LAICHWILTACH FAMILY LIFE SOCIETY

Aboriginal Child Development Referral / Consent Form

Name of Child: _________________________ Date of Birth: ______/___/____ Sex: M F
Month / Day / Year

Parents/Guardian Name(s): ____

Address: ____

Home Phone: ____________________ Cell: __________________________

Email: ____

Affiliated Band: ____________________________ or Metis: _______

Referred by: __________________________ Organization: _______________________

Telephone #: __________________________ Fax: ______________________________

Email: ____

Services Requested:
___ T.P. (Traditional Parenting - Mon) ___ Parents & Tot Group (Tuesdays)
___ Baby Group (Wednesdays) ___ Indigenous Doula
___ AIDP (Aboriginal Infant Development) ___ AOT (Aboriginal Occupational Development)
___ ASLS (Aboriginal Speech & Language) ___ ASCD (Aboriginal Support Child Development)

I __________________________ (Parent/Guardian) request and consent to the Aboriginal Child Development Center (ACDC) staff of Laichwiltach Family Life Society provide services for my child listed above. My consent is to allow the ACDC Staff to share and obtain pertinent information about my child listed above; whether considered confidential or privileged from:

Laichwiltach Family Life Society Staff
Family Physician/Pediatrician/Medical Specialist
Ministry of Children and Family Development
Birth Parents
Foster Parents
Other Family Members_____________
Behavior Consultants
KDC Health Offices
Other ________________________________
Dogwood Place Resources
Supported Child Development Program
Ministry of Human Resources
Child's Daycare Staff
Mental Health Services
School District Staff
Public Health Nurses/CHR's/

Please cross out those you do not want information to be shared with

The reason for giving consent to share and obtain information is to allow Laichwiltach Family Life Society to coordinate with other services my child is involved in. I understand that I may revoke this consent (verbally or in writing) at any time, however, this choice may result in discontinuation of services.

________________________________ ________________________________

Signature of Legal Guardian **Date**

441-4th Ave Campbell River, B.C.V9W-3W7
Telephone: (250) 286-3466 Fax: (250) 286-3483
E-mail: ascd_daycare@lfls.ca

LAICHWILTACH FAMILY LIFE SOCIETY
Aboriginal Child Development Intake Form

IDENTIFYING AND FAMILY INFORMATION

Child's Name: ________________________ Birthdate: ____________________ Sex: M or F
Corrected Date of Birth: ____________________
My child attends this daycare/preschool: __________________ Days/Time: _________________
If no, are you interested in having your child attend our Head Start Pre-School or Daycare? Y or N
My child has ___ siblings: ____
Is there anything else the practitioners need to know about your child or home for visits? (Allergies, pets, etc.) ____
____
____

Health History:
Were there any problems during the pregnancy? __ No __ Yes (please indicate) _______________
____

Were there any problems during the birth? __ No __ Yes (please indicate) ___________________
____
Was your pregnancy? ___ Full Term ___ Pre-Mature (how?) _________ Birth Weight _________
What are some significant facts about your pregnancy or birth that you would like us to know?
____
Did you smoke, consume alcohol, prescription, or non-prescription drugs? __ Yes or __ No (is yes, please indicate): ____
Do you have a family doctor? __ No __ Yes: Who? _______________
Has your child seen/being seen by a pediatrician? __ No __ Yes: Who? _________________
Does your child take regular medications? __ No __ Yes (please indicate)
____
Has your child had their vision screened? __ No __ Yes (when/where?) _____________________
Has your child had their hearing screened? __ No __ Yes (when/where?) ____________________
Does your child receive any other services? __ No __ Yes (please indicate) _____________________
____

Please check off areas that apply to your child:

Speech and Language: is there family history of speech/language problems? __ Yes or _No
My child communicates by: ___ body language (reaching/pointing) ___ sounds (grunts) ___ single words ___ 2-4 words ___ sentences longer than 4 words
Concerns: ___ lack of sounds or words ___ not putting words together ___ clarity of speech
Other: ____

Hearing: is there family history of hearing problems? __ Yes or __ No
My child does not: ___ turn to noise in environment ___ respond to their name ___ follow directions
Other: ____

Motor Skills: My child does not:
0-6 months: ___ lift head while on back ___ performs tummy time with ease ___ rolls over both directions ___ pushes up on arms ___ sits unassisted
6-12 months: __sits alone ___ reaches for toys or objects ___ pinches or grabs toys or objects ___ crawls on belly ___ crawls on hands/knees ___ pulls to standing position
12-18 months: __ walks alone with one hand ___ walks alone well ___ holds a cup ___ holds a spoon
__ scribbles with crayon __ kicks a ball forward
18-24 months: __ throws a ball __ jumps in place with both feet __ walks and runs fairly well
__ walks up and down stairs alone
24-36 months: __ balance on 1 foot for a few seconds __ walk backwards __ jumps down from steps
__ draws lines __ catches a large ball
Other: ____

Cognitive Development: my child struggles with: ___ following directions ___ learning new information
Other: ____

Play and Social Interaction: my child struggles with: ___ turn-taking ___ eye contact ___ playing in groups or on their own
Other: ____

Eating and Feeding: my child struggles with: ___ picky eating ___ coughing/choking at mealtime
Any Concerns with early feeding? __ Yes or __ No (if yes, please indicate): ____ latching
____ on breast ____ on bottle ____ choking ___ gagging ___ sucking - other ________________
Other: ____

Behaviour: my child struggles with: __ sleeping __ emotional regulation: ____________________

___ attention span ___ reaction to touch/noise/people
Other: ____

Was this form filled out over the phone? __ Yes or __ No

Additional Information: ____
____
____

Please note that if you miss 3 consecutive visits without any notification, we will do our best to keep in contact, after that, you will be removed from the program and put on our waitlist. By signing below, you are ensuring you understand, and that all information provided is correct.

Parent/Guardian Signature: ______________________________ Date: _______________

Staff Signature: _________________________ Date: _______________

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