MAURITIUS INSTITUTE OF TRAINING AND DEVELOPMENT

Checklist for Parents and Referring Agencies

Section	To be completed by:	List of Documents
Section I	Parents / Referring Agency	**Supporting Documents** (maximum file size: 1MB) ❒ Photocopy of Student's Identification: ❒ Photocopy of Parents'/Guardian's Identification: (NIC) ❒ Report book results / Progress reports (if applicable) ❒ Workplace Literacy and Numeracy scores (if applicable)
Section II	Teacher	
Section III	Medical Doctor, i.e. General Practitioner or Medical Specialist	
Section IV	Psychologist	

Application Form

Section I

APPLICANT'S PERSONAL PARTICULARS

SURNAME: (MR / MRS / MISS)

OTHER NAME(s):

MAIDEN NAME :
(If applicable)

ADDRESS: .....

.....

DOB: / / AGE : GENDER: MALE FEMALE

NATIONALITY: ..... NIC:

PHONE NO : MOBILE:

EMAIL ADDRESS: ..... RESIDENCE/WORK PERMIT NO : .....
(If applicable)

Home Languages Spoken :

English French Any other Languages _____

Is the child living with his/her parents? Yes No

Child's Educational Information History

1. Please indicate the education institution(s) the candidate had been enrolled in. If the child was not enrolled in any formal educational setting, please indicate this under the heading 'Others'.

Medical and Allied Health Professionals' Involvement

2. Current involvement by medical and/or allied health professionals should be listed in this table. Please provide a copy of the relevant reports from the professionals listed below, if available.

Professional	Name	Organisation	Frequency of involvement	Start date	End date

Declaration by Parent/ Guardian

I certify that my child/ward has received a professional recommendation for a special course in IT serving the following profile:

- Autism Spectrum Disorder (with no intellectual impairment)
- Others

I/We hereby consent for my child to enrol for the IT course that can support my child's educational and developmental needs.

SCHOOL REPORT

CANDIDATE'S PARTICULARS

Full name			
BC/NIC no.		**Gender**	
Date of birth (dd/mm/yyyy)		**Age**	
School		**Class / Level**	

NEEDS INVENTORY

For all items, check the most appropriate option(s) that best describe the child's functioning based on your observations of the child across settings and over time.

1. Sensory

☐ Hearing Concerns
☐ Vision Concerns
☐ Others; please specify _____
☐ No concerns

Please elaborate on the sensory concerns and support strategies that have helped the child, if any:

_____

_____

2. Literacy Skills (e.g. knowing letter names and sounds, reading, spelling, reading comprehension)

☐ Attained at least age-appropriate reading and writing skills compared to same-age peers.
☐ Able to read and write basic sight words and simple sentences.
☐ Able to read and write some basic sight words.
☐ Knows most/all of the letters of the Alphabet
☐ Very limited or no literacy skills

Please elaborate on student's literacy skills and support strategies that have helped the child:

_____

_____

3. Numeracy Skills (e.g. counting forward and backward, basic addition and subtraction)

☐ Higher than average level of numeracy skills compared to same-age peers
☐ Attained age-appropriate level of numeracy skills compared to same-age peers
☐ Knows simple computations (e.g. addition/subtraction) and Math concepts
☐ Able to count and recognise numbers up to 20
☐ Very limited or no numeracy skills

Please elaborate on student's numeracy skills and support strategies that have helped the child:

_____

_____

4. Self-help Skills

☐ Recognises when a problem exists and tries to solve it
☐ Seeks help appropriately from others when necessary
☐ Locates and cares for personal belongings
☐ Avoids dangers and responds to warning words

Please elaborate on student's self-help skills and support strategies that have helped the child:

_____

_____

5. Toileting

☐ Fully independent
☐ Supervision required
☐ Assistance required

Please elaborate on student's toileting skills and support that have been helped the child, if any:

_____

_____

6. Dressing

☐ Fully independent
☐ Verbal reminders and/or guidance required
☐ Periodic or partial assistance required
☐ Fully dependent

