

SCOTTISH RITE CHARITABLE FOUNDATION  
LEARNING CENTRE, CALGARY

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  Mother  Sibling  

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

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 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<br>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: \_\_\_\_\_