Kackaamin
FAMILY DEVELOPMENT CENTRE
7830 Beaver Creek Road
Port Alberni, BC V9Y 8N3

Toddler Intake Application – Newborn to 4 Years

Client File Overview:

(This Intake Package is to be completed by the Referral Worker with Parent(s). Please print all responses.)

Date of Application: ______________

Last Name: ________________ First Name: _____________________

Male ❑ Female❑ Birthdate: _______/____/_____ Age: ________
YYYY MM DD

Aboriginal Ancestry: Yes ❑ No ❑ On Reserve ❑ Off Reserve ❑

Band Name: ________________________________ Status number: _______________________
Please include both

Personal Health Number: ____________________

Home Address: _____________________________City: ________________________________

Province: ________ Postal Code: ______________Telephone: __________________________

Full Name of Parents/ Legal Guardians:
____

Please note, children must be in parental care/ legally returned by MCFD to attend our program

Emergency Contact: (*Please list a person who may be contacted in case of emergency)*

Name: _____________________________ Relationship: ________________________________

Contact Phone #: ____

Immunizations:

Is your child up-to-date on immunizations? Yes ❑ No ❑

If No, is there a medical reason for not immunizing? Please explain:

*******Please note, we require a copy of child's up-to-date immunization records sent in with application and unless medically unable, all children MUST be immunized to attend our program*******

Parent Initials ________

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Are there any physical challenges/ chronic health/ developmental conditions that require special attention? *Please specify:*

If your child has allergies that we need to be aware of, please list them:

<u>* Please bring epi-pen (plus refills) prescribed by your family physician if required. KFDC does not supply epi-pens for clients or children****</u>***

Client Family Name: ____________________________

Referral Worker Name: _________________________________

Referral Agency: ____

Address: ____

Business #/Cell: ___________________________ **Fax**: _________________________________

Email Address: ____________________________

Parent Initials ________

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Consent to Release Confidential Information

I *(parent)* ___________________ hereby request and permit KFDC staff to discuss any and all confidential information about my child/ren with my referral worker listed below.

Child Client's Name: ____________________________

Name of Parent: _____________________

Signature of Parent: ____________________________ Date: _____________

Referral Worker's Name: ________________________

Referral Worker's Signature: ______________________

Referral Worker Organization/Agency's Name: ___________________________

Address: ___________________________ City: ___________________________

Province: ______ Postal code: ___________

Telephone: ____________________ Fax #: _____________________

Email address: ____

Alternate contact person within your organization: _________________________

******* The alternate contact person is for the confirmation or admission process only – the alternate contact will not be included in the release of confidential information prior to, during, or after treatment. The client may change the name of the person that receives the Discharge Summary at any time. It is up to the client to inform their referral worker of that change.*** **This form is only applicable for one year after the date it is signed. *****

Parent Initials ________