

Niagara Children's Centre School Authority School Age Program Application

Child's Last Name		Child's First Name			
Gender	<input type="checkbox"/> M	<input type="checkbox"/> F	Date of Birth (yyyy/mm/dd)		
Medical Diagnosis (If applicable)					
Mother/Guardian Name			Father/Guardian Name		
Home Address			City	Postal Code	
Home Phone Number			Cell/Work Phone Number	E-mail	
Home (Community) School			Phone Number		
Teacher/Resource Teacher			School Board Affiliation	<input type="checkbox"/> DSBN	<input type="checkbox"/> NCDSB
				Other:	
Daycare/Preschool			Phone Number		
Family Physician Name			Phone Number		
Specialist Name			Phone Number		
Specialist Name			Phone Number		

<i>Office Use Only</i>			
Referral Received _____	Observation/Tour _____	Referral Complete	Y N

For questions/additional information please contact:
Jennifer Gibbs, Special Education Consultant, NCCSA
 (905) 688-1890 ext. 232 or at
jennifer.gibbs@niagarachildrenscentre.com

Catherine Hodson, Principal, NCCSA
 (905) 688-1890 extension 230 or at
catherine.hodson@niagarachildrenscentre.com

Child's Name: _____

Date of Birth: _____

FAMILY INFORMATION AND CONSENT

(Must be completed by the parent/legal guardian for all applications):

	YES	NO
A. I have seen the entire application package being submitted on behalf of my child.	<input type="checkbox"/>	<input type="checkbox"/>
B. I understand that members of the Admissions Committee (composed of Niagara Children's Centre School Authority Staff, and/or Niagara Children's Centre Therapists) may observe my child in their current school setting for the purpose of determining program eligibility and class placement. I consent to this observation.	<input type="checkbox"/>	<input type="checkbox"/>
C. Are the concerns identified by the school staff also observed at home?	<input type="checkbox"/>	<input type="checkbox"/>
D. Please indicate any additional concerns and/or comments.		
E. I am willing to attend assessment and/or follow-up visits at school.	<input type="checkbox"/>	<input type="checkbox"/>
F. I am willing to attend school therapy sessions, parent education and engagement sessions, or group sessions, if recommended as part of my child's services.	<input type="checkbox"/>	<input type="checkbox"/>
G. I am willing to follow through with home programming recommendations.	<input type="checkbox"/>	<input type="checkbox"/>
Name of Parent/Legal Guardian: _____		
Signature: _____		



CONSENT TO USE, SHARE and DISCLOSE PERSONAL INFORMATION

**Personal information includes personal, health and educational information*

By signing and dating below, I/We understand that this **two-way** exchange of information is to be used to inform the Full-Day Learning Program admissions process at Niagara Children's Centre School Authority (NCCSA). I/We understand that my/our child's personal information will be disclosed between organizations and this information will be held in confidence and maintained securely in accordance with Ontario's privacy law.

I/We _____

Print First and Last Name of Parent(s)/Legal Guardian(s)

Of _____

Street

City

Postal Code

Email address: _____ Phone number: _____

hereby consent to an exchange and release of information (written and verbal) between the Niagara Children's Centre School Authority and relevant staff from the following agencies:

District School Board of Niagara
Niagara Catholic District School Board
Niagara Children's Centre
School Based Rehabilitation Services (SBRS)
Contact Niagara

HCCSS (LHIN)
Bethesda
Community Living
Niagara Support Services
Other (Specify): _____

of the following information:

1. Sharing assessments, reports and recommendations
2. Sharing strategies that assist with daily programming
3. To schedule a school observation in conjunction with the in-school team

NCCSA Admissions Committee members may:

1. Interact and engage with your child during an observation in their classroom and/or school

In respect of: _____

Name of Student

Date of Birth (dd/mm/yyyy)

I understand the purpose for collecting and disclosing this information noted above. I understand consent may be revoked at any time and that if not revoked, this consent is in effect for one year. I understand that I can refuse to sign this consent.

Signature of Parent/Guardian

Relationship to Student

Dated this _____ Day of _____, _____.
(Month) (Year)

Personal information contained in this form is collected pursuant to the Education Act and the Municipal Freedom of Information and Protection of Privacy Act. Questions about the collection and use of this personal information should be directed to Human Resources at the Niagara Children's Centre School Authority at 905-688-1890.

