction with your child's picture, such as the child's name or name of school.

We are asking your permission for this privilege for the 2022-2023 school year ending August 31, 2023.

Name of Student \_\_\_\_\_

I give permission for my child to be photographed/videoed. I understand these photographs/videos may be used at the discretion of the OROT Staff and Board of Directors.

I DO NOT give permission for my child to be photographed or videoed.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Signature

