COMOX VALLEY
Child Development Association

UWONA

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

APPLICATION FOR SERVICE

CHILD AND FAMILY INFORMATION

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

Gender: _____ Pronouns: _____ Family Doctor:_____

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

Address: _____ Postal Code: _____

Home Phone: _____Cell Phone: _____E-Mail: _____

2) 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(m/d/y): _____

FOR INTERNAL USE ONLY

Intake/Orientation: _____
(date)

Programs:

Notes: