

TVCCA HEAD START REFERRAL CARD

TODAY'S DATE: ____/____/____

DATE OF BIRTH: ____/____/____

CHILD'S LAST NAME: _____ CHILD'S FIRST NAME: _____

PARENT/GUARDIAN LAST/FIRST NAME: _____

ADDRESS: _____ CITY/TOWN: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

COMMENTS: (Such as Direction, to home, best day and time to meet, etc.): _____

IS CHILD IN DCF CUSTODY (i.e. foster care): __Y or __N

DCF SOCIAL WORKER NAME: _____ PHONE NUMBER: _____

DOES CHILD HAVE ANY FOOD ALLERGIES/RESTRICTIONS? __Y__N SPECIFY: _____

IS CHILD ON ANY MEDICATION? __Y__N SPECIFY: _____

DOES YOUR CHILD HAVE A MEDICAL CONDITION? __Y__N SPECIFY: _____

DOES YOUR CHILD HAVE A SUSPECTED OR DOCUMENTED DISABILITY? __Y__N SPECIFY: _____

DATE OF LAST PHYSICAL: _____ DATE OF LAST TB (PPD, TINE TEST): _____

WHO'S TAKING THIS REFERRAL: _____ HOW DID YOU HEAR ABOUT US? _____

IF AGENCY REFERRAL...PLEASE COMPLETE THE FOLLOWING:

AGENCY NAME: _____ CONTACT: _____ PHONE #: _____

REVISED: 03/09

****PLEASE LOG ALL CONTACT ON BACK OF REFERRAL CARD****