Please elaborate on student's dressing skills and support that have helped the child, if any:

_____

_____

7. Feeding

☐ Independent (with hands)
☐ Independent (with utensils)
☐ Verbal reminders and/or guidance required
☐ Learning to eat; guidance and monitoring needed
☐ Frequent supervision needed to ensure physical safety
☐ Needs to be fed

Please elaborate on student's feeding skills and support that have helped the child, if any:

_____

_____

Any other comments:

_____

_____

For students aged 17 and above

Items 8 to 10 are only applicable to students aged 17 years and above.
For item 9 on 'Attendance and punctuality in the last 12 months', attendance and punctuality rates should be calculated using the following formula:

$$\text{Attendance (\%)} = \frac{\text{Number of days where the student is present}}{\text{Total number of school days in the school term}} \times 100\%$$

$$\text{Punctuality (\%)} = \frac{\text{Number of days where the student is punctual}}{\text{Total number of school days in the school term}} \times 100\%$$

8. <u>Ability to travel independently</u>

☐ Fully independent
☐ Support required (please describe): _____
☐ Unable to travel independently

9. <u>Attendance and punctuality in the last 12 months</u>

Please provide student's rates of attendance in the last 12 months of enrolment at his/her sending school.

Attendance (%)
Punctuality (%)

Please provide additional information (in the last 12 months) as follows:

Number of days that student was on medical leave: _____
Number of days that student was absent from school with valid reasons: _____
Number of days that student was late to school with valid reasons: _____

10. <u>Work readiness</u> (work attitude, work habits, interpersonal and communication skills, self-management)

☐ Low level of work support needed
☐ Moderate level of work support needed
☐ High level of work support needed

Please describe the type of support required by the student.

_____

_____

Please provide details of prior work experience that the student has undergone.
(e.g. part time work or internship at xxx company for y months)

_____

_____

BEHAVIOURS IN THE SCHOOL/CLASSROOM CONTEXTS

In this section, the teacher should report his / her observations of the child's behaviour in group learning contexts. When describing specific behaviours, teachers should elaborate on how often these behaviours occur and the extent to which they impact the child's ability to function in a group learning setting.

1. (a) How long have you known the child? _____ **(b) What is the teacher-student ratio in the current class? _____**
2. What are the child's strengths and interests?
3. Describe the child's behaviour in class on a regular school day. **Is the child able to get along with his peers? (e.g. ability to play with his friends, work cooperatively in groups). Please elaborate and provide specific examples.**
4. Does the child present with any behavioural problems in school? Has any disciplinary action been meted out by the school in the last one year? **If yes, please give specific examples and the frequency of occurrence.**

5. Please give specific examples of strategies that have helped to support the child's behaviour.

COMPLETED BY:			
Name(s)		**Designation(s)**	
E-mail(s)		**Contact no.(s)**	
Name of School / Organisation		**Signature(s) & Date**	

_____

Name & Signature of Principal

_____

Date

Section III:

To be completed by a Medical Doctor,
i.e. General Practitioner or Medical Specialist

For children with sensory (e.g. vision, hearing) concerns, please approach a medical specialist for help with this section.

For all other children, please approach a Medical Specialist or a General Practitioner (e.g. family doctor) for help with this section.

MEDICAL REPORT

To the Doctor-in-charge:

This report is a mandatory section of the MITD Application Form to be completed by a medical professional. The patient has been assessed to be eligible for placement in an MITD Training Centre in view of his/her special educational needs. Kindly assist the patient in completing this medical report to facilitate his/her application to a course. Please attach all the relevant reports that were used as the basis for completion of this section. Thank you.

