



Application for Early Learning Intensive Support Pilot

| Child Information | | | |
|---|-------------|----------------|-------------|
| Last Name: | First Name: | Middle Name: | |
| Child's Date of Birth (DD/MM/YR): | | Catholic: | Yes No |
| Name of Parish: | | Date Baptized: | |
| 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. | | | | | | |
| Please indicate the support services that your child receives and the frequency of services *Referral-referral has been made; awaiting appointment. *Report Available-a report has been completed and can be obtained for review. | 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 eligibility to participate in the Early Learning Intensive Support Pilot program and non-identifying information may be used to evaluate the pilot program.

Please send application for admission and accompanying documents to:

Shannon Hahn, Supervisor of Instruction and Learning
shannon.hahn@cttcs.ca

OR

Mike Reavie, Coordinator of Student Achievement and Supports
mike.reavie@cttcs.ca

45A Palliser Way
Yorkton SK S3N 4C5
1-306-783-8787

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

**Please note that transportation is the responsibility of the family.