

**PRE-ASSESSMENT/ RELEASE FORM - CHILD**  
**CONDUCTIVE EDUCATION REHABILITATION SERVICES**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Manitoba Health PIN: \_\_\_\_\_

**PARENT INFORMATION**

Mother's Name: \_\_\_\_\_ Res Tel: \_\_\_\_\_ Bus Tel: \_\_\_\_\_

Address: (if different from above) \_\_\_\_\_

Mother's Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Res Tel: \_\_\_\_\_ Bus Tel: \_\_\_\_\_

Address: (if different from above) \_\_\_\_\_

Father's Cell: \_\_\_\_\_ Email \_\_\_\_\_

**EMERGENCY CONTACT (if parents can not be reached)**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Tel: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Tel: \_\_\_\_\_

**CHILD'S INFORMATION**

Diagnosis: \_\_\_\_\_

Symptoms of condition: \_\_\_\_\_

What services/therapies/treatments are being used? \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Physio/Occupational Therapists: \_\_\_\_\_

Other Specialists: \_\_\_\_\_

Daycare / Preschool / School: \_\_\_\_\_ Tel: \_\_\_\_\_

Daycare Worker / T.A. Name: \_\_\_\_\_

Does your child have seizures? YES  NO

If yes, please describe:

---

---

Action to be taken in the event of a seizure:

---

---

Does your child have any known allergies? YES  NO

If yes, please list and describe reaction:

---

---

Is your child currently on any medication? YES  NO

If yes, please describe below:

Medication	Dose/frequency	Reason for use

Does your child have any hearing difficulties? YES  NO

If yes, please describe:

---

---

Does your child have any visual difficulties? YES  NO

If yes, please describe:

---

---

Were there any complications during pregnancy or at birth?

---

---

At what age was your child's condition first noticed? By whom?

---

Please indicate below which milestones have been reached and at what age.

Lifting head: <input type="checkbox"/> _____	Rolling over: one way <input type="checkbox"/> _____ both ways <input type="checkbox"/> _____	Sitting: with support <input type="checkbox"/> _____ independently <input type="checkbox"/> _____
Standing: w/ support <input type="checkbox"/> _____ independently <input type="checkbox"/> _____ holding something <input type="checkbox"/> _____	Walking: independently <input type="checkbox"/> _____ w/ support <input type="checkbox"/> _____	Pull to stand: <input type="checkbox"/> _____
Making sounds/babbling: <input type="checkbox"/> _____	Saying words: <input type="checkbox"/> _____	Fluent speech: <input type="checkbox"/> _____

What methods of communication does your child have?

---

---

Is your child toilet trained? YES  NO   
Has your child had any surgery? YES  NO   
If yes, please give details:

---

---

Please list your child's:

**Likes:** \_\_\_\_\_  
\_\_\_\_\_

**Dislikes:** \_\_\_\_\_  
\_\_\_\_\_

**Aims and Goals for Conductive Education:**

How did you hear about Conductive Education and The Movement Centre?

---

What are your child's aims?

---

---

What are your aims?

---

---

Other Information / Comments:


---

---

Signature (Parent/Guardian)

Date \_\_\_\_\_

**IMPORTANT – PLEASE READ CAREFULLY**

Note:  We are a peanut free environment.

**GETTING STARTED** - Once The Movement Centre receives your completed pre-assessment form, one of our Conductors will contact you to discuss it further. If they feel that Conductive Education may benefit the child, they will discuss a suitable time to bring the child here for an assessment. It will take approximately an hour and we ask that the child wear loose, comfortable clothing. The fee for the assessment is \$75. The Conductor will provide recommendations based on the current programs offered. A written assessment report will be mailed at a later date. Placements are at the discretion of the Conductor and are subject to change.

**FEES / COSTS** – Fees charged reflect a highly subsidized rate and are to be paid by the family on or before the start of the program block. A receipt is issued to the family for which you can claim under medical expenses when filing your annual income tax return. Because fundraising initiatives are held throughout the year in order to maintain this subsidized rate, it is expected that all families assist and volunteer in fundraising efforts. Agencies that pay fees on behalf of the family are subject to a non-subsidized rate.

**Assessment Fee** - \$75 (due at time of assessment)

**Annual Membership (Jan – Dec)** - \$25 (active participants must be members in good standing)

**Program Costs** – Invoices are issued according to program blocks which are typically 10 – 15 weeks each. Program fees are due on or before the first day of the program. If you prefer to pay after the start date or select a payment plan, a \$20 late fee will apply which is incurred one time during the program block (additional late fees may apply for program fees not paid by the end of the program block).

**Self Fundraising Option** – We are happy to offer our clients fundraising opportunities in which they can earn credits towards their Conductive Education fees. If you are interested in hearing how this works, please contact our office at 204-489-2679.

Name of Participant: \_\_\_\_\_

Date: \_\_\_\_\_

I, \_\_\_\_\_, hereby consent to the following:  
(Participant, parent, guardian or caregiver)

1. Take / release photos and/or videos for the purpose of advertising / public relations regarding The Movement Centre of Manitoba Inc programs or facilities.

YES  NO

2. Provide/release information to healthcare and/or education providers.

YES  NO

Name of Parent/Guardian/Caregiver: \_\_\_\_\_  
(print)

Signature of Parent/Guardian/Caregiver: \_\_\_\_\_  
(if participant is under 18 years of age)

Signature of Participant or Caregiver: \_\_\_\_\_  
(if participant is over 18 years of age)

**If at any time you choose to make changes to this form, please let us know and we will replace it accordingly.**

**Thank you.**

**Conductive Education**  
Teaching Independence – Transforming Lives