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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 Aboriginal, Band #**_____ ☐ **Non-Status Aboriginal**
☐ **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: **Phone number:**	**Name of Family Doctor:** **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: _____