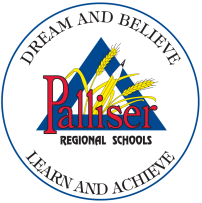
**Child/Student Intake Form**

Please complete page one and signature section for **all** new students. Complete the remaining pages as required. Provide copies to the Classroom Teacher, LST, Principal, and Home

**Legal Name: DOB.**

**Preferred Name: ASN:**

|  |  |
| --- | --- |
| **Is this child/student in care? Yes □ No □ (If *yes*, please determine the following)**  Name of Case Worker - Contact - | |
| **Parent/Guardian/Foster Parent (circle one)**  **Name**  **Phone (home)**  **(work)**  **(cell)**  **Email** | **Parent/Guardian/Foster Parent (circle one)**  **Name**  **Phone (home)**  **(work)**  **(cell)**  **Email** |

**Previous School/Contacts:**

|  |
| --- |
| Comments: |

**Social:** *friends, interactions, groups involved in*

|  |
| --- |
| Comments: |

**Things your child is able to do/Accomplishments/Skills/Interests:**

|  |
| --- |
| Comments: |

**Things your child is currently working on:**

|  |
| --- |
| Comments: |

**Fears/Dislikes of your child:**

|  |
| --- |
| Comments: |

**Indicators your child is struggling/is happy:**

|  |
| --- |
| Comments: |

**Complete this page only if identified needs**

**IPP: □ If yes, will copy be provided (check one) by PARENT □ OR by Previous School □**

**Programming:** *K&E, Life Skills…*

|  |
| --- |
| Comments: |

**Services Student Has Received in Past Two Years***: e.g. Children’s CARE Services, Alberta Mental Health, Family School Liaison Counselor, Behavior Solutions, KCC, REACH, FSCD, ELI, interventions at school level …*

|  |
| --- |
| Comments: |

**Assessments:** *Fill out a Release of Information-unless a copy provided.*

|  |
| --- |
| Comments: |

**Medical** *Fill out a Release of Information for all medical conditions-unless a copy provided - Permission to post Medical Emergency*

|  |
| --- |
| Comments: |

**Diagnosis:** Date\_\_\_\_\_\_, Medical Professional\_\_\_\_\_\_\_\_

|  |
| --- |
| Comments: |

**Allergies:**

|  |
| --- |
| Comments: |

**Other Medical Conditions:**

|  |
| --- |
| Comments: |

**Medication(s*):*** *If administered at school, complete Permission to Administer Medication form*

|  |
| --- |
| Comments: |

**Doctors:** *Names and Clinics,* *Signed Release in order to gather information related educational programming*

|  |
| --- |
| Comments: |

**Family Background** *Culture/Language/Other Considerations*

|  |
| --- |
| Comments: |

**Eating Snack/Drinking*:*** *Independent or need assistance- how do we assist?*

|  |
| --- |
| Comments: |

**Toileting:** *Independent or need assistance- how do we assist?*

|  |
| --- |
| Comments: |

**Communication:** *How does your child communicate? Gather information on words, sign, gestures, pictures*…

|  |
| --- |
| Comments: |

**Strategies that work:** *Accommodations, assistive technology, calming/alerting, learning…*

|  |
| --- |
| Comments: |

**Goals Parents have for their child:**

|  |
| --- |
| Comments: |

**Provide family with school contact information in case they have questions or concerns:**

*Explain to the family that we use a team approach to resolving concerns, setting new goals, and changing goals. Parent ideas and solutions are very important.*

SIGNATURES

This information was provided to by

(Intake Representative) (Parent/Guardian/Foster Family)

Signature: Signature

(School Personnel/Position) CIRCLE One: (Parent/Guardian/Foster Family)

Date Date

Date of school entry: (based on providing supports to meet the student’s needs).

dd/mm/yyyy