Comox Valley Child Development Association: Application for Service

237 Third Street, Courtenay, BC V9N 1E1
250-338-4288; Fax: 250-338-9326; advocate@cvcda.ca

CHILD AND FAMILY INFORMATION

Child's Name: _____ Birthdate: _____

Personal Health # _____ Family Doctor: _____

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

Address: _____ Postal Code: _____

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

Preferred Method of Contact: phone _____ cell _____email _____ text _____

2) Parent/Guardian Name(s): _____

Address: _____ Postal Code: _____

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

Current Child Care/Preschool/School: _____

Preferred method of contact: phone _____ cell _____email _____ text _____

REFERRAL INFORMATION

Reason for Referral/ List your specific concerns: _____

_____

_____

_____

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 aware 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)

Office Use Only
[ ] Intake/Orientation _____
(Date)

[ ] A.S.L.P. [ ] P.T. [ ] S.L.P.
[ ] I.D.P [ ] O.T. [ ] S.C.D.
[ ] ADV [ ]T.A.P. [ ] C.I.P.

Notes: