MACL
Mission Association for Community Living

SUPPORTED CHILD DEVELOPMENT – REFERRAL FORM

Please be aware that information on this form will be shared with the Ministry of Children and Family Development, which funds this Supported Child Development Program, and your name address and phone number will be entered in the MACL database.

Child's Name		Gender Pronoun	Date of Birth
Home address			Postal Code
Mailing address (if different than above)			Postal Code
Does your child identify as Indigenous? (If Yes, First Nations, Metis, Inuit?) ❒Yes ❒No		*Referrals for children who are indigenous are encouraged to send a referral to ASCD with **STÓ:LŌ HEALTH SERVCES**	
Name of Person(s) Child Lives with (Legal Guardian ❒Yes ❒No)	Relationship to Child	Phone	Email Address
Name of Person(s) Child Lives with (Legal Guardian ❒Yes ❒No)	Relationship to Child	Phone	Email Address
Legal Guardian/Social Worker Name (if different than above)		Phone	Email Address
Address		Postal Code	Agency
Are you comfortable communicating in English? ❒Yes ❒No	Preferred Language(s) spoken at home:		Interpreter needed? ❒Yes ❒No
Name of Preschool, Daycare, Out of School Care		Days & Hours that child attends	
If not enrolled in childcare, type of childcare program preferred: (preschool, family childcare, group daycare, Out of School care)			
Reason for Referral: (Briefly describe the type and level of support your child will need in a childcare setting) (i.e. mobility, communication, behaviour, self-help, social and emotional regulation)			
Does your child have other support services? (i.e. Infant/Child Development Program, Therapists, CYSN Social Worker, etc.) Please list:			
Please describe language, cultural, ethnic, or religious practices which are important to consider when working with your child and family?			
Referral completed by:			Date of Application
Agency or Facility		Phone	Fax
Has the parent or legal guardian consented to this referral ❒Yes ❒No	(this referral will not be processed without parental/legal guardian consent)		
Signature of Parent/Guardian:			

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At your option, check ethnic background *(for demographic research)*: ☐ Caucasian ☐South Asian ☐ Asian ☐Indigenous ☐Other

At your option, please check whether your child was prenatally exposed to drugs or alcohol: ☐Yes ☐No

At your option, has your child experienced any trauma: ☐Yes ☐No

Are immunizations up to date: ☐Yes ☐No **Hearing Test:** ☐Yes ☐No **Vision Test:** ☐Yes ☐No

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