Supported Child Development
Request for Support/Intake – Child Care Program

Child's Name: _____ *Birthdate:* _____

Today's Date _____ ◈ **Please contact us if you need help filling out this form** ◈

Please sign below to indicate you have permission from parent or guardian to provide details about the child and their needs, in relation to this request for SCD support.

Yes, we have parent/guardian permission to speak with Supported Child Development staff regarding the child identified below.

Child Care Program Supervisor Signature: _____

Date Signed: _____

Child Care Program Supervisor Name: _____
(please print)

Child's Name: _____ **Birthdate:** _____

Child Care Setting Name: _____

Phone: ( ) _____ **Cell:** ( ) _____

Email: _____

Best **day/time** for child care staff to meet with SCD:

Day: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time: _____

Best **place** for child care staff to meet with SCD:

☐ Child Care ☐ SCD Office ☐ Other: _____

How **long** has the child attended the centre?

_____

When did you first notice concerns?

_____

_____

Does the child you are referring have a diagnosed medical condition or disability?

No ☐ Yes ☐ If yes, please describe

_____

_____

Shuswap Children's Association ★ Box 2579 ★ Salmon Arm, B.C. ★ V1E4R5
Phone: (250) 833-0164 ★ Fax: (250) 833-0167 ★ E-mail: sca@shuswapchildrens.com ★Web: www.shuswapchildrens.ca

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Child's Name: _____ DOB:_____

Please identify the areas of concern – check ☑ all that apply:

❒ *Behaviour (where → when → with Whom → what precedes it → what guidance have you tried → intensity → duration)*

~ how many times per day or per week

_____

_____

_____

❒ *Social interactions (playing with friends)*

_____

_____

_____

❒ *Boundaries*

_____

_____

_____

❒ *Following rules & directions*

_____

_____

_____

❒ *Waiting (e.g. finds it hard to wait for a turn/toy)*

_____

_____

_____

❒ *Communication*

_____

_____

_____

❒ *Transitions (e.g. moving from one activity to another)*

_____

_____

_____

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Child's Name: _____ DOB:_____

❒ *Group Participation*

_____

_____

_____

❒ *Safety and awareness of environment (e.g. leaves yard, opens gates, runs into the street)* _____

_____

_____

❒ *Attention span (e.g. listening to a story, circle time)*

_____

_____

_____

❒ *Motor development activities & experiences:*

❍ *Fine-motor (e.g. holding a spoon, fastening buttons/zippers)*

_____

❍ *Gross-motor (e.g. running, climbing, going up and down stairs)*

_____

❒ *Sensory concerns (e.g. child is either OVER or UNDER sensitive to different sounds, light, touch, etc.):*

_____

_____

_____

❒ *Other areas of concern (e.g. eating, sleeping, vision, hearing, anxiety)*

_____

_____

_____

Please provide additional details for any of the above. How do these concerns affect the child's ability to participate in your program?

_____

_____

_____

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Child's Name: _____ DOB: _____

Request for Program Assistant: ☐ Yes ☐ No

If you requesting the temporary support of a Program Assistant, what days and times would be most helpful?

Days: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Times: _____

Please Note: Program Assistant Budget is Limited

Program Assistant Support is determined by a priority rating scale and funds available in the budget. This is reviewed at a minimum of every three months.

1. How are you the child care supporting the child now?

_____
_____
_____
_____
_____

2. What are the child's strengths?✸ What do they like doing?👍

_____
_____
_____
_____
_____

3. What do you enjoy about this child? ☺

_____
_____
_____
_____
_____

4. Is there anything else you think we should know?

_____
_____
_____
_____
_____

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