Comox Valley Child Development Association: Application for Service

250-338-4288; Fax: 250-338-9326; advocate@cvcda.ca

CHILD AND FAMILY INFORMATION

Child's Name: _____

Birthdate: _____ Gender: _____

Personal Health # _____ Family Doctor: _____

1) Parent/Guardian Name(s): _____ _____

Address: _____ Postal Code: _____

Home Phone: _____ Alternate Phone: _____ E-Mail _____

2) Parent/Guardian Name(s): _____ _____

Address: _____ Postal Code: _____

Home Phone: _____ Alternate Phone: _____ E-Mail _____

Current Child Care/Preschool/School: _____

REFERRAL INFORMATION

Reason for Referral: _____

_____

_____

List your specific concerns for this child: _____

_____

_____

Does this child have a diagnosed condition? If so, what is the diagnosis? _____

Name of Referral Source: _____ Phone: _____

Other Involved Service Providers:

Name: _____ Agency: _____ Phone: _____

_____ _____ _____

_____ _____ _____

Has anyone in the family accessed service from the CDA previously? _____

Does anyone in the family identify as being Aboriginal? _____

Does anyone in the family require an interpreter? If so, what is language spoken? _____

Is there anything we should be award of regarding your family, cultural and/or spiritual needs/beliefs? _____

_____

_____

Guardian Signature: _____ Date: _____

(the legal guardian must sign this form in order for the application to be complete)