Speech Camp

Registration Package

July 8 - 11, 2019

9:00AM - 3:00PM

We're excited for Speech Camp and we can't wait to meet you!

Boreal Clinic
Speech & Language Therapy

4149 4th Ave, Suite 102, Whitehorse, Yukon Y1A 1J1

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Speech & Language Therapy

Speech Camp Overview

Who is Speech Camp for?

Speech Camp is for children ages 6 to 12 who are experiencing difficulties with their speech fluency (stuttering) or with the articulation of speech sounds.

What does Speech Camp offer?

At Speech Camp, a minimum of twice a day, your child will have one-to-one speech therapy sessions tailored to their specific speech needs. The rest of their day at camp will be filled with crafts, outdoor play, and fun and engaging group activities that teach and reinforce phonological awareness, literacy and social skills. Your child will have the opportunity to meet other children who face challenges with their speech and to build both skills and confidence.

What are Speech Camp's hours?

9:00 to 3:00 Monday to Friday (drop-off 8:30-9:00, pick up 3:00-3:30). Note that we understand this may be a long a day for some children and we are happy to accommodate half-day attendance if needed.

Where will Speech Camp happen?

Camp will be at Boreal Clinic, 4149 4th Ave, Suite 102.

What does Speech Camp cost?

$850. This service is covered in part or whole by most health insurance plans.

To help us plan to meet the individual needs of your child, we ask that you fill out the following questionnaire and contact us to set up an appointment to meet with Evie, our lead speech-language pathologist, before June 30, 2019.

1. Basic Information

Child's Full Name: _____

Goes by: _____ Date of Birth: _____

Parent/s or Guardian/s: _____

Cell #: _____ Home #: _____

Work #: _____

Home Address: _____

Emergency Contact (Name & Phone #): _____

_____

School: _____ Grade: _____

Teacher: _____

2. Medical History & Diagnoses

Physician/Pediatrician's name: _____

Does your child have problems hearing? Y N If yes, describe: _____

_____

Does your child have any problems seeing? Y N Wear glasses? Y N

Please list the names and contact info for any other professionals who are currently or have recently worked with or assessed your child (e.g. pediatrician, ENT, psychologist, therapist, neurologist, physical therapist, occupational therapist):

_____

_____

_____

_____

_____

Please list any other pertinent medical history:

_____

_____

_____

Allergies and Sensitivities:

_____

_____

Conditions or Diagnoses that we should be aware of:

_____

_____

_____

3. Family Information

Language(s) spoken in the home: _____

Does your child have siblings? Y N If so, what are their names and ages?

_____

_____

4. Speech and Language History

Has your child ever received a speech and/or language evaluation and/or therapy? Y N

If so, when? _____

Who provided the service? _____

Please attach copies of speech or language assessments and progress reports if applicable.

Does your child use speech consistently to communicate? Frequently Occasionally Never

Does your child use gestures to communicate? Frequently Occasionally Never

Does your child get frustrated by his/her difficulty to communicate?
Frequently Occasionally Never

Does your child speak in complete sentences? Frequently Occasionally Never

If your child talks now, can you understand? Always Frequently Occasionally Never

Can family members? Always Frequently Occasionally Never

Can strangers? Always Frequently Occasionally Never

Does your child stutter or stammer? Always Frequently Occasionally Never

Does your child answer questions? Always Frequently Occasionally Never

Does your child follow directions? Always Frequently Occasionally Never

Does your child have difficulty learning/using new words? Y N

5. Literacy and Learning

Does your child have difficulty learning/retaining new information? Y N

Has your child had any problems learning to read? Y N Learning to write? Y N

What does your child enjoy reading? Y N

Does your child know the alphabet? Y N

Can your child write well for his/her age? Y N

Has your child worked with tutors? Y N With resource teachers? Y N

Does your child receive any services from Student Support Services? Y N

How do you believe you child learns best? _____

_____

6. Social Skills

Is making friends challenging for your child? Always Frequently Occasionally Never

Have your child's teachers had any concerns about your child's behavior, learning, or social development? Y N If so, explain:

_____

_____

_____

Describe any behaviors that you feel are of concern: _____

_____

_____

7. Strengths and Interests

What are your child's strengths?

_____

_____

_____

What does your child like to do in her/his spare time? _____

_____

_____

Please state any additional information or comments you feel would helpful to us in planning to make camp a great experience for your child:

_____

_____

_____

_____

_____

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_____

_____

Authorization for Sharing of Information

Completion of this form will serve as written permission for Boreal Clinic to communicate with the individuals you have listed below for the purposes you identify. This authorization will be considered valid throughout the course of treatment unless otherwise requested by the client and/or guardian.

Child's Name: _____

I authorize release of information to/from Boreal Clinic to/from:

Name of Individual and Role or Agency:	Phone, e-mail, and/or fax:

For the purposes of (check all that apply):
_____ Coordinating services, techniques, treatment strategies among other professionals (school personnel, pediatricians, audiologists, etc.)
_____ Updating progress towards goals
_____ Providing continuity of services
_____ Other: _____

Shared information may include:
_____ No restrictions, all information relevant/pertinent to coordinating patient treatment
_____ Session notes only
_____ Evaluations only
_____ Informal progress updates only
_____ Other: _____

Communication to/from these individuals may occur in a variety of ways (in person, phone conversations, email, fax transmittals, etc.) and may include information from the patient's medical record, for example, speech-language evaluation results or effective speech-language therapy strategies and techniques. Please know you have the right to restrict how information about you or your child is shared. Kindly indicate any restrictions you wish to request regarding how information about you or your child is shared with the above named individuals.
_____ I do not have any restrictions for how information is shared.
_____ I wish to apply the following restrictions (i.e. phone calls only, no emails, etc.):
_____
_____

Signature: _____ Date: _____

Printed Name & Relationship to Child: _____

Emergency Medical Care

I hereby grant permission for the staff at Boreal Clinic to secure the necessary emergency medical treatment needed by my son/daughter, in the event that I cannot be reached to otherwise authorize the same.

Parent or Guardian's Name: _____
(please print)

Parent or Guardian's Signature: _____

Date: _____