



# BEACON HEIGHTS ECS – ENROLLMENT FORM

Enrollment Date (DD/MM/YYYY):	
ECS Start Date (DD/MM/YYYY)	
<b>Child Information</b>	
Child's First Name	
Child's Last Name	
Sex (Male/Female)	
Date of Birth (DD/MM/YYYY)	
Age at ECS Commencement	
ECS (Full Time / Part Time)	
Home Address	
City	
Postal Code	
Copy of Birth Certificate Attached	<input type="checkbox"/> YES <input type="checkbox"/> NO

<b>Parent/Guardian Information</b>	
Mother	Father
Name:	Name:
Address:	Address:
City: _____ Postal Code: _____	City: _____ Postal Code: _____
Phone: _____	Phone: _____
Email: _____	Email: _____



# BEACON HEIGHTS ECS – ENROLLMENT FORM

Emergency Contacts & Authorizations	
Primary Emergency Contact:	Secondary Emergency Contact (OPTIONAL)
Name:	Name:
Relation with Child:	Relation with Child:
Address:	Address:
City: _____ Postal Code: _____	City: _____ Postal Code: _____
Phone: _____	Phone: _____
Email: _____	Email: _____
<p>I authorize the Beacon Heights ECS staff to take whatever emergency medical measures are deemed necessary for the protection of my child while he/she is in their ECS. I understand this authorization includes calling a physician, implementing his instructions, and transporting the child to the hospital if a parent or guardian cannot reasonably be located. I agree to be responsible for the cost of such an emergency.</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
Permission for photographs for use in ECS	<input type="checkbox"/> YES <input type="checkbox"/> NO
Access Permissions for Pickup and Dropoff	
Names of Individual with Full Access	
Individuals with No Access	
Child Profile & Family Information	
Goals for the Year	
Interests, Likes, Dislikes, Family Changes	
Toilet/Sleeping/Social Habits	
Languages Spoken at Home	
Cultural Traditions & Holidays	
Parent Willingness to Volunteer in ECS	<input type="checkbox"/> YES <input type="checkbox"/> NO



# BEACON HEIGHTS ECS – ENROLLMENT FORM

Medical Information	
Alberta Health Card Number	
Family Doctor's Details (If available)	Name:
	Address:
	Phone:
Immunization Status	<input type="checkbox"/> YES <input type="checkbox"/> NO
Past Illnesses	<input type="checkbox"/> YES <input type="checkbox"/> NO
	If Yes, Details:
Diagnosed Medical Conditions	<input type="checkbox"/> YES <input type="checkbox"/> NO
	If Yes, Details:
Food Restrictions	<input type="checkbox"/> YES <input type="checkbox"/> NO
	If Yes, Details:
Allergies (Type & Severity)	<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> MILD <input type="checkbox"/> SEVER
	If Yes, Details:

Parent Signature: \_\_\_\_\_

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

Teacher Signature: \_\_\_\_\_

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

# BEACON HEIGHTS ECS – PERMISSION FOR SCREENING/ASSESSING FOR EARLY INTERVENTION SERVICES

Beacon Heights, as an approved ECS, in partnership with Outside the Box, provides early intervention screening to identify developmental areas in which your child may require additional support, such as speech and language, fine or gross motor, regulation, behavioral and classroom support.

Early Childhood Services (ECS) refers to programming offered by school authorities during pre-school and kindergarten years and meets the diverse needs of young children and their families. In ECS programs, young children participate as active learners within developmentally appropriate learning experiences and develop knowledge, understanding and skills that lay the foundation for subsequent learning.

## Screening Process:

- Completed by a multidisciplinary team including certificated teachers, speech-language pathologists, occupational therapists and behavioral therapists.
- Takes between 10 – 20 minutes to complete.
- Screening occurs during class time. (While attending preschool, kindergarten or childcare)
- Will help determine if our multidisciplinary team services may be recommended for your child.

## Following Screening:

Results and recommendations will be shared with parents/guardians and the school/daycare staff.

By filling out the consent form below, you are walking the first step towards Early Childhood Services to support your child's development and educational needs.

## Child Information

Child's First Name

Child's Last Name

Sex (Male/Female)

Date of Birth (DD/MM/YYYY)

## BEACON HEIGHTS ECS – PERMISSION FOR SCREENING/ASSESSING FOR EARLY INTERVENTION SERVICES

<b>Parent/Guardian Information</b>	
Mother	Father
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ Postal Code: _____	City: _____ Postal Code: _____
Phone: _____	Phone: _____
Email: _____	Email: _____
<b>Has your child ever been assessed by: *</b>  - <b>Speech Language Pathologist</b> - <b>Occupational Therapist</b> - <b>Psychologist</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO  If Yes, Details: _____  _____  _____
Does your child have medical diagnosis that may impact their learning	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Permission to screen: Beacon Heights ECS provides early intervention screening to identify developmental areas in which your child may require additional support, such as speech and language, fine or gross motor and/or regulation, and behavior. *</b>  I /we give permission for my child to be screened by the Outside the Box early intervention team. <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>Permission to proceed to assessment: Sometimes, during screening, the therapists determine a need for assessment. If a need for more information is determined during screening, I give permission for the speech-language therapist, occupational therapist and/or behavioral therapist to assess my child. The assessment determines if your child qualifies for early intervention grants from Alberta Education. *</b>  I /we give permission for my child to be assessed by the Outside the Box early intervention team. <input type="checkbox"/> YES <input type="checkbox"/> NO	

## BEACON HEIGHTS ECS – PERMISSION FOR SCREENING/ASSESSING FOR EARLY INTERVENTION SERVICES

**Permission to proceed to registration: The assessment results will indicate ECS funding eligibility.**

I/we give Beacon Heights ECS permission to apply for PUF or Mild Moderate funding, based on my child's assessment results and needs: ☐ YES ☐ NO

**Please describe any areas of concern you may have about your child's development or social and emotional growth.**

**Has your child received any therapies (speech/language, occupational therapy, physical therapy, or psychology) before? If so, which therapies, and when?**

**If your child has attended preschool or daycare, describe how they responded to the experience.**

**Note:** The information disclosed within this application form is used for Beacon Heights ECS registration purposes only and will be kept confidential.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please send us duly filled and signed form at [info@beaconheightschool.com](mailto:info@beaconheightschool.com)