



Getting Ready for Inclusion Today

The GRIT Program

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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: <i>(Please provide a copy of the birth certificate with this application)</i>					
Child's Birth date (DD/MM/YR):			Alberta Health Care Number:		
Parent/s Names					
Mother's Name:			Father's Name:		
Address:		City/Town:		Postal Code:	
Home Phone Number	Mom's Cell	Mom's Work	Dad's Cell	Dad's Work	
E-mail address:					
Social Worker or Guardian/s Names (If Applicable):					
Address:		City/Town:		Postal Code:	
Phone Number:					
E-mail address:					
Childcare provider (if applicable) e.g. daycare, day home, grandparent, etc. Name/Day Care/Day Home:					
Address:			Phone:		
Please list names and ages of other children in the home:					
Who referred you to our Program:					
Name of Pediatrician:			Name of Family Doctor:		
Address and/or phone number:			Address and/or phone number:		

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

- Status Indian/First nations
 Métis

- Non-Status Indian/First Nations
 Inuit

Languages spoken in the home:

If English is not your first language is an interpreter required? Yes No

Does your child have a formal diagnosis? Yes No

If yes please state diagnosis and attached a physician's letter stating the diagnosis.

If no please indicate areas of delay:

If your child has had any of the following assessments, please check the categories and *please include copies of the reports with your application.*

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Speech | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Physio Therapist |
| <input type="checkbox"/> Home Care | <input type="checkbox"/> Audiologist | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Feeding Clinic/ Home nutrition | <input type="checkbox"/> Preschool Assessment Service |
| <input type="checkbox"/> Other _____ | | |

Please list any agencies or programs your child has previously been involved in, (e.g. 1 2 3 Go!, Early Intervention, CASA.)

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

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. _____

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

Parent Signature: _____

Guardian Signature: _____

Date: _____

PLEASE ENSURE a copy of the Birth Certificate and supporting documentation is included with this application.