☐ ST. CLAIR CATHOLIC DISTRICT SCHOOL BOARD ☐ Lambton Kent District School Board

Special Needs Pre-School Intake

☐ **LKDSB** ☐ **SCCDSB** **Consent on File** ☐ **Yes** ☐ **No**

Parent/Guardian Signature_____

Agency: ☐ Pathways Health Centre for Children ☐ St. Clair Child and Youth Services ☐ Lambton College ECE Centre

School _____ **School Year** _____

Date completed: _____ **Grade:** _____

Prepared By: _____

Name: _____ **D.O.B.:** _____

Address: _____ **C.A.:** _____

_____ **Daycare:** _____

Parent/Guardian: _____ **Preschool:** _____

Telephone (home): _____ **Telephone (work):** _____

Diagnosis(es): _____

Diagnosing Physician(s): _____ **Date of Diagnosis(es):** _____

Additional Info: _____

Current / Active Services

Service	Agency	Frequency / Status	Contact / Ext.	Report Available (date)

*For detailed / specific information please refer to the reports.

Summary of Needs:

☐ **HIGH NEEDS**: Children with high needs are those children who definitely require extensive support in the classroom, special equipment, transportation, constant supervision/redirection, or children who may experience difficulty with transitions (e.g. behavioural or mental health needs)

☐ **MODERATE NEEDS**: Those children who require teacher awareness, frequent supervision/redirection, a moderate amount of 1:1 support and who may require on-going therapy.

☐ **Transportation Needs**: ☐ Regular Bus ☐ Wheelchair accessible ☐ Car Seat

Other:_____

_____

_____

_____

Behaviour Concerns:

☐ Verbal outbursts ☐ Safety of self ☐ Attention and concentration
☐ Physical outbursts ☐ Safety of others ☐ Impulsiveness
☐ Poor Social skills ☐ Difficulty following routines ☐ Inappropriate eye contact
☐ Child wanders ☐ Child attempts to run away ☐ Overly passive
☐ Other_____

Behaviour triggers ☐ Undetermined ☐ Transitions ☐ Frustration ☐ Other

Additional Comments:

_____

Play Skills

Child demonstrates:

☐ Inappropriate Play ☐ Functional Play ☐ Solitary Play ☐ Parallel Play

☐ Associative Play ☐ Cooperative Play

Supervision and redirection

	Circle Time	Free Play	Activity Tables	Play Ground	Climbing Equipment
None					
Some					
Frequent					
Constant					

Useful Strategies_____

_____

General Knowledge and Understanding

Child needs: [Please check the appropriate needs statement(s)]

☐ To develop attention and concentration skills ☐ To develop eye contact/attention to speaker

☐ To follow routines ☐ To develop functional academic skills ☐ To develop problem solving skills

☐ To develop fine motor skills

Activities of Daily Living

Feeding ☐ Independent ☐ Tube Fed ☐ Total Assistance
☐ Requires Supervision ☐ Medical Concerns ☐ Assistive Devices _____
Feeding Time_____

Dressing

	Coat	Pants	Footwear	Fasteners
Independent				
Total Assistance				
Supervision				
Verbal Assistance				
Partial Assistance				

Toileting

☐ Independent ☐ Bowel Incontinence ☐ Bladder Incontinence
☐ Training program ☐ Equipment Needed_____

Additional Comments:
_____
_____
_____

Communication Skills	Age Appropriate		Extent of Delay		
	Yes	No	Mild	Mod.	Sev.
Ability to follow directions, answer questions and listen for critical elements					
Ability to use grammar, vocabulary and basic concepts					
Length of utterance (give example)					
Ability to use eye contact, joint attention, initiation, turn taking, etc.					
Ability to be understood by familiar listeners (please indicate)	Limited	25%	50%	75%	100%
Sound errors ☐yes (please describe) ☐ no					

Please describe ways they communicates: (e.g. sign language, words, eye gaze, natural gesture, etc.)					
Requires use of specialized equipment and/or materials (please indicate):	Visual Strategies ☐	Voice Output ☐	Sign Lang. ☐	Picture Exchange ☐	Other:
Level of support received in setting (please indicate):	SLP ☐	CDA ☐	SLP Consult ☐	Resource Support ☐	Other:

Referrals to date:	Yes	No	Referral Date	Transition Date
School Board SLP				
SHSSP (CCAC)				
Occupational Therapy				
Physiotherapy				
Other				

Vision/Hearing	Normal		Not evaluated	Details
	Yes	No		
Vision				
Hearing				
Central Auditory Processing				

Physical / Medical Concerns

☐ Seizures ☐ Allergies ☐ Orthopaedic concerns ☐ Fragile bones ☐ Spasticity

☐ Nursing services required ☐ Other_____

Medications_____
_____
_____

Additional health concerns_____
_____
_____
_____
_____
_____

Gross Motor

Independent Means of Mobility: ☐ Walks ☐ Creeps / Crawls ☐ Other_____

Equipment Needs: ☐ None ☐ Wheelchair ☐ Stroller ☐ Walker ☐ Helmet ☐ Splints

☐ Standing Frame ☐ Crutches ☐ Other_____

Physical Concerns_____

_____

_____

_____

Is special handling required? Yes ☐ (please describe) No ☐

_____

_____

_____

Additional Comments:

_____

_____

_____

Summary of Specialized Equipment Needs

Device/Equipment	Purchase Details		Prescriptive letter available		Prescribing Therapist	Instructions for use/Who will provide instructions	Equipment will travel to school	
	Owns	Requires Purchase	Yes	No			Yes	No

Comments _____

_____

_____

Child's Strengths_____

_____

_____

_____

Summary of Concerns / Additional Information (Please include any accommodations that are made for this child and include any helpful strategies).

_____

_____

_____

_____

_____