1) CHILD'S PARTICULARS			
Full name			
BC/NRIC no.		**Gender**	
Date of birth (dd/mm/yyyy)		**Age**	

2) DIAGNOSTIC INFORMATION & MEDICAL BACKGROUND

Diagnosis relevant to referral: ☐ Autism Spectrum Disorder ☐ Intellectual Disability
☐ Visual Impairment ☐ Hearing Loss
☐ Multiple Disabilities ☐ Others: _____

Description of Diagnosis: _____

_____

Onset / Date of diagnosis (delete where applicable)	
Cause of condition	☐ Unknown ☐ Please specify: _____

Other diagnoses / medical conditions:
(e.g. epilepsy, psychiatric conditions)

Onset / Date of diagnosis (delete where applicable)	
Cause of condition	☐ Unknown ☐ Please specify: _____
Is the child currently on medication?	☐ Yes ☐ No If yes, please specify schedule of administration & possible consequences if not medicated:

Is the child having any side-effects from medication?	☐ Yes ☐ No If yes, please specify:
Does the child have G6PD Deficiency?	☐ Yes ☐ No
Does the child have any allergies?	☐ Yes ☐ No If yes, please specify:
Does the child have recurring medical condition(s) (e.g., epilepsy, brain related injury/condition, physical impairment, etc)?	☐ Yes ☐ No If yes, please specify:

3) BIRTH HISTORY AND DEVELOPMENTAL MILESTONES

4) PHYSICAL EXAMINATION

Head circumference	☐ Normal ☐ Microcephaly ☐ Macrocephaly
Dysmorphic features (if any)	

Is there a medical condition for the following?

Heart	
Lungs	
Musculoskeletal system	

Hearing: Has the child undergone hearing screening (e.g. Universal Neonatal Hearing Screening (UNHS))?	☐ Yes ☐ No If yes, please specify date: If the child failed the UNHS, was the child sent for further assessments? If yes, please specify date & outcome:			
	Right ear drum		Left ear drum	
Does the child have hearing loss?	☐ Yes ☐ No **If yes, please include a copy of the audiogram.** Please specify details of a) Degree of hearing loss: b) Cause of hearing loss: c) Hearing devices used and Year of fitting: d) Year of cochlear implantation (if applicable):			
Vision: Does the child have visual impairment?	☐ Yes ☐ No If yes, please specify details:			
Right eye	6 /		Left eye	6 /
Squint?	☐ Yes ☐ No		Astigmatism?	☐ Yes ☐ No
Does the child have any physiological and/or medical conditions that schools have to take note of (e.g. hydrotherapy, horse riding, physical education, swimming)? Please provide details/reasons.				

5) ANY OTHER MEDICAL PRECAUTIONS

6) REMARKS / RECOMMENDATIONS / PROGNOSIS

COMPLETED BY:			
Doctor's name		**Signature**	
Contact no.		**Date**	

Hospital / Clinic (Official stamp)	

Section III:To be completed by a Medical Doctor,
i.e. General Practitioner or Medical Specialist

For children with sensory (e.g. vision, hearing) concerns, please approach a medical specialist for help with this section.

For all other children, please approach a Medical Specialist or a General Practitioner (e.g. family doctor) for help with this section.

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1) CHILD'S PARTICULARS			
Full name			
BC/NRIC no.		**Gender**	
Date of birth (dd/mm/yyyy)		**Age**	

2) DIAGNOSTIC INFORMATION & MEDICAL BACKGROUND

Diagnosis relevant to referral: ☐ Autism Spectrum Disorder ☐ Intellectual Disability ☐ Visual Impairment ☐ Hearing Loss ☐ Multiple Disabilities ☐ Others: _____

Description of Diagnosis: _____

_____

Onset / Date of diagnosis (delete where applicable)	
Cause of condition	☐ Unknown ☐ Please specify: _____

Other diagnoses / medical conditions:
(e.g. epilepsy, psychiatric conditions)

Onset / Date of diagnosis (delete where applicable)	
Cause of condition	☐ Unknown ☐ Please specify: _____
Is the child currently on medication?	☐ Yes ☐ No If yes, please specify schedule of administration & possible consequences if not medicated:
Is the child having any side-effects from medication?	☐ Yes ☐ No If yes, please specify:
Does the child have G6PD Deficiency?	☐ Yes ☐ No

