PARKLAND
EARLY CHILDHOOD
INTERVENTION PROGRAM

83 North Street
Yorkton, SK S3N 0G9
Telephone: (306) 786-6988
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APPLICATION FOR EARLY CHILDHOOD INTERVENTION SERVICES

DATE:______________________________

NOTE: Please answer only those questions that are relevant to your family. The information you provide will be kept in strictest confidence by the Early Childhood Intervention Program.

CHILD'S NAME:____
(First) (Middle) (Last)

SEX: Male □ Female □ **DATE OF BIRTH:**______________________________ **AGE:**____
(Day) (Month) (Year)

ADDRESS: ____
(House #, Street name, Box #, City/Town, Postal Code)

PARENT/FOSTER PARENT/GUARDIAN: (CIRCLE ONE)

NAME:________________________________ **NAME:**______________________________

ADDRESS:_____________________________ **ADDRESS:**__________________________

CITY:_______________**POSTAL:**__________ **CITY:**____________**POSTAL:**_________

PHONE:________________________________ **PHONE:**_____________________________

Relationship to child:______________________ **Relationship to child:**_________________

SIBLINGS **BIRTHDATE** **DOES CHILD LIVE WITH THIS SIBLING?**

_____________________________________ **YES □** **NO □** **SOMETIMES □**

_____________________________________ **YES □** **NO □** **SOMETIMES □**

_____________________________________ **YES □** **NO □** **SOMETIMES □**

_____________________________________ **YES □** **NO □** **SOMETIMES □**

Please describe your concerns about your child's development.

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Please describe why you would like to receive early childhood home based intervention services.

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In which of the following general skill areas would you like to see your child improve?

______ feeding

______ toileting

______ approaching people

______ paying attention

______ controlling temper

______ walking or moving

______ using hands

______ playing

______ listening

______ understanding speech

______ following directions

______ talking, communication

______ getting along with others

______ dressing

______ other, please specify ______________________________________

____

AGENCY INVOLVEMENT:
Has your child been seen by, or is your child currently served by individuals at any of the following agencies of programs?

	If yes, how often	No	Date last seen or to be seen next
1. Neonatal Intensive Care Unit (NICU) Location:			
2. Wascana Children's Program □ **Alvin Buckwold Child Development Program □**			
Physician:			
Occupational Therapist:			
Physical Therapist:			
Speech & Language Pathologist:			
Social Worker:			
Other:			
3. Developmental Assessment Clinic			
4. Community Health			
Public Health Nurse			
Family Physician			
Pediatrician			
Audiologist			
5. Community Living Service Delivery			
6. Child & Youth Mental Health Services			
7. Ministry of Social Services			
8. KidsFirst			
9. School Division GSSD □ CTTSD □ Horizon □ Prairie Valley □			
10. Other (please list)______________________________ ____			

MEDICAL INFORMATION:

A. Please describe any significant events before, during and after the birth of your child:

____

____

____

B. Is your child receiving medications? If yes, please list and describe the effects on your child:

____

____

C. Has your child had a major illness and what are the effects?

____

____

D. Has your child been hospitalized? Why? At what age? What was the duration of his/her stay?

____

____

E. Please describe any hearing concerns:

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____

F. Please describe any vision concerns:

____

____

G. Please describe any allergies:

____

____

H. Does your child have any other physical an/or health needs that would affect program implementation for your child? Please describe.

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____

I. Please describe your child's strengths:

____

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____

J. Any additional comments:

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____ ________________________

Signature of Parent/Legal Guardian Date