

Early Childhood Training & Consultation Program REFERRAL FORM

Referral Date):	_	Referred B	Зу:			
Childcare Pro	ogram/Provider:						
Program Address:				Zip Code:			
Program Con	ntact #:						
Email:			Fax #:				
Classroom To	eacher(s)						
Identified Ch							
Name:			Date of	Date of Birth:			
Gender: Male Female			Ethnici	Ethnicity:			
Primary Lang	guage:		Religio	n			
Home Addres	SS:				_Zip Code:		
Family Const	ruct: Mother	Fathe	er# of Sib	lings	Other		
Date of Enrol	llment in your Progr	am:					
Does the chil	d fill a contract/voud	cher slot?					
Parent/Guar	dian:						
Name:			Relationsl	hip to Child:			
Contact #:		Primary	Language: _				
Ethnicity:	Religion:						
Concerns:							
	Behavioral		Developmental		Speech		
	Other:						

if benaviora	i, piease check all that a	ірріу:			
	Aggression			Poor social skills	
	Self injurious behavior			Fearful, anxious, withdrawn	
	Temper tantrums			Overactive	
	Sexualized behavior			Non-compliant, oppositional	
	Destruction of property			Inattentive, unable to focus	
Is the child	at risk of suspension/ex	pulsion fro	om the	program?	
	Yes □	No			
Other service	ces child has received/is	receiving	:		
	Early Intervention			Department of Children & Families	
	Individual/play therapy	<i>'</i>		504 Plan	
	Family therapy			Special Education Evaluation	
	IEP/IFSP			Medication	
Has the pare	ent/guardian signed the	consent to	o receiv	ve services form?	
	Yes	No			
	Ad	dditional C	Comme	nts:	
Consultation Progressions Consultants to obs	ram on service year experve and assess the need consult to classroom sta	ectations a eds of the	and pro	s Early Childhood Training and ovide access to the classroom to enable d child; develop a written behavioral ents; and model applicable interventions to	
Program Director			Date		
ECTC Consultant, JRI					

Referrals will not be processed without asigned consent form from the parent/guardian.

Please fax completed forms to: 508-822-2601





Early Childhood Training & Consultation Program

CONSENT TO RECEIVE SERVICES

Child's Name:	Date of Birth:
Parent/ Guardian:	
Home Address:	
Contact #:	
Child Care Program Name:	
Program Contact #:	
	hildhood Training &Consultation Program (ECTC) consultant to ervices at the child care program listed above:
Observation of my ch	nild in the school or childcare setting
2. Consultation to the te	
Modeling strategies t	hat support my child's participation in activities
	itions for ongoing services
5. Maintain my child's E	ECTC record in a confidential file
I give permission for ECTC to commu	nicate with the following individuals and/or agencies:
	nd I understand that the ECTC staff will be contacting me and es that are recommended and/or provided.
I also understand that I may revoke th	nis consent to receive services at any future time.
Parent/ Guardian Signature	 Date

This Consent to Receive Services is valid for one year from date signed above.

