

# Psychological Associates

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## ADMISSIONS TESTING INFORMATION FORM

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current School: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_

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

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

E-mail Address: \_\_\_\_\_

Schools to which report should be sent:

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Is this a retest?    Yes            No  
If yes, when was child last tested? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

By signing this form you are agreeing that reports can be mailed to the above listed schools:

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date