

ADMISSION APPLICATION

FORM CD 2  
Page 1 of 5

SCOTTISH RITE CHARITABLE FOUNDATION  
LEARNING CENTRE \_\_\_\_\_

Office Use Only

Date Rec'd \_\_\_\_\_

File No. \_\_\_\_\_

Child's Full Name: \_\_\_\_\_ Male  Female

Date and Place of Birth: \_\_\_\_\_ Age in Years \_\_\_ and Months: \_\_\_

Parent(s) Names(s): \_\_\_\_\_

Address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

E-mail: \_\_\_\_\_ Other Contact No. ( ) \_\_\_\_\_

**SCHOOL INFORMATION**

Name of School \_\_\_\_\_ Grade: \_\_\_\_\_

Has your child received any type of remedial instruction in school? Yes  No

Explain: \_\_\_\_\_

Has the school created an Individual Education Plan (IEP) or similar plan? Yes  No

If yes, please enclose a copy with this application.

Has a psycho-educational assessment been completed by a registered psychologist?

Yes, through the school  Yes, privately  No

Please enclose a copy with this application or contact the Centre Director if not available.

**FAMILY HISTORY**

Have any other members of the family had learning difficulties? Yes No

Father	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>
Sibling	<input type="checkbox"/>	<input type="checkbox"/>

Explain: \_\_\_\_\_

Describe your child's learning difficulties:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child know the alphabet? Yes  No

Can your child print his/her name? Yes  No

How well do other people understand your child's speech?

\_\_\_\_\_

Is English the first language? Yes  No  If not, what language? \_\_\_\_\_

Is English the child's primary or main language spoken at home? Yes  No

If no, explain \_\_\_\_\_

Do you know of any other problems? Yes  No

If yes, explain \_\_\_\_\_

**PHYSICAL HISTORY**

Has your child ever been chronically ill?

Yes    No  
    

If yes, explain: \_\_\_\_\_

Has your child ever had an extremely high fever?

    

Does your child have any physical problems which you feel may cause difficulty in learning?

    

If yes, explain: \_\_\_\_\_

Does your child have allergies?

    

If yes, what allergies: \_\_\_\_\_

Has your child ever had a severe blow to the head?

    

Is your child currently taking medication?

    

If so, please list: \_\_\_\_\_

Does your child have difficulty hearing?

    

Does your child have difficulty seeing?

    What other relevant medical history should the *Centre* know about?\_\_\_\_\_  
\_\_\_\_\_

**BEHAVIOURAL OBSERVATIONS**

	Yes	No
Do you often have to repeat instructions to your child?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child seem to have difficulty following instructions?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child spend more time than is appropriate on homework?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child need an extraordinary amount of help with homework?	<input type="checkbox"/>	<input type="checkbox"/>
Do your child's grades in reading, writing and spelling seem low Compared to his/her ability to think and understand?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child talk favourably about school?	<input type="checkbox"/>	<input type="checkbox"/>
How often do you spend time reading with your child?	_____times per week	
Does your child seem to enjoy being read to?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child hesitate to read to you?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have behavioural problems at school?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, explain: \_\_\_\_\_

Please include all information which might help us to help your child. Use the space below or the back for other relevant information.

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How did you hear of us? \_\_\_\_\_

The above information is true and accurate to the best of my knowledge. I agree with the planned program to tutor my child using the Orton-Gillingham Approach to remedial tutoring, and will abide by the policies and practices of the Scottish Rite Charitable Foundation Learning Centres Program. I attest that I am (we are) legally responsible for decisions made about this child.

Signature(s): \_\_\_\_\_

Date: \_\_\_\_\_

## Contact Information

Please fill in the following information for our records. We would like to ensure that the information we have on file is complete so that we will be able to reach you in case of cancellations, etc.

Child's Name \_\_\_\_\_

Parent(s) Name \_\_\_\_\_

Address: \_\_\_\_\_ PC \_\_\_\_\_

Phones: Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Fax or E-Mail: \_\_\_\_\_

Other Contact (relative, friends) \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

School \_\_\_\_\_