



Application for 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.						
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: _____						
MidWest Family Connections Name: _____ Phone/Email: _____						
Alvin Buckwold Child Development Program/Kinsmen Children Center Other: _____ 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 Intensive Support Pilot program.

Please send application for admission and accompanying documents to:

Glenda Kary
Deputy Director of Education
Lloydminster Catholic School Division
6611B 39 Street
Lloydminster, AB, T9V 1W7

gkary@lcsd.ca

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