Does the child have any allergies?	☐ Yes ☐ No If yes, please specify:
Does the child have recurring medical condition(s) (e.g., epilepsy, brain related injury/condition, physical impairment, etc)?	☐ Yes ☐ No If yes, please specify:

3) BIRTH HISTORY AND DEVELOPMENTAL MILESTONES

4) PHYSICAL EXAMINATION

Head circumference	☐ Normal	☐ Microcephaly	☐ Macrocephaly	
Dysmorphic features (if any)				
Is there a medical condition for the following?				
Heart				
Lungs				
Musculoskeletal system				
Hearing: Has the child undergone hearing screening (e.g. Universal Neonatal Hearing Screening (UNHS))?	☐ Yes ☐ No If yes, please specify date: If the child failed the UNHS, was the child sent for further assessments? If yes, please specify date & outcome:			
	Right ear drum		Left ear drum	
Does the child have hearing loss?	☐ Yes ☐ No **If yes, please include a copy of the audiogram.** Please specify details of a) Degree of hearing loss:			

	b) Cause of hearing loss: c) Hearing devices used and Year of fitting: d) Year of cochlear implantation (if applicable):		
Vision: Does the child have visual impairment?	☐ Yes ☐ No If yes, please specify details:		
Right eye	6 /	Left eye	6 /
Squint?	☐ Yes ☐ No	Astigmatism?	☐ Yes ☐ No
Does the child have any physiological and/or medical conditions that schools have to take note of (e.g. hydrotherapy, horse riding, physical education, swimming)? Please provide details/reasons.			
5) ANY OTHER MEDICAL PRECAUTIONS			
6) REMARKS / RECOMMENDATIONS / PROGNOSIS			

COMPLETED BY:			
Doctor's name		**Signature**	
Contact no.		**Date**	
Hospital / Clinic (Official stamp)			

D. PARENT REPORT

This section is for parents to provide information about their child. Referring agencies should assist parents in completing this section if necessary. The information will help the MITD to better understand the child's strengths and needs and how to keep the child safe.

CANDIDATES PARTICULARS

Full name			
BC/NIC no.		**Gender**	
Date of birth		**Age**	
School (if applicable)		**Class / Level**	

1. What are your child's strengths and interests?
2. What is your child's behaviour like on a typical day?
3. What are some situations that may cause your child to be upset or distressed (e.g. changes to routines, unable to get what he or she wants, going to new places)? How often do they occur (e.g. once a day, 3 – 4 times a week)?
4. What does your child do when he/she is upset or distressed? **What are some of your child's behaviours that *may* involve health and safety risks for your child or others (e.g. tendency to run away from school or house if unsupervised, injures self or others)?**

5. What do you do to help your child to calm down when he/she is upset or distressed?

Section IV:

To be completed by a psychologist

Section IV must be completed by a qualified psychologist.

PSYCHOLOGICAL REPORT

When using standardised tests or rating scales, please ensure that the names of instruments are accurately stated, and all scores obtained (including sub-test scores) are included as appendices.

CANDIDATE'S PARTICULARS

Full name			
BC/NIC no.		**Gender**	
Date of birth		**Age**	
School (if applicable)		**Class / Level**	

DIAGNOSTIC INFORMATION (attach supporting documents if any)

Diagnosis relevant to referral	Diagnosis/diagnoses: Date of diagnosis: Agency / Professional:
Other diagnoses (if any)	Diagnosis/diagnoses: Date of diagnosis: Agency / Professional:

BACKGROUND INFORMATION

Please provide details of relevant information about the child's medical history, past assessments or family background in this section.

