

**COMOX VALLEY CHILD DEVELOPMENT ASSOCIATION
APPLICATION FOR SERVICE**

CHILD'S NAME: _____ **BIRTHDATE:** _____ **GENDER:** _____

BC CARE CARD: _____ **FAMILY DOCTOR:** _____

CURRENT DAYCARE/PRESCHOOL/SCHOOL: _____

PARENT/GUARDIAN NAME(S): _____ (2) _____

MAILING ADDRESS: _____ **POSTAL CODE:** _____

STREET ADDRESS: _____ **PHONE:** _____

eMAIL: _____ **PHONE: (cell):** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

SERVICES REQUESTED:

- | | |
|---|--|
| <input type="checkbox"/> INFANT DEVELOPMENT PROGRAM | Services to children who are at risk for developmental delay (birth to 36 months) |
| <input type="checkbox"/> SUPPORTED CHILD DEVELOPMENT | Services to children who require extra support (birth to 12) for child care |
| <input type="checkbox"/> COMMUNITY INTEGRATION | Services to children and teens with a mental challenge (up to 19 th birthday)
(referral through MCFD - CYSN only) |
| <input type="checkbox"/> THE AUTISM PROGRAM | Services to children who have a diagnosis of autism and autism funding (birth to 19) |
| <input type="checkbox"/> COMPLEX DEVELOPMENTAL
BEHAVIOURAL CONDITIONS (CDBC) | North Island assessment services for children with query autism, query FASD,
and complex behaviour (birth to 18 / referral through pediatrician only) |

EARLY INTERVENTION THERAPY PROGRAM: (birth to Kindergarten eligibility)

- | | |
|---|--|
| <input type="checkbox"/> SPEECH-LANGUAGE PATHOLOGY | Assessment and treatment for children with speech/language delays |
| <input type="checkbox"/> OCCUPATIONAL THERAPY | Assessment and treatment for children with developmental delays (motor,
cognitive, visual perceptual) |
| <input type="checkbox"/> PHYSIOTHERAPY | Assessment and treatment for children with gross motor delay |

PRIMARY CONCERNS: _____

DOES YOUR CHILD HAVE ANY ALLERGIES, DIAGNOSIS OR OTHER SIGNIFICANT MEDICAL CONDITIONS?

IS YOUR CHILD TAKING ANY MEDICATIONS? _____

LANGUAGE(S) SPOKEN BY PARENTS: _____ **TRANSLATION SERVICES REQUIRED: YES/NO**

**IS THERE ANYTHING THAT WE SHOULD BE AWARE OF REGARDING YOUR FAMILY, CULTURAL AND/OR SPIRITUAL
NEEDS/BELIEFS?** _____

OTHER RELEVANT SERVICES/AGENCIES CURRENTLY INVOLVED WITH CHILD: _____

PARENT SIGNATURE: _____ **DATE:** _____
(The legal guardian must sign this form in order for the application for service to be complete).

REFERRAL SOURCE: _____ **DATE:** _____