



**PEI Council of People with Disabilities**

**Summer Tutoring Program for Children with Disabilities  
2017 Registration Form**

***Application Deadline: Thursday May 25, 2017***

The PEI Council of People with Disabilities Summer Tutoring Program is **only available to Children with Disabilities**. Other children who need summer tutoring should contact their child's teacher about programs in their area. Acceptance to the program is on a first come first served basis, regardless of previous participation. **Payment and a completed registration form (4 pages) must be received in order for your child to be registered.**

***Program Dates: July 3 – August 25, 2017***

**Child Information**

Name: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_ School: \_\_\_\_\_  
Age: \_\_\_\_\_ Grade: \_\_\_\_\_

**Parent Information**

Parent's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ (mother) \_\_\_\_\_ (father) \_\_\_\_\_ (other) \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Civic Number: \_\_\_\_\_  
Email: \_\_\_\_\_

If you have a rural address, what town or village is closest to you? \_\_\_\_\_

**Registration Fee (\$150.00) Enclosed    cheque \_\_\_\_\_    money order \_\_\_\_\_**

(Make cheque payable to the PEI Council of People with Disabilities). Payments can be refunded up until the second week of the program. After that all payments are final.

<b>For Office Use</b>	<b>Date Received</b> _____	<b>Transaction #</b> _____
_____ Registration Form Received (all 4 pages)		
_____ Payment Received		
_____ Payment not yet received		_____ Staff Signature

1. Was your child in the program last year? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Will your child be enrolled in any other education program over the summer?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If **YES**, please specify the name of the program and the amount of time in this program:

\_\_\_\_\_

3. What area(s) of tutoring does your child require?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. **\*MUST BE COMPLETED\***: Please describe your child's disability (Autism, Down's syndrome, learning disability, developmentally delayed, etc.).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. What main skills do you and your child's teachers want your child's program to focus on (Ex. academic; reading, writing, math, communication)?

1 \_\_\_\_\_  
2 \_\_\_\_\_  
3 \_\_\_\_\_

6. Where would the program take place? (Check one)

- (a) In your home \_\_\_\_\_
- (b) In another building \_\_\_\_\_
- (c) Other (please describe) \_\_\_\_\_

***(Parents are responsible for finding another location if the program cannot take place in the home.) \*\*NOTE- It is our policy that there must be an adult over the age of 18 present for every session\*\****

7. Please describe your child’s speech (check one):

- Normal \_\_\_\_\_
- Difficult to understand \_\_\_\_\_
- Limited speech \_\_\_\_\_
- Other (sign language, etc.) - please specify \_\_\_\_\_

8. Is your child being assisted by a: **Name (if known)** (Yes or No)

- Speech-Language Pathologist \_\_\_\_\_
- Occupational Therapist \_\_\_\_\_
- Teacher Assistant \_\_\_\_\_
- Resource Teacher \_\_\_\_\_
- Reading Recovery Teacher \_\_\_\_\_
- Other (specify) \_\_\_\_\_

9. Does your child have any medical concerns that we should know about? \_\_\_\_\_

(Yes or No)

If “yes”, please describe these concerns briefly. (We will be asking you for further information in June): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10. Program sessions are 1 hour in length. Please indicate your preference:

- \_\_\_ 1 session per week
- \_\_\_ 2 sessions per week
- \_\_\_ 3 sessions per week

Check off the following days of the week and time preference you would like your child to be involved in the program. **(PLEASE NOTE: we cannot guarantee to schedule your first choice priority is given to early submissions).** Please be as specific as possible with time choices

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					
Afternoon					

Any time is fine: \_\_\_\_\_ (Check here if it applies)

11. Please outline the reasons why your child requires a specific time of day ( medical, parent supervision, program demands etc.). \_\_\_\_\_

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12. Is there a time during the summer your child will not be available (family vacation, swimming, camps etc.)?

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13. Is there any additional information you would like to provide that will help us to get to know your child better in order to develop the necessary supports that your child may require?

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**Please forward payment of \$150.00 to the PEI Council of People with Disabilities**

5 Lower Malpeque Road, Landmark Plaza, Unit 2

Charlottetown, PEI C1E 1R4

902 892 9149 ext #225

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Note: Due to allergies we ask that there is no smoking or peanut products consumed during the tutoring sessions. We would also ask that you please have your children ready to start when the tutor arrives for his/her session. Thank you for your cooperation.**

**The PEI Council of People with Disabilities thanks Easter Seals and its generous donors for its valuable contribution to our summer tutoring program.**