

**ADMISSION APPLICATION**

**Form CD 2**

Page 1 of 5

Scottish Rite Charitable Foundation  
Learning Centre Halifax

Office use only
Date rec'd _____
File No. _____

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

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

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

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

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.

Do any other members of the family have learning difficulties? Please circle Yes No

Please provide relevant details:

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Describe your child's learning difficulties:

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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?

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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 any 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 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"/>
Does 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 Centre Program. I attest that I am (we are) legally responsible for decisions made about this child.

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

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