

## N/K Intake Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Name used: \_\_\_\_\_

***Please provide the following information in order to help us best meet the needs of your child.***

Morning or Afternoon class preference:

- ☐ AM 8:25 to 10: 55
- ☐ PM 12:25 to 2:55
- ☐ Either is fine

Child lives with:

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Parents  | <input type="checkbox"/> Foster Parent(s)              |
| <input type="checkbox"/> Mom      | <input type="checkbox"/> Grandparent(s)                |
| <input type="checkbox"/> Dad      | <input type="checkbox"/> Other – please specify: _____ |
| <input type="checkbox"/> Guardian |  |

Is your child toilet trained?

- ☐ Yes
- ☐ No     If no, please describe:

\_\_\_\_\_

Has your child had any pre-school or daycare experiences, or been involved in any organized activities to date?

- ☐ No
- ☐ Yes     If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

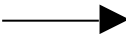
Does your child have any social/emotional/behavioral/ sensory needs?

- ☐ No
- ☐ Yes     If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Over 

Has your child received a diagnosis or are they waiting for an assessment for any of the following?

- ☐ Autism (ASD)
- ☐ Global Developmental delay
- ☐ Speech Language delay
- ☐ ADHD
- ☐ Other: \_\_\_\_\_

Has your child received supports for/from any of the following?

- ☐ SSCY Centre
- ☐ Child Development Clinic
- ☐ SLP (Speech Language)
- ☐ OT (Occupational Therapy)
- ☐ PT (Physical Therapy)
- ☐ Other \_\_\_\_\_

Does your child have a family doctor/ pediatrician?

- ☐ No
- ☐ Yes- Name of doctor: \_\_\_\_\_

Does your child have any health needs (asthma, allergies, other)?

- ☐ No
- ☐ Yes    If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

Is there any other relevant information about your child we should be aware of?

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