Inclusive Child Care Program

Helping to ensure the inclusion of young children so that they may achieve their full developmental and learning potential.

REFERRAL FORM

COMPLETED FORMS CAN BE FAXED TO 780 532-9621 OR EMAILED TO iccp@ssdcs.ca

Child's Name:_____ Date of Birth (Y/M/D):_____
(please print) ( ) male ( ) female

FAMILY INFORMATION

Mother: _____ Father: _____
Mailing Address: _____ Mailing Address: _____
_____ _____
Postal Code: _____ Postal Code: _____
Home Phone: ( ) _____ Home Phone: ( ) _____
Work Phone: ( ) _____ Work Phone: ( ) _____
Cell Phone :( )_____ Cell Phone :( )_____
Email address: _____ Email address: _____
( ) Single Parent Family ( ) 2 Parent Family ( ) Blended Family ( ) Other_____

Siblings: ☐No ☐Yes
Name: _____ Age:_____ Name:_____ Age:_____
Name: _____ Age:_____ Name:_____ Age:_____
Other people residing in the home: _____
Ethnicity: _____ Language(s) spoken in the home:_____
Are there any cultural practices or preferences you would like this program to be aware of? _____
_____
_____

CHILD CARE PROGRAM INFORMATION

( ) **Not applicable – seeking child care**

Name of Child Care Program: _____ Phone ( )_____
(Day Care Centre, Family Child Care Program or Preschool)
Is this your child's first licensed/approved child care program? ( ) Yes ( ) NO_____
Aide Hired? ( ) NO ( ) YES (Funding provided through):_____
Early Childhood Educator(s), Preschool Teacher(s):
_____ _____ _____
Family Day Home Provider:_____ Phone ( )_____
Address _____
Days & Hours attending program: _____Start Date:_____, 201___

CHILD'S INFORMATION

Why are you seeking support services for your child? Check all that apply.

( ) SPEECH & LANGUAGE SKILLS: *(How the child communicates his/her wants or needs.)*

( ) FINE MOTOR SKILLS: *(Hand / finger movements including puzzles, coloring, etc.)*

( ) GROSS MOTOR SKILLS: *(Refers to the ability to control and coordinate the large muscles of the body)*

( ) SOCIAL/EMOTIONAL BEHAVIORS: *(How the child relates to adults and other children.)*

( ) ATTENTION & MEMORY ABILITIES: *(How the child recalls & responds to visual and auditory information.)*

( ) SELF-HELP SKILLS: *(Things the child does to promote independence.)*

( ) OTHER: _____

Please describe your child: _____

_____

_____

Likes: _____ Dislikes:_____

_____ _____

_____ _____

Are you aware of any allergies your child may have? ( ) No ( ) Yes: _____

Has your child had his/her: vision checked? ( ) No ( ) Yes _____

hearing checked? ( ) No ( ) Yes_____

Is your child currently taking any medications? ( ) No Yes: _____

_____

Does your child have any medical conditions or diagnosed developmental delays? ( ) No ( ) Yes (describe):_____

_____

_____

Has your child recently received or is currently receiving services from any of the following:

- ☐ Disability Services (formerly FSCD) ..... Contact Name:_____
- ☐ Speech / Language Pathology..... Contact Name:_____
- ☐ Occupational Therapy..... Contact Name:_____
- ☐ Early Intervention ..... Contact Name:_____
- ☐ Program Unit Funds (P.U.F.) ..... Contact Name:_____
- ☐ Mental Health..... Contact Name:_____
- ☐ Other:_____... Contact Name:_____
- ☐ Other:_____.... Contact Name:_____

REFERRAL SOURCE - must be completed

Name of person making this referral: _____Date:_____

( ) Parent Request ( ) Child Care Program/Agency Recommendation: _____

Has your child received ICC support services in the past? ( ) Yes ( ) No ( ) Unsure

PARENT / GUARDIAN CONSENT FOR ICCP SERVICES

I _____ give my consent for the Inclusive Child Care Program to provide supports and resources as deemed necessary to assist with the healthy development of my child. I am aware that services may include; on-site and one-on-one monitoring and support, supports assessments and/or diagnostic screening, and developmental programming (including the development of Individual Program Plans).

I further understand:

1. My child's licensed child care facility/program may release pertinent information regarding my child to ICCP.

2. Videos, and/or pictures of my child may be taken within their child care program for developmental programming purposes.

3. I can request access to information in my child's file.

4. This is a voluntary service and consent may be revoked by myself at any time.

Name (please print): _____

Signature: _____ Date: _____

Child's Name: _____ Date of Birth: _____

Grievance Process:

- If you have a complaint of any kind, please direct it to the program staff
- Resolution will be sought with the staff member directly involved
- Conflicts/grievances will be dealt with in a timely manner
- Efforts will be made to reach a mutually agreeable solution whenever possible
- If a situation arises where resolution is not found with the direct staff member, ask to be referred to the Regional ICCP Program Coordinator
- If the situation remains unresolved, address your complaint/grievance in writing to the Executive Director of Stepping Stones Day Care Society. If a satisfactory resolution is not found, then a request may be made for the issue to be presented at the next Board of Directors meeting.

Inclusive Child Care Program

AUTHORIZATION FOR THE RELEASE OF INFORMATION & AUTHORIZATION FOR THE EXCHANGE OF INFORMATION

I hereby give my consent to the Inclusive Child Care Program to request and/or exchange pertinent confidential information with following agencies/programs regarding my child for the purpose of:

1. *Establishing and implementing appropriate Individual Program Plans*
2. *Utilizing appropriate community support services and resources*

I understand that all information which is exchanged is confidential and will be available to only those persons directly involved with the purposes stated above.

In the event that my child no longer receives services through ICCP, this authorization will be made void. I may amend or void this authorization through written notice at any time.

Please indicate agencies and/or programs your <u>has recently</u> or <u>is currently</u> receiving support and/or services from.

( ) Speech/Language Pathology….. Contact:_____ initial _____

( ) Occupational Therapy…….. Contact:_____ initial _____

( ) Physical Therapy…… Contact:_____ initial _____

( ) Early Intervention…….. Contact:_____ initial _____

( ) Disability Services (formerly FSCD) Contact:_____ initial _____

( ) Mental Health…….. Contact:_____ initial _____

( ) Preschool/Kindergarten:_____ Contact:_____ initial _____

Others: (please specify)

_____ Contact:_____ initial _____

_____ Contact:_____ initial _____

_____ Contact:_____ initial _____

Signature not required if you child has <u>NOT</u> accessed any of the above support services.

Parent/Guardian Name: _____

Child's Name: _____

Signature: _____ Date: _____