

Date of intake: _____ ID #: _____ Family Tracking Name: _____
 Data Base Generated ID #: _____
 Builder Assigned _____ Best Times _____

Referral Source: Self School Health Ad Children Service
 In Home program Presentations other: _____

Circle main adult participant *Check box if adult lives in primary household of child*

| | Guardian/Parent/adult | Relationship to child | Age ¹ | Education completed ² |
|--------------------------|-----------------------|-----------------------|------------------|----------------------------------|
| <input type="checkbox"/> | _____ | _____ | _____ | _____ |
| <input type="checkbox"/> | _____ | _____ | _____ | _____ |
| <input type="checkbox"/> | _____ | _____ | _____ | _____ |

Family Configuration: Nuclear Blended Divorce Single Step Parent Grandparent Foster
 (Can be more than 1) Other _____
 Phone Number: _____ Email: _____

| | | |
|---|------------|-------------|
| Mailing Address | Directions | Rural/Urban |
| Postal Code: _____ District: _____ MD, Calgary, High River, Okotoks, Black Diamond, Turner Valley, Longview | | |

Primary Child: Learning Disability ___ Diagnosed ___ Not Diagnosed ___
 Physical Disability ___ Diagnosed ___ Not Diagnosed ___
 Other ___ Diagnosed ___ Not Diagnosed ___

| First & Last Name | Birth Date | Age ³ Grade | School | M/F |
|--------------------|------------|------------------------|--------|-----|
| Child _____ | | | | |
| Sibling/s 1. _____ | | | | |
| 2. _____ | | | | |
| 3. _____ | | | | |
| 4. _____ | | | | |

Do you self identify as: First Nation Métis Inuit

Do you self identify as being from another culture no yes or another language group ? no yes

Level of English Language: Basic Intermediate Advanced:
 Need for a translator: Yes No Available Yes No
 First Language: _____ Other Languages spoken in the home: _____

Medical Problem⁴ _____ Medication _____

Eye exam: Yes / no When: _____ Hearing Test: Yes / no When: _____

Family Indicators:

¹ <16 17-21 22-35 >35
² < Grade 12 Grade 12 >Grade 12 Post Secondary
³ Age at intake
⁴ Only information that is pertinent to the child's learning, development and safety (severe allergies)

Other Services/Programs: Speech Occupational Therapy In Home Support
 Family School Liaison Worker Learning/Reading Support Other: _____

Signature indicates permission for Builder/Supervisor to contact:

Teacher Health Nurse Family Support Worker Doctor Family School Liaison Worker
 Other: _____.

The contact will be for the sole purpose of gaining information that will help the Builder/supervisor understand the child’s learning and development. This information will be shared with the parent.

Parent Signature: _____ **Date:** _____

Parent informed of Essential Skills Pilot: yes no

Teacher: _____ Phone Number: _____

Other Contact: _____ Phone Number: _____

Information Parent has received from Teacher or other resources that pertain to child’s learning and development.

Coordinator’s Comments:

Unacceptable Topics: _____

What brought you to Building Blocks? Child’s interests, pets, smoking, etc.

Type of Session: Long Term: _____ Short Term: _____

Referred to another service? _____