Learn without limits

# APPLICATION FORM

**Child's Legal Name (as stated on Birth Certificate)** **Gender: M( ) F( )**

**First:** ______________________ **Middle:** __________________ **Last:** __________________________

**Given name if different from legal / AKA:**

**Child's Birth date (MM/DD/YR):**

**Where does child reside?** (e.g., hospital, Mom, Dad, Grandparent):

| Parent / Guardian 1: | Parent / Guardian 2: |
|---|---|
| | If different from child: |
| Address: ______________________ | Address: ______________________ |
| City/Town: ______________________ | City/town: ______________________ |
| Postal Code: ______________________ | Postal Code: ______________________ |
| Home Phone#: ______________________ | Home Phone#: ______________________ |
| Cell: ______________________ | Cell: ______________________ |
| Work: ______________________ | Work: ______________________ |
| E-mail: ______________________ | E-mail: ______________________ |

**If you wish to declare that you are an Aboriginal person, please specify. (This information is for Alberta Education)**

- ☐ Status Indian/First nations, Band # ___________________
- ☐ Non-Status Indian/First Nations
- ☐ Métis
- ☐ Inuit

**Languages spoken in the home:**

**Is child Canadian Citizen?** ☐ Yes ☐ No **If No, indicate status:**
☐ Permanent Residency ☐ Work Visa (parent) ☐ Visiting Visa ☐ Refugee Status ☐ Other: ______________________

**If English is not your first language, would an interpreter be helpful?** ☐ Yes ☐ No

**Does your child have a formal diagnosis?** ☐ Yes ☐ No
**If yes, please state diagnosis and date it was given.**

**If no, please indicate areas of delay:**

**If your child has had any of the following assessments, please check the categories and date of the assessment. *Alberta Education* requires assessments be dated after *March 1 of the current year*.**

| | Date: | | Date: |
|---|---|---|---|
| ☐ Speech | __________ | ☐ Psychiatry | __________ |
| ☐ Occupational Therapy | __________ | ☐ Audiologist | __________ |
| ☐ Physio Therapist | __________ | ☐ Psychologist | __________ |
| ☐ Home Care | __________ | ☐ Preschool Assess. Service | __________ |
| ☐ Other __________ | __________ | ☐ Feeding Clinic/ Home nutrition | __________ |

**Please list any agencies or programs your child is involved with or has previously been involved in, (e.g. IPAS, Glenrose, Elmtree Clinic, Early Intervention, CASA, FSCD, Specialized Services)**

**Please list any specialists your child has been involved with on a regular basis (e.g. neurologist, pulmonologist, audiologist):**

| **Name of Pediatrician:**<br><br>**Phone number:** | **Name of Family Doctor:**<br><br>**Phone number:** |
|---|---|

**Tell us about your child's Development:**

**Lifting required:** ☐ **yes** ☐ **no** **Weight of child:** ______ **lbs/kg**

**Communication:** ☐ **verbal** ☐ **non-verbal** ☐ **signing** ☐ **pictures**

**Speech and Language**: ____________________________________________

**Social Interaction** ____________________________________________

**Behaviour Management** ____________________________________________

**Feeding issues**: ____________________________________________

**Visual/Sensory Impairments** ____________________________________________

**Other**: ____________________________________________

**Mobility:** ☐ **scooting** ☐ **crawling** ☐ **walking** ☐ **wheelchair**

**Any Medical Procedures/needs, e.g. oxygen, g-tube fed, seizures, etc.** ______________________________

____________________________________________

____________________________________________

**Social Worker (If Applicable):**

**Email:** **Phone:**

**Childcare provider (if applicable) e.g. daycare, day home, grandparent, etc.**
**Name/Day Care/Day Home:**

**Email:** **Phone:**

**Who referred you to our program:**

**Is there any thing else we need to know about your child and/or family?**

**Parent Signature:** ______________________________

**Guardian Signature:** ____________________________

**Date:** ________________________________________