

Niagara Children's Centre School Authority Preschool Transition to School 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 | DSBN <input type="checkbox"/> | NCDSB <input type="checkbox"/> |
| | | | | 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: _____ | | |

PROGRAM APPLICATION

Child's Name: _____

Current Grade: _____

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

1. Children entering our school must be age 4 by December 31st, 2024
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 | Moderate to Severe impairment in receptive, expressive language and/or speech development |
| Augmentative and Alternative Communication | Exhibits face to face communication needs and/or written communication needs |

* children who require speech language intervention as well as development of an alternative or augmentative communication system would be considered as having needs in 2 areas

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.

***NOTE: A copy of your child's Functional Checklist must be attached to this application. You may attach any additional reports/information that may help us in determining placement eligibility.**



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:

- | | |
|---|---|
| <input type="checkbox"/> District School Board of Niagara | <input type="checkbox"/> HCCSS (LHIN) |
| <input type="checkbox"/> Niagara Catholic District School Board | <input type="checkbox"/> Bethesda |
| <input type="checkbox"/> Niagara Children's Centre | <input type="checkbox"/> Community Living |
| <input type="checkbox"/> School Based Rehabilitation Services (SBRIS) | <input type="checkbox"/> Niagara Support Services |
| <input type="checkbox"/> Contact Niagara | <input type="checkbox"/> Other (Specify): _____ |

of the following information:

1. Sharing assessments, reports and recommendations
2. Sharing strategies that assist with daily programming
3. To schedule an observation in conjunction with the therapy/resource team

NCCSA Admissions Committee members may:

1. Interact and engage with your child during an observation in their therapy/preschool session

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.