PROGRAM APPLICATION

Child's Name: _____

Current Grade: _____

Students must meet the following eligibility criteria to be considered for admission:

1. Children entering our school are between the ages of 4 (by December 31st, 2025) and 21.
2. Children must reside in the Regional Municipality of Niagara.
3. The child must require a multidisciplinary team approach for academics and therapy.
4. Children must have complex needs and meet the criteria for active intervention in two or more of the following therapy areas:

Therapy Area	Area of Need
Physiotherapy	Moderate to Severe impairment in gross motor development
Occupational Therapy	Moderate to Severe impairment in fine motor development and functional or daily living skills
Speech Language Pathology / Augmentative and Alternative Communication	Moderate to Severe impairment in receptive, expressive language and/or speech development Exhibits face to face communication needs and/or written communication needs

The potential student:

- Has the ability to tolerate a full-day in a classroom setting
- Can attend to a range of activities for a short period of time
- Can participate in a shared support environment (without direct, one-to-one support for significant amounts of time)

PLACEMENT GOALS:

Please describe the rationale for this application, including identifying any goals to enhance participation in the school setting.

CURRENT EDUCATIONAL PROGRAM INFORMATION

Date Completed: _____

Completed by: _____

***NOTE: Please attach a copy of all current reports where "YES" is indicated.**

SECTION A: CURRENT EDUCATIONAL INFORMATION

		YES	NO
Student has an Individual Education Plan.		<input type="checkbox"/>	<input type="checkbox"/>
Student has been identified through the IPRC process. Identification: _____		<input type="checkbox"/>	<input type="checkbox"/>
Student receives educational assistant support.		<input type="checkbox"/>	<input type="checkbox"/>
If yes, details of EA Support: <input type="checkbox"/> Shared <input type="checkbox"/> Individual	Duration _____ Frequency _____ Any additional Information: _____		
The following school board resources are currently involved in supporting this student:	<input type="checkbox"/> Learning Resource Teacher <input type="checkbox"/> ABA Facilitator <input type="checkbox"/> Central EA / Facilitator <input type="checkbox"/> Consultant / Coordinator	<input type="checkbox"/> Board Speech Language Pathologist <input type="checkbox"/> Social Worker / CYW <input type="checkbox"/> Other: _____	
Student is on a modified day.		<input type="checkbox"/>	<input type="checkbox"/>
If yes, rationale:			
Days/Times Attending (Please check all that apply):	<input type="checkbox"/> AM Only	<input type="checkbox"/> PM Only	<input type="checkbox"/> Full Day
<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday
<input type="checkbox"/> Friday			
Student has a current positive behaviour support plan.		<input type="checkbox"/>	<input type="checkbox"/>
Student has a current safety plan.		<input type="checkbox"/>	<input type="checkbox"/>

Please attach a copy of the student's current IEP, or if an IEP is not currently in place, provide a brief overview of the student's current academic skills and program areas of focus in terms of literacy and numeracy below (eg., Letter/sound recognition, decoding skills, encoding skills, counting, patterning, etc.), as well as any alternative program areas being developed.

SECTION B: CURRENT EQUIPMENT

SEA Equipment:	<input type="checkbox"/> Stander	<input type="checkbox"/> Walker	<input type="checkbox"/> Specialized Feeding
<input type="checkbox"/> Slings	<input type="checkbox"/> Transfer Belt	<input type="checkbox"/> Specialized Seating	<input type="checkbox"/> Sensory
Other :			
ADP Equipment:	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walker	<input type="checkbox"/> Orthotics
<input type="checkbox"/> AAC Device	<input type="checkbox"/> Writing Aid	<input type="checkbox"/> Other:	

SECTION C: CURRENT SBRS THERAPY INFORMATION

Discipline	Therapist's Name	Status		Report/Notes Available	
OT		<input type="checkbox"/> Active	<input type="checkbox"/> Waitlist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PT		<input type="checkbox"/> Active	<input type="checkbox"/> Waitlist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SLP		<input type="checkbox"/> Active	<input type="checkbox"/> Waitlist	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SECTION D: OTHER AGENCY SUPPORT/INVOLVEMENT

Agency	Provider / Contact Name	Phone Number / Email
<input type="checkbox"/> Bethesda		
<input type="checkbox"/> Pathstone		
<input type="checkbox"/> Community Living		
<input type="checkbox"/> FACS		
<input type="checkbox"/> Blind/Low Vision Program <input type="checkbox"/> VLRO		
<input type="checkbox"/> HCCSS		
<input type="checkbox"/> ABA Provider _____		
<input type="checkbox"/> Private Therapy Services _____		
<input type="checkbox"/> OTHER _____		
Please provide additional details (Eg., days attending/receiving service, number of hours/week, etc.) for any services currently active.		