TEST BEHAVIOUR

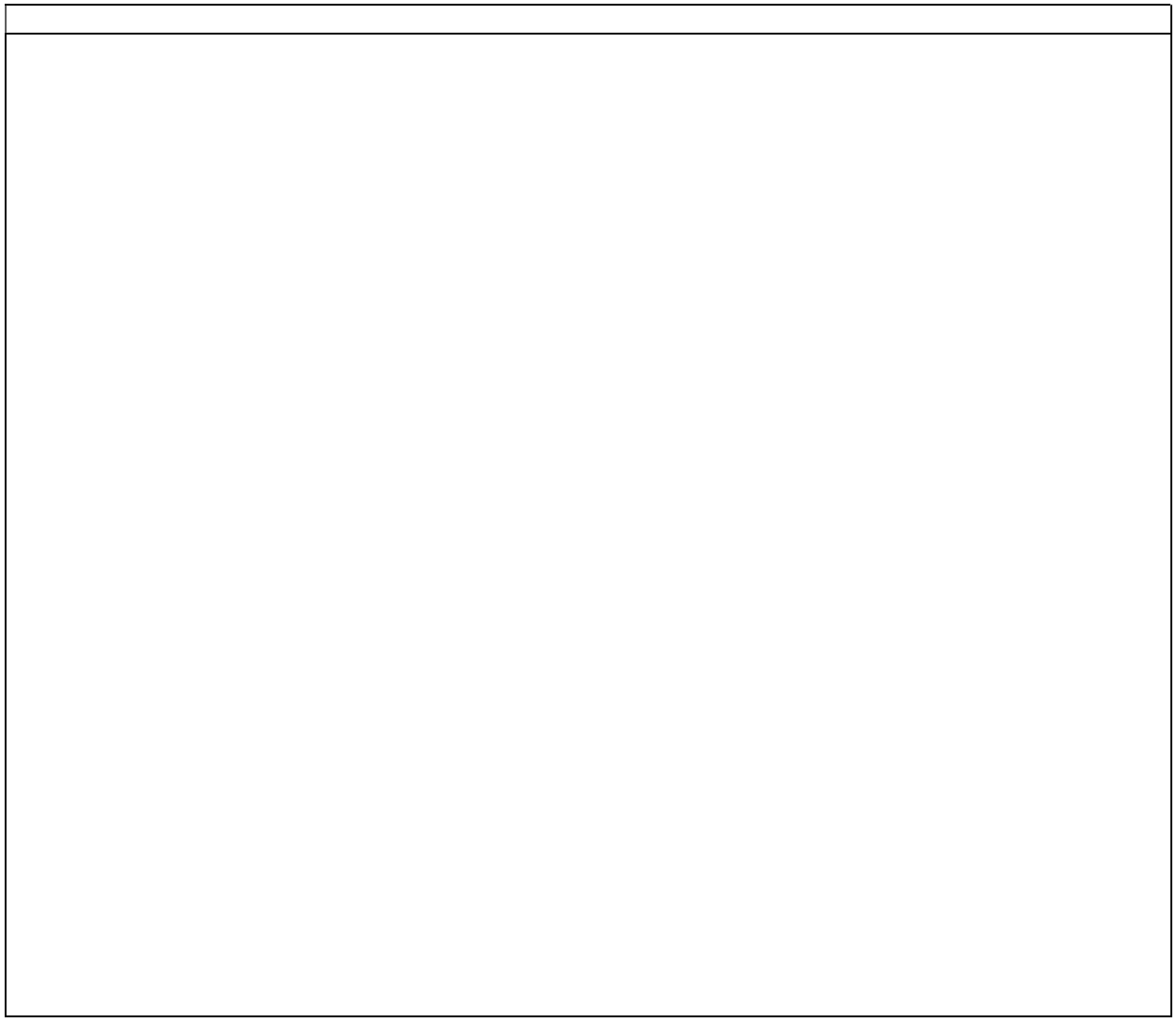
Please provide qualitative descriptions of the child's test behaviours during the testing session(s) which may have implications for the interpretations of the tests results, e.g. child's level of engagement and compliance during testing, reactions to challenges, and understanding of instruction and language used. Any accommodations and adaptations of the standardised administration protocol should also be documented here. If any of the tests were discontinued, please provide your reasons for doing so.

