



Application for Early Entrance and Early Learning Intensive Support Pilot

| Child Information | | | |
|-----------------------------------------|-------------|--------------|--|
| Last Name: | First Name: | Middle Name: | |
| Child's Date of Birth (DD/MM/YR): | | | |
| | | | |
| Family Information | | | |
| Parent Name: | | Parent Name: | |
| Address: | | Address: | |
| City/Town: | | City/Town: | |
| Postal Code: | | Postal Code: | |
| | | | |
| Contact Information | | | |
| Home #: | | Home #: | |
| Cell #: | | Cell #: | |
| Work #: | | Work #: | |
| Email: | | Email: | |
| What is the best method to contact you? | | | |
| Neighborhood School Name: | | | |

| Background Information | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------|--------|---------|--------|-------------------|
| *Support Services will not be contacted until a consent to contact has been signed. | | | | | | |
| <p>Please indicate the support services that your child receives and the frequency of services</p> <p style="text-align: center;">*Referral-referral has been made; awaiting appointment.</p> <p>*Report Available-a report has been completed and can be obtained for review.</p> | N/A | *Referral | Weekly | Monthly | Yearly | *Report Available |
| Speech-Language Pathologist Name: _____ Phone/Email: _____ | | | | | | |
| Physical Therapist Name: _____ Phone/Email: _____ | | | | | | |
| Occupational Therapist Name: _____ Phone/Email: _____ | | | | | | |
| Psychologist Name: _____ Phone/Email: _____ | | | | | | |
| Hearing Specialist Name: _____ Phone/Email: _____ | | | | | | |
| Vision Specialist Name: _____ Phone/Email: _____ | | | | | | |
| Child and Youth Services Name: _____ Phone/Email: _____ | | | | | | |

| | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|
| Autism Services Name: _____ Phone/Email: _____ | | | | | | |
| Ability in Me(AIM) Name: _____ Phone/Email: _____ | | | | | | |
| Alvin Buckwold Child Development Program/Kinsmen Children Center Wascana Rehabilitation Center Name: _____ Phone/Email: _____ | | | | | | |
| Early Childhood Intervention Program(ECIP) Name: _____ Phone/Email: _____ | | | | | | |
| Socialization, Communication and Education Program(SCEP) Agency Contact: _____ | | | | | | |
| Cognitive Disability Program Counsellor/Social Worker Agency Contact: _____ | | | | | | |
| Other(please add any other support services not listed above) | | | | | | |
| | | | | | | |
| | | | | | | |
| Does your child attend a Licensed Child Care Facility? Yes No | | | | | | |
| Name of Facility: | | | | | | |
| Phone number: | | | | | | |
| Does your child receive Enhanced Accessibility Grant funding? Yes No | | | | | | |
| Tell us about your child's development | | | | | | |
| Please outline the strengths and needs of your child in the following areas: | | | | | | |
| <ul style="list-style-type: none"> • Social/Emotional development (playing with other children, interacting with adults) <i>(Max. 800 characters)</i> | | | | | | |
| <ul style="list-style-type: none"> • Intellectual Development (talking clearly, listening, following directions, using complete sentences) <i>(Max. 800 characters)</i> | | | | | | |

• Physical development (like running and jumping, holding a crayon, catching a ball or using a spoon) (Max. 700 characters)

Mobility: Describe how your child moves from one place to another:

Scotting

Crawling

Walking

Wheelchair

Lifting required: Yes No Weight of child: lbs./kg.

Medical Needs: (e.g., oxygen, g-tube fed, seizures, etc.) (Max. 400 characters)

Feeding Needs: (allergies, food preferences, texture preferences, etc.) (Max. 400 characters)

Visual Needs: (glasses, visual devices, braille, etc.) (Max. 400 characters)

Sensory Needs: (sounds, lighting, touch, smell, etc.) (Max. 400 characters)

Hearing Needs: (hearing aid, sign language, etc.) (Max. 400 characters)

Toileting Needs: (Max. 400 characters)

Other Needs: *(Max. 400 characters)*

Is there anything else you would like to share about your child and/or family? *(Max. 800 characters)*

Signature of Parent

Date of Application

The information provided will be used for the purposes of determining your child's recognition of intensive needs for accessing educational programming supports and/or eligibility to participate in the Early Learning Intensive Support Pilot program. Non-identifying information may be used to evaluate the pilot program.

Please send application for admission and accompanying documents to:

Neda Wilson
neda.wilson@spiritsd.ca
Box 809 Warman, SK S0K 4S0

Following receipt of the application you will be contacted to gather additional information and discuss options for your child.