



**PROLITERACY AMERICA/BEAUMONT PUBLIC LIBRARY SYSTEM  
CONFIDENTIAL STUDENT ENROLLMENT**

DATE: \_\_\_\_\_

**Requirements to be eligible to apply as a student:**

1. Be 18 years or older and not have been enrolled in regular school for at least 6 months.
2. Agree to meet at an approved site and be able to get to and from the site without assistance of the tutor or the program.
3. Be willing to commit to at least 1-4 hours per week and 36 weeks per year of instructional time as agreed upon between tutor and student.
4. Demonstrate the ability to attend to task for at least 60 minutes.
5. Demonstrate behavior appropriate to learning with a tutor.

\*\*Other requirements for instruction as a reading student or English as a Second Language student will be reviewed at time of evaluation.

Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr. \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ OKAY to CALL? Yes \_\_\_\_\_ No \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_ OKAY to CALL? Yes \_\_\_\_\_ No \_\_\_\_\_

Place of Birth \_\_\_\_\_ Marital Status M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_

Parent: Yes \_\_\_ No \_\_\_ Number of Children \_\_\_\_\_ Ages of Children \_\_\_\_\_

Native Language \_\_\_\_\_ Ethnic Group \_\_\_\_\_

How many years of schooling have you had? \_\_\_\_\_ Where did you go to school? \_\_\_\_\_

Did you graduate from high school? Yes \_\_\_ No \_\_\_ Are you employed? Yes \_\_\_ No \_\_\_

(over)

If employed, what is your occupation? \_\_\_\_\_

Income \_\_\_\_\_ Where did you hear about us? \_\_\_\_\_

What days and times are you available for study? \_\_\_\_\_

Do you have transportation so that you can attend your study sessions? \_\_\_\_\_

What is your reason for wanting to improve your skills? \_\_\_\_\_

Do you need or wear glasses? Yes \_\_\_ No \_\_\_

When was your last eye examination? \_\_\_\_\_

Do you wear a hearing aid? Yes \_\_\_ No \_\_\_

Have you experienced any of the following:

- |  |                |
|--|----------------|
| -multiple, chronic ear infections          | Yes ___ No ___ |
| -multiple, chronic sinus problems          | Yes ___ No ___ |
| -serious accident resulting in head trauma | Yes ___ No ___ |
| -prolonged, high fevers                    | Yes ___ No ___ |
| -diabetes                                  | Yes ___ No ___ |
| -severe allergies                          | Yes ___ No ___ |
| -frequent headaches                        | Yes ___ No ___ |
| -concussion or head injury                 | Yes ___ No ___ |
| -convulsions or seizures                   | Yes ___ No ___ |
| -long-term substance abuse problem         | Yes ___ No ___ |
| -serious health problems                   | Yes ___ No ___ |

Are you currently taking any prescription medications? Yes \_\_\_ No \_\_\_ If yes, please list on the lines below.

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**Student Signature**