KIN-DIR Education Foundation

Unit #5, 2611-37th Avenue NE Calgary, AB T1Y 5V7
Phone: 403.277.0425 / Fax: 403-277-7101

Student Registration Form 2021-2022

Child Information

Child's Full Name (First/Last):	
Child's Preferred Name:	
Gender:	☐ Male ☐ Female ☐ Other
Date of Birth (M/D/Y):	
Place of Birth:	
Citizenship:	☐ Canadian Citizen ☐ Legal Resident
Primary Address:	
Name of Preschool/Daycare:	
Days of Attendance:	
My child is exposed to more than one language at home: ☐ No ☐ Yes	

	Parent/Guardian	Parent/Guardian
Preferred Name:		
Primary Address: (if different from above)		
Phone:		
Email:		
Preferred Method of Contact	☐ Email ☐ Phone	☐ Email ☐ Phone
Are there any Separation Agreements/Court Orders/Access/Custody Agreements pertaining to this child? ◯ No ◯ Yes (please attach copies)		

Completed by: _____ Signature: _____ Date: _____

KIN-DIR Education Foundation
Outreach Program (Main): Unit #5. 2611 - 37th Avenue NE Calgary, AB T1Y 5V7
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ENGLISH LANGUAGE LEARNERS QUESTIONNAIRE

Child's Full Name (First/Last):	

Please check ONE of the following boxes:

☐ **English is the only language spoken in our home. If this is the case, you do not need to fill out the rest of this questionnaire. Please sign the bottom and continue to the next page.**

☐ **Our family speaks a language other than English in the home. Please answer questions 1-7 to give us more information on your child's language exposure.**

1. Was your child born in Canada? ☐ Yes
   ☐ No- how long has your child lived in Canada? _____

2. What languages are spoken in the home and how often:

	First Language	%	Second Language	%
Child				
Parent(s)				

3. Does your child have older brother/sisters who speak English? ☐ Yes ☐ No
4. How long has your child been exposed to English? (eg. since birth? Has your child attended an English speaking daycare/preschool or community program such as gymnastics/library group/music?)

   _____

5. Does your child have difficulty understanding their first language? ☐ Yes ☐ No
6. Do you have concerns regarding your child's communication skills? ☐ Yes ☐ No

   If yes, please explain concerns:

   _____

   _____

   _____

Completed by (print): _____ Signature: _____ Date: _____

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INFORMED CONSENT FOR SERVICES 2021-2022

Child's Full Name (First/Last):	

I **give consent** for my child to participate in Kin-Dir Education Foundation's screening process. This may include individual or small group sessions conducted by Speech Language Pathologists, Occupational Therapists, Physiotherapists, Psychologists and/or their support staff. The purpose of these sessions is to provide more detail about my child's learning and to determine whether further assessment is recommended.

If areas of delay are identified, I **give consent** for Kin-Dir Education Foundation to complete a formal assessment with my child. I understand that I will be contacted by phone/email to discuss the results and will then have the option to set up an in-person meeting if I have further inquiries.

Assessment results may assist with access to supports, resources and/or government funding. However, I understand that an assessment completed by Kin-Dir Education Foundation does not necessarily mean that my child will receive early intervention services or guarantee that skills will be improved. I understand that the decision to access services can be postponed to a later date and that there are alternative options available.

Should funding be granted based on assessment results, I **give consent** for Kin-Dir Education Foundation's therapists and support staff to provide Early Childhood Services by way of direct therapy sessions, consultation and referrals.

I understand that the information gathered through the services provided is considered private, confidential and protected by law. I understand that information pertaining to my child or myself will not be released without my written consent or knowledge. Kin-Dir Education Foundation is obligated to release information, if requested, by Calgary Child and Family Services and City of Calgary Police Department. Please be aware that a copy of all student information will be added to your child's Cumulative File.

I **give consent** for relevant information to be shared with my child's preschool/daycare: _____, so that therapeutic strategies can be implemented in the classroom and interventions can be applied more continuously.

I understand that I may withdraw this consent at any time and that this signed consent form will only remain valid for the current school year.

Completed by (print):_____ Signature:_____ Date:_____

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CHILD HISTORY

Child's Name:	Parent's Name:
Preschool/Daycare:	Date:

We appreciate you taking the time to provide developmental history information for your child. Speech-Language Pathologists, Occupational Therapists, Physiotherapists, and Psychologists will use this information in addition to their screening and/or assessment results to better understand your child's development. This information is important in helping each team member make the best clinical decisions for your child. Please complete this questionnaire by providing the most accurate information you have by answering the questions below. Should you have any questions regarding the questionnaire, please do not hesitate to contact the office at the number above.

