exceptional minds inc.
Adaptive Learning Services

2026 FALL PROGRAM SCHEDULE

Weeks	Dates
1	September 15 & 17
2	September 22 & 24
3	September 29 & October 1 + Friday Social Event: Game Show Night (Oct 2)
4	October 6 & 8
5	October 13 & 15
6	October 20 & 22
7	October 27 & 29 + Friday Social Event: Halloween Costume Party (Oct 30)
8	November 3 & 5
9	November 10 & 12
10	November 17 & 19
11	November 24 & 26 + Friday Social Event: PJ & Movie Night with Hot Chocolate and Popcorn (Nov 27)
12	December 1 & 3
13	December 8 & 10
14	December 15 & 17 + Friday Social Event: Holiday Dinner (Dec 18)

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Registration for Fall After School Program

Student Information

First Name: _____ Last Name: _____
Date of Birth: _____ Age: _____ Grade: _____ Gender: M ___ F ___
Diagnosis: _____ Provided by: _____
Medications: _____
Allergies: _____
Use an Epi-Pen: Yes ___ (1 pen required)
Health Card Number: _____
Special Diet: _____

Parent/Guardian Information
Father's Name: _____ Cell: _____
Email: _____
Address: _____
Mother's Name: _____ Cell: _____
Email: _____
Address (if different): _____

Emergency Contact Information
Contact 1: Name _____ Phone _____ Relationship _____
Contact 2: Name _____ Phone _____ Relationship _____

Language(s) spoken at home:
1._____ 2. _____

Funding Sources (check all that apply)

- □ Access OAP – Student's Access OAP #: _____
- □ Special Services at Home funding
- □ Passport funding
- □ Private
- □ Other: _____

Supports and Services (if applicable)
School and/or other placements:

_____

_____

Student Background Information
Social Interactions with Peers:
□ Generally harmonious
□ Occasional disagreements
□ Bossy/frequent disagreements
Can your son/daughter have a 2-way conversation with family members/peers?
□ Yes □ No
Skills and Interests (check all that apply):
□ Knows how to play basic board games
□ Wants to have friends
□ Knows how to play team sports
□ Knows how to play video/electronic games
Games/Activities your son/daughter enjoys:

_____

_____

Behavioural Information
Can your son/daughter work independently in small group settings?
□ Yes □ No
Has your son/daughter had any behavioral challenges in the last 90 days?
□ Yes □ No
If yes, please describe:

_____

_____

Are there specific strategies, cues, or supports that help your son/daughter succeed in group settings?

_____

_____

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Daily Living Skills:

Preparing simple meals or snacks:
□ Yes □ Sometimes □ No
Using kitchen tools safely (knife, stove, microwave):
□Yes □ Sometimes □ No
Cleaning up after cooking:
□ Yes □ Sometimes □ No
Making their bed or keeping personal space tidy:
□ Yes □ Sometimes □ No
Sorting laundry, folding clothes:
□ Yes □ Sometimes □ No
Basic household chores (sweeping, wiping surfaces, putting away items):
□ Yes □ Sometimes □ No

Money & Shopping Skills:

Handling money or using a debit/credit card:
□ Yes □ Sometimes □ No
Shopping with a list and following simple instructions:
□Yes □ Sometimes □ No

Self-Care & Personal Hygiene:

Independent hygiene routines (brushing teeth, washing hands, showering):
□ Yes □ Sometimes □ No
Dressing independently: □ Yes □ Sometimes □ No

Communication & Social Skills:

Does your son/daughter require support communicating or expressing needs?
□ Yes □ Sometimes □ No
How comfortable is your son/daughter interacting with peers in a small group?
□ Very comfortable □ Somewhat comfortable □ Needs support

Behavior & Support Needs:

How does your son/daughter typically respond to changes in routine or schedule?
□ Easily adapts □ Sometimes struggles □ Needs significant support

Additional Information:

_____

_____

_____

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Consent

Medical Consent & Statement

I have shared all important medical information about my son/daughter with Exceptional Minds Adaptive Learning Services and can be reached at the contact number(s) listed above. In case of an emergency, I give permission for staff to provide first aid and seek medical care if needed, following guidance from medical professionals.

Consent & Liability Waiver

I give permission for my son/daughter to participate in activities during their scheduled sessions with Exceptional Minds Adaptive Learning Services. I understand that all activities carry some risks, and I accept these risks as part of my child's participation.

While every effort is made to keep children safe, I understand that Exceptional Minds Adaptive Learning Services cannot be held responsible for any injuries or lost/damaged personal belongings.

Transportation Consent

I give permission for my son/daughter to be transported to and from community locations as part of the curriculum.

Parent/Guardian Name: _____ Date: _____
Signature: _____

Payment Details

Payment Methods: E-Transfer or Credit Card

- E-TRANSFER payments can be sent to: accountingservices@exceptionalminds.ca
- CREDIT CARD:
  - Name on Card: _____
  - Card Number: _____
  - Expiry Date: _____ CVV: _____

Cardholder's Signature: _____

Policies

- Late Fees: $10 per student for every 15 minutes of late pick-up.
- Attendance: Fees are non-refundable for late arrivals, early departures, absences, or missed sessions.
- Behaviour Policy: Students exhibiting inappropriate language/behavior or requiring 1:1 support will not be allowed to stay in the program. Please inquire about our 1:1 ABA services if needed.