

APPLICATION FORM

Child's Legal Name (as stated on Birth Certificate) Gender: M() F()	
First: _____ Middle: _____ Last: _____	
Given name if different from legal / AKA: <i>(A copy of the birth certificate is required with this application)</i>	
Child's Birth date (DD/MM/YR):	Alberta Health Care Number:
Where does child reside? (e.g., hospital, Mom, Dad, Grandparent):	
Mother's Name:	Father's Name:
Address: _____	If different from child:
City/Town: _____	Address: _____
Postal Code: _____	City/town: _____
Home Phone Number: _____	Postal Code: _____
Mom's Cell: _____	Home Phone Number: _____
Mom's Work: _____	Dad's Cell: _____
E-mail address: _____	Dad's Work: _____
E-mail address: _____	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, Band # _____ Non-Status Indian/First Nations
 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 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 & attach assessments:

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.