COGNITIVE FUNCTIONING

Date of Assessment (no more than 2 years from the date of application): _____

Level of cognitive functioning	Nonverbal cognitive functioning Please tick one of the following: ☐ Adequate functioning ☐ Mild impairment ☐ Moderate to severe impairment	Overall cognitive functioning Please tick one of the following: ☐ Adequate functioning ☐ Mild impairment ☐ Moderate to severe impairment ☐ Not computed
	Verbal cognitive functioning Please tick one of the following: ☐ Adequate functioning ☐ Mild impairment ☐ Moderate to severe impairment	

Please provide details of the child's cognitive functioning below.
Cognitive functioning refers to intellectual processes by which the student becomes aware of, perceives, or comprehends ideas. It involves his / her perception, thinking, reasoning and memory.



ADAPTIVE FUNCTIONING

Date of Assessment (no more than 2 years from the date of application): _____	
Communication Skills	Please tick one of the following: ☐ Adequate communication skills ☐ Mild deficit in communication skills ☐ Moderate to severe deficit in communication skills
Please provide details of the child's communication skills below. Communication skills refer to the child's ability to listen, understand and attend to messages, follow instructions, use interactive speech and express his/her ideas).	
Daily Living Skills	Please tick one of the following: ☐ Adequate daily living skills ☐ Mild deficit in daily living skills ☐ Moderate to severe deficit in daily living skills

Please provide details of the child's daily living skills below. Daily living skills refer to aspects of the child's self-care, home-living, motor, self-direction, safety, health and leisure skills.

Socialisation Skills	Please tick one of the following: ☐ Adequate socialisation skills ☐ Mild deficit in socialisation skills ☐ Moderate to severe deficit in socialisation skills

Please provide details of the child's socialisation skills, i.e. responding to others, expressing and recognizing emotions, social communication, maintaining friendship, recognizing social cues, leisure skills, etc.

LITERACY AND NUMERACY SKILLS

Literacy Skills	Please tick one of the following: ☐ Adequate literacy skills ☐ Mild deficit in literacy skills ☐ Moderate to severe difficulties in literacy skills	**Numeracy Skills**	Please tick one of the following: ☐ Adequate numeracy skills ☐ Mild deficit in numeracy skills ☐ Moderate to severe difficulties in numeracy skills

Please provide details of the student's literacy and numeracy skills below. The child's literacy and numeracy skills can be determined from multiple sources such as observations, work samples and parent / teacher's reports.

OTHER ASSESSMENT INFORMATION (if available)

Please include details and information on other assessments that you have conducted here.
(e.g. Autism Diagnostic Observation Schedule, Autism Diagnostic Interview – Revised)

Date of Assessment (no more than 2 years from the date of application): _____

DAILY CLASSROOM FUNCTIONING

Please provide details of the student's daily classroom functioning (e.g. level of on-task behaviour, degree of supervision needed, low student-teacher ratio required, behaviour support to address challenging behaviours).

VOCATIONAL SKILLS (if applicable)
This section should be completed for students aged 17 years and above who are applying to a SPED school that offers vocational certification.

Date of Assessment (no more than 2 years from the date of application):	
Level of work readiness	Name of instrument used for vocational assessment: _____ Level of work readiness: _____

OTHER COMMENTS

Please provide details of any other relevant needs, child's views, interests and strengths. For children with sensory and/or physical impairments, please include information about developmental prognosis, if available.

CONCLUSIONS & RECOMMENDATIONS

In this section, please make a clear statement of the child's diagnosis/diagnoses. The psychologist is required to integrate all the evidence which provide the bases for the child to be recommended special education. In addition, appropriate educational recommendations that will meet the child's needs in the short and long term should also be included here.

COMPLETED BY:			
Psychologist's name		**Signature**	
Designation		**Contact No.**	
Organisation		**Date**	
Email			
Professional Affiliations (if any)			
Supervised by (if applicable)		**Signature**	