Hamilton-Wentworth Catholic District School Board
Believing, Achieving, Serving

Entry to School
Students with Extensive Special Education Needs

HWDSB Specialized Services

The purpose of this form is to facilitate the entry to school for students with extensive special education needs. Students must be fully registered at the home school before the process can begin.

Please complete this form and return it to the applicable school board by Monday, February 3rd, 2025.

Catholic School Board

Teresa Nocciolino
Hamilton-Wentworth Catholic District School Board
44 Hunt Street
Hamilton, ON L8R 3R1
(905) 525-2930 ext. 2877
intake@hwcdsb.ca

Public School Board

John Manzin
Hamilton-Wentworth District School Board
20 Education Court
Hamilton, ON, L9A 0B9 (905)
527-5092 ext. 2804
entrytoschool@hwdsb.on.ca

Child's Demographic Information

Child's First Name:	**Child's Last Name:**
Child's Gender (Optional):	**Child's DOB (DD/MM/YYYY):**
Child's Home Address: **City** **Postal Code**	
Parent/Legal Guardian Name (1): ** please add address if different from child's home address*	**Parent/Legal Guardian Name (2):** ** please add address if different from child's home address*
Phone (1):	**Phone (2):**
E-Mail (1):	**E-Mail (2):**
Language(s) spoken at home:	**Interpreter required?** ☐ **Yes** ☐ **No**
Diagnosed Condition: **Name of Developmental Pediatrician:**	

School Registration

Hamilton-Wentworth District School Board ☐	**Hamilton-Wentworth Catholic District School Board** ☐ **Parent Baptized Roman Catholic** ☐ **Child Baptized Roman Catholic** ☐ **Family Directing Support to the Roman Catholic School System (MPAC)** ☐

Name of HOME SCHOOL your child will attend in September 2025:
(School Registration Opens February 3rd, 2025)

To determine the home school, please check the appropriate board school locator "HWCDSB School Locator" or "HWDSB Find a School" in your browser

Medical

Please note that conditions such as allergies, asthma, epilepsy, and diabetes should be reported at the time of school registration.

☐ Catheterized
☐ Medical Equipment
☐ Ostomy
☐ Suctioned
☐ Tube Fed
☐ Currently receiving nursing care

Other (please specify)

Physical

Vision Loss:
- ☐ Blind
- ☐ Low Vision

☐ Requires walker
☐ Requires wheelchair
☐ Requires lifting, transferring and/or repositioning

Other (please specify)

Daily Living

Dressing
☐ Fully dependent on adult for all dressing needs

Eating
☐ Fully dependent on adult for eating and drinking

Toileting
☐ Adult required to toilet
☐ Adult required to diaper
☐ Adult required for personal hygiene

Other (please specify)

Communication and Social Skills

☐ Not yet talking
☐ Speech is difficult to understand
☐ Difficulty putting words together
☐ Difficulty following spoken instructions
☐ Uses visual supports
☐ Uses augmentative communication (e.g. pictures, sign language)

Hearing Loss:
☐ Cochlear implants
☐ Hearing aids

Does your child play:
☐ Primarily alone
☐ Primarily with adults
☐ Doesn't play with a variety of toys in a variety of ways

Self-Regulation

Oppositional Behaviour:
☐ Often loses temper
☐ Refuses to comply with adult requests
☐ Initiates inappropriate physical contact with peers and/or adults (e.g. hit, pinch, bite, kick, scratch)
☐ Destroys property

Self-Injurious Behaviour:
☐ Head bangs
☐ Bites self
Other:

Safety Concerns:
☐ Climbs
☐ Elopes
☐ Swallows/chews inedible objects
☐ Wanders away

Other (please specify)

Community Support

Name and Address of Early Years Child Care Provider:

Supervisor: **Email:**

Resource Consultant: **Email:**

Home and Community Care Support Services Coordinator (Nursing):
Email:

	Name	Agency	Email
ABA/Autism Service Provider			
Audiologist			
Blind/Low Vision Support			
Early Childhood Resource Specialist			
Occupational Therapist			
Ontario Infant Hearing			
Physiotherapist			
Speech Language Pathologist			
Other (Please specify)			

If further information is required, an entry to school meeting will be scheduled. Please complete the Consent to Disclose Personal and/or Medical Information below. If an entry to school meeting is scheduled, all community support personnel consented for below will be invited.

CONSENT TO DISCLOSE PERSONAL AND/OR MEDICAL INFORMATION

I, _____, the parent/guardian of _____ hereby consent to the disclosure, sharing and exchange of verbal/written information between HWDSB/HWCDSB staff and (please check all that apply):

☐ABA/Autism Program
☐Audiologist/Infant Hearing
☐Blind/ Low Vision Resource Program
☐Child Care Provider
☐Early Childhood Resource Specialist
☐Home and Community Care Support Services
☐Occupational Therapist
☐Physiotherapist
☐Speech Language Pathologist
☐Other: _____

☐I consent for school board staff to observe my child at the preschool or childcare centre.

_____ _____
Signature of Parent/Guardian Date

_____ _____ _____
Signature of Person Who Helped Complete Form Title/Agency Date

Consent is valid for 12 months.

Please return this form to your School Board by February 3, 2025 and RETAIN A COPY FOR YOUR PERSONAL RECORDS

The HWDSB & HWCDSB are committed to keeping your child's personal and health information private and confidential. Information is collected, used, safeguarded, disclosed, retained and disposed of in accordance with the Municipal Freedom of Information and Protection of Privacy Act [MFIPPA] and the Personal Health Information Protection Act [PHIPA]. Any reports provided will be stored in your child's OSR at the school. Please be aware that although we protect your privacy, if the law requires it, we will have to reveal certain personal information, for example, in circumstances where your child's safety is at risk or under a police investigation or court order.