EARLY MILESTONES HISTORY

1. At what age did your child:
   a. Babble (e.g.: "bababa"): _____
   b. Use first words: _____
   c. Use two-word phrases (e.g.: "more milk"): _____
   d. Use full sentences: _____
   e. Sit unsupported (by themselves): _____
   f. Crawl (on hands and knees) or bum scoot (on hands and bottom), please tell us which one:
   _____
   g. Walk without support (by themselves): _____
   h. Feed him/herself using fingers: _____
   i. Use utensils to eat: _____

CURRENT ABILITIES

1. Toilet Training: (Please select all that apply), my child…
   a. ☐ wears diapers
   b. ☐ wears Pullt Ups
   c. ☐ knows when he/she is wet
   d. ☐ pees in the toilet
   e. ☐ asks to go the bathroom
   f. ☐ independently wipes themselves
2. Dressing:
   a. Is your child able to dress themselves? Please mark: ◯ **YES** ◯ **NO**
   b. Can he/she undress themselves? Please mark: ◯ **YES** ◯ **NO**
3. Can your child undo: ☐ buttons ☐ zippers (Please ✓)
4. Can your child do up: ☐ buttons ☐ zippers (Please ✓)

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5. Attention: (Please select all that apply), my child…
   a. ☐ makes good eye contact
   b. ☐ points at things
   c. ☐ turns when I speak
   d. ☐ waits patiently
   e. ☐ can copy what I do
6. Does your child sometimes get frustrated when he/she cannot get his/her ideas across to others? (Please ✓)
   ☐ Yes ☐ No
   If you said "yes" above, what is your child's reaction?
   _____
7. How much of his/her speech do you understand? (Please ✓): ☐ 25% ☐ 50% ☐ 75% ☐ 90-100%
8. How much of his/her speech would a stranger understand? (Please ✓): ☐ 25% ☐ 50% ☐ 75% ☐ 90-100%
9. How well does your child do the following with family members? (Please ✓):

	Never	Rarely	Sometimes	Often	Always
Answer questions	☐	☐	☐	☐	☐
Follow Directions	☐	☐	☐	☐	☐
Understand words	☐	☐	☐	☐	☐

10. Is there any family history for speech-language or learning difficulties? Please explain. (e.g., dad was late to talk, a first cousin stuttered)
    _____
11. Is there any family history of motor difficulties? Please explain. (e.g., muscle weakness, toe walking, W- sitting, spina bifida, muscular dystrophy)
    _____
12. Do you have any safety concerns for your child? Please explain. (e.g., do they trip often or struggle with balance/coordination? Do they run away from you and/or daycare/school?)
    _____

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13. Do you have any concerns about your child's social, emotional or behavioural skills in the following areas:

a) Nervousness, worrying, sadness or spending too much time alone?

_____

_____

b) Overexcited and busy, anger, attention and focus, social and play skills or activities of daily living?

_____

_____

MEDICAL INFORMATION

1. Birth History (Please ✓ all that apply):
   - i. ☐ Full term
   - ii. ☐ Preterm: Number of gestational weeks: _____
   - iii. ☐ Difficult or complicated birth
   - iv. ☐ Use of forceps and/or suction
   - v. ☐ C-Section delivery
   - vi. ☐ Natural delivery
   - vii. Please provide your child's birth weight: _____
   - viii. Please let us know if there were any complications you feel we should know about

   _____

   _____

2. Has your child ever been hospitalized? Please explain. (e.g., Neonatal Intensive Care Unit (NICU), surgeries, illness, testing) _____

   _____

3. Has your child had:

   ☐ Frequent ear infections
   ☐ A vision test: Did he/she**: PASS / FAIL** (please circle) – Date of most recent test: _____
   ☐ Visual deficits (eg: myopia, astigmatic, etc.): _____
   ☐ A hearing test: Did he/she: **PASS / FAIL** (please circle) – Date of most recent test: _____
   ☐ A diagnosis/delay: (if yes please specify)

   _____

4. a) If your child has a diagnosis, have you accessed services through FSCD? (Family Supports for Children with Disabilities.) Please ✓ ☐ Yes ☐ No

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b) Do you have any support through Alberta Health Services (AHS), community programs, or other service providers? (Please ✓) ☐ Yes ☐ No

CURRENT AREAS OF NEED

Please ✓ all that apply: My child …

- ☐ is hard to understand when they speak
- ☐ has troubles following directions and/or answering questions
- ☐ has a hard time joining in activities with other children
- ☐ struggles with daily living skills (eg: toileting, dressing themselves, etc.)
- ☐ has a hard time sitting still
- ☐ sometimes throws things or uses their body physically when they are angry or frustrated
- ☐ has a hard time working with their hands (eg: colouring, using scissors, etc.)
- ☐ sometimes chokes on food and/or is a picky eater
- ☐ is sometimes clumsy, and will trip or fall occasionally
- ☐ walks on their tippy-toes, or walks with their toes pointed inward
- ☐ has difficulties with motor skills (eg: jumping, hopping, running, balancing, coordination)

ADDITIONAL HEALTH INFORMATION

Has your child ever been assessed and/or treated by a therapist, (e.g. a Physiotherapist, Psychologist, Occupational Therapist or Speech-Language Pathologist). (Please ✓)

☐ Yes ☐ No

If so, please let us know what services were received.

Therapy	Name of Program	Date Received	Results/Outcome
❒ Physiotherapy			
❒ Psychology			
❒ Occupational Therapy			
❒ Speech-Language Pathology			

By signing below, I confirm that I have answered these questions accurately and agree to the above information.

_____ _____ _____

Parent/Guardian Name (Please Print) **Parent/Guardian Signature** **Date**