deaf children's society of bc

REGISTRATION FORM

Child's Name: ______________________________ DOB: ______________________________

Nickname: ______________________________ Medical # ______________________________

Gender: Male ☐ Female ☐

Parent/Guardian Names: 1) ____

2) ____

Address (including postal code): ____

____

Home Phone: ______________________________ Email: ______________________________

Parent _____________ Work #: ______________________ Cell # ________________________

Parent ______________ Work #: _____________________ Cell # ________________________

Siblings (names, ages): ____

Pets (type, name): ____

Languages used in the home: ____

Hearing History

1) At what age was your child's hearing level first identified? __________________________
2) Has a cause been identified? If so, what was it? ______________________________
3) What were the results of your child's most recent audiological assessment? ____________

   ____
4) Does your child have any medical concerns (ie: epilepsy, diabetes, allergies, vision, etc.)?

   ____

Hearing Aid and/or Cochlear Implant Information

Aids worn (✓): Right _____ Left _____ Make: __________________ Serial # ________________

Cochlear Implant (✓): Right _____ Left _____ Make: ______________ Serial # _____________

I am registering for *(please check all that apply):*

DCS Preschool	☐
DCS Group Services ELF (Early Literacy Foundations)	☐
Parent (family) Sign Group	☐
Grandparents Sign Group	☐
Parent Trek (Transition Resources for Entry to Kindergarten)	☐
DCS Speech Language Pathology Intervention Services	☐
DCS Sign Language Instruction Intervention Services	☐
DCS Group Child Care	☐
DCS Outreach Services	☐

Program	**MON**	**TUES**	**WED**	**THURS**	**FRI**
Morning Daycare 8am-9am					
Preschool 9am-12pm					
Bridge LAB 12pm-2pm					
Afternoon Daycare 2pm-4pm Estimated Pick Up Time:					
Afternoon Daycare 2pm-6pm Estimated Pick Up Time:					

Home Visits

Please indicate your top three preferred days and times for home visits by marking #1, #2 and #3 in the table below.

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					
Afternoon					
Evening					

I would like to receive intervention services in the following location:
My home ☐ DCS Preschool ☐ DCS Office ☐

Receiving Services from Other Early Intervention Agency

I am receiving additional services from the following:

Agency	Services Received
BC Family Hearing Resource Centre ☐	
Children's Hearing & Speech Centre of BC ☐	