

Application - 2025/2026 - ELIS PROGRAM

(Early Learning Intensive Support Program)

Child Information									
Last Name:		First Name:		Middle Name:					
Child's Date of Birth (DD/MM/YR):									
Date Baptized:									
Family Information									
Parent Name:			Parent Name:						
Address:			Address:						
City/Town:			City/Town:						
Postal Code:			Postal Code:						
Contact Information									
Home #:			Home #:						
Cell #:			Cell #:						
Work #:			Work #:						
Email:			Email:						
What is the best metho	od to contact you?								
Neighborhood School	Name:								
Background Information	on *Support Services	s will not be contacted	duntil a consent to con	tact has bee	en sigr	ed.			
Please indicate the support services that your child receives and the frequency of services *Referral-referral has been made; awaiting appointment. *Report Available-a report has been completed and can be obtained for review.					*Referral	Weekly	Monthly	Yearly	*Report Available
Speech-Language Pa Name:		Phone/Email:							
Physical Therapist Name:	F	hone/Email:							
Occupational Therapi Name:		Phone/Email:							
Psychologist Name:	F	Phone/Email:							
Hearing Specialist Name:	F	Phone/Email:							
Vision Specialist Name:		Phone/Email:							
Child and Youth Service Name:		Phone/Email:							

Autism Services Name:	Phone/Email:							
Ability in Me(AIM) Name:	Phone/Email:							
Alvin Buckwold Child Development Program/Kinsmen Children Center: Wascana Rehabilitation Center:								
Name:	Phone/Email:							
Early Childhood Intervention Program (E Name:	CIP) Phone/Email:							
Socialization, Communication and Educ Agency Contact:	Socialization, Communication and Education Program (SCEP) Agency Contact:							
Cognitive Disability Program								
Counsellor/Social Worker Agency Contact:								
Other: (please add any other support se	ervices not listed above)							
Does your child attend a Licensed Child	d Care Facility? Yes	No						
Name of Facility:	,							
Phone Number:								
Does your child receive Enhanced Accessibility Grant funding? Yes No								
Tell us about your child's development								
Please outline the strengths and needs of your child in the following areas:								
Social/Emotional Development (playi	ng with other children, interacting with ad	dults) (Max.	800 ch	aract	ers)			
Intellectual Development (talking clearly, listening, following directions, using complete sentences) (Max. 800 characters)								

Physical Development (like running and jumping, holding a crayon, catching a ball or using a spoon) (Max. 700 characters)						
700 Characters)						
	your child moves from	om one place to another:				
Scooting		Crawling				
Walking	V N-	Wheelchair	Here Here			
Lifting required:	Yes No	Weight of child:	lbs./kg.			
Medical Needs: (e.g	, oxygen, g-iube	fed, seizures, etc.) (Max	k. 400 Characters)			
Feeding Needs: (alle	rgies, food prefere	ences, texture preferenc	ces, etc.) (Max. 400 characters)			
Visual Needs: (glasse	es, visual devices, l	braille, etc.) (Max. 400 c	characters)			
Sensory Needs: (sounds, lighting, touch, smell, etc.) (Max. 400 characters)						
Hearing Needs: (hearing aid, sign language, etc.) (Max. 400 characters)						
Treating Meeas. (Hea	ining dia, sigit iding	100ge, e1c.) (Max. 400 c	rial acters)			
Toileting Needs: (Max. 400 characters)						

Other Needs: (Max. 400 characters)					
Is there anything else you would like to share about your child and/or family? (Max. 800 characters)					
Signature of Parent	Date of Application				

The information provided will be used for the purposes of determining your child's eligibility to participate in the Early Learning Intensive Support Program.

Please send application for admission and accompanying documents to:

Regina Catholic Schools Student Services: Natasha Scammell studentservices@rcsd.ca 306-791-7273

Following receipt of the application, you will be contacted to gather additional information and discuss options for your child.