SECTION E: OTHER CONSIDERATIONS

Personal Care:	<input type="checkbox"/> Toilet Trained	<input type="checkbox"/> Not toilet trained	<input type="checkbox"/> Toilet seat/commode required
<input type="checkbox"/> Change table required	<input type="checkbox"/> Stands to change	<input type="checkbox"/> Catheterization	<input type="checkbox"/> Other
Health/Medical:	<input type="checkbox"/> Seizures	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Allergies:
<input type="checkbox"/> Asthmatic	<input type="checkbox"/> Hearing Concerns	<input type="checkbox"/> Vision Concerns	<input type="checkbox"/> Other:
<input type="checkbox"/> Medication Required at school	<input type="checkbox"/> Nursing Required at school (Oxygen, Tube feeds, Suctioning, etc) Details: _____		

SECTION F: ASSESSMENTS IMPACTING LEARNING

Assessment Type	Date of Most Recent Assessment		Recommendations
<input type="checkbox"/> Vision Assessment			Followed by: _____
Wears Glasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Hearing Assessment			Followed By: _____
Hearing Aids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cochlear Implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Educational Psychology Assessment			
Other _____			

SECTION G: FUNCTIONAL SKILLS

COMMUNICATION: (check any that apply)

Student requires development/revision of communication strategies for classroom participation.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Student requires trialing and prescription of equipment in the areas of:	<input type="checkbox"/> Face to Face Communication	<input type="checkbox"/> Writing Aid
Please indicate the student's current status with the AAC Clinic.	<input type="checkbox"/> Active	<input type="checkbox"/> Waitlist
AAC Device	<input type="checkbox"/> Prescribed <input type="checkbox"/> _____	<input type="checkbox"/> Currently being trialed
Articulation (production of speech sounds)	Comments / Additional Information:	
<input type="checkbox"/> Hoarseness		
<input type="checkbox"/> Nasality		
<input type="checkbox"/> Dysfluency (Stuttering)		
Receptive Language (Oral Comprehension)		
<input type="checkbox"/> Understands Oral vocabulary & directions		
<input type="checkbox"/> Understands verbal messages/stories		
<input type="checkbox"/> Understands Basic Concepts (spatial, quantity)		
<input type="checkbox"/> Responds Appropriately to Oral Questions/Follows Directions		
<input type="checkbox"/> Responds to name		
Expressive Language (Spoken Language)	Comments / Additional Information:	
<input type="checkbox"/> Demonstrates oral grammar/sentence structure		
<input type="checkbox"/> Uses appropriate vocabulary to label objects		
<input type="checkbox"/> Organizes/sequences messages		
<input type="checkbox"/> Is able to tell stories orally		
Conversation Skills		
<input type="checkbox"/> Initiates conversation		
<input type="checkbox"/> Makes/maintains eye contact		
<input type="checkbox"/> Maintains Topic		
<input type="checkbox"/> Takes turns		
Other	Comments / Additional Information:	
<input type="checkbox"/> Uses a visual schedule or graphic		

SECTION G: FUNCTIONAL SKILLS

MOTOR AND SELF-HELP SKILLS (check any that apply)

Student requires development/revision of strategies for classroom participation in the areas of:			
<input type="checkbox"/> Mobility / Gross Motor Function	<input type="checkbox"/> Fine Motor Function	<input type="checkbox"/> Self-Care / Activities of Daily Living	<input type="checkbox"/> Self-regulation
Student requires trialing and prescription of equipment in the areas of:		<input type="checkbox"/> Mobility	<input type="checkbox"/> Positioning
Other:		<input type="checkbox"/> N/A	

	Skill not developed	With assistance	Independent	
Gross Motor Function:				Comments
Sitting				
Standing				
Walking (without assistive device)				
Mobility (with assistive device)				
Exhibits protective reactions				
Balance on Indoor surfaces				
Balance on Outdoor surfaces				
Fine Motor and Self-Help Skills:				Comments
Bilateral Manipulation of objects				
Dressing				
Feeding				
Self-Regulation				Comments
	Always	Sometimes	Never	
Follows routines/teacher requests				
Aggressive towards adults				
Aggressive towards peers				
Aggressive towards self				
Throws objects				
Easily over stimulated				
Learning Readiness Skills				Comments
	Always	Sometimes	Never	
Interacts socially with peers				
Exhibits age appropriate play skills				
Plays with objects demonstrating their function				
Plays comfortably in a small group of children				
Attends to activity within a small group				
Transitions well between activities				
Safety Concerns:				Comments
	Always	Sometimes	Never	
Mouths inedible objects				
Leaves classroom without warning				
Puts self in danger				
Climbs stairs independently				
Plays safely on playground equipment				