



# SVRC SUPPORT SKILLS PROGRAM EXPRESSION OF INTEREST FORM

Student's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Referred by: \_\_\_\_\_ Date: \_\_\_\_\_

Name of parents / carers: \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (M) \_\_\_\_\_

Parent / carer email address: \_\_\_\_\_

Student school: \_\_\_\_\_ Grade / Year level: Year \_\_\_\_ in 201\_\_\_\_

Reading medium: Print / Braille      Print Size \_\_\_\_\_      Braille: Contracted / Uncontracted

Independent reader: Yes / No      Musical instruments played if any: \_\_\_\_\_

Technology used: \_\_\_\_\_

Vision impairment: \_\_\_\_\_

Visual acuities: Right eye: \_\_\_\_\_ Left eye: \_\_\_\_\_ BEO: \_\_\_\_\_

Any additional disabilities / medical issues: \_\_\_\_\_

Visiting teacher: \_\_\_\_\_ Telephone: \_\_\_\_\_

Please indicate your priority areas – number in order of preference:

Art	
Braille Maths	
Careers	
Library & Research	
Orientation & Mobility	
Sport & Recreation	
Vision Issues	

Braille	
Braille Music	
Daily Living Skills	
Music	
Social & Communication	
Technology	
Other	

Please feel free to add additional information and comments overleaf.