Living Sky School Division No. 202
Application for Early Learning Intensive Support

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.**

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:

- Social/Emotional development (playing with other children, interacting with adults) *(Max. 800 characters)*

- Intellectual Development (talking clearly, listening, following directions, using complete sentences) *(Max. 800 characters)*

- 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:

☐ Scooting	☐ 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 program and non-identifying information may be used to evaluate the program.

Please send application for admission and accompanying documents to:

Monique Sommerfeld
monique.sommerfeld@lskysd.ca
306-937-7702

509 Pioneer Avenue,
North Battleford, SK S9A 4A5
Fax: (306) 445-4332

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.