# COMOX VALLEY
## Child Development Association

U WONA

237 Third Street, Courtenay, BC V9N 1E1
TEL: 250-338-4288 * FAX: 250-338-9326
www.cvcda.ca * april@cvcda.ca

Some programs operated through
*Upper Island Women of Native Ancestry*
*960 Cumberland Rd, Courtenay, BC, V9N 2E4*

## APPLICATION FOR SERVICE

### CHILD AND FAMILY INFORMATION

Child's Name: _____ Birthdate(m/d/y): _____

Gender: _____ Family Doctor: _____

1) Parent/Guardian Name(s): _____ Relationship to Child: _____

Address: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ E-Mail _____

1) Parent/Guardian Name(s): _____ Relationship to Child: _____

Address (if different from above): _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ E-Mail _____

Current Child Care/Preschool/School: _____

### REFERRAL INFORMATION

Reason for Referral: _____
_____
_____

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

Name of Referral Source: _____ Phone: _____
Do we have consent to contact the referral source? ☐   (please leave unchecked if consent not given)

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

Does anyone in the family identify as Indigenous (Inuit/Métis/First Nations)? _____
(proof of status is not required to access services)

Preferred Language(s): English☐ French☐ Other: _____Would you like an interpreter?☐

**PARENT/GUARDIAN CONSENT:**
*The child's legal guardian(s) __must__ be informed of this referral & __sign this form__ for the application to be processed.*

Guardian Signature: _____ Date: _____

**FOR INTERNAL USE ONLY:**

Intake/Orientation: _____
(date)
Programs:

Notes: