Children's Services Division
Social Services Department
82 Erie Street, Stratford, Ontario N5A 2M4
Phone: 519-271-3773 Toll Free: 1-800-669-2948

Referral to The City of Stratford's Children's Resource Consultant Program

! This referral is to be completed by the Referral Source

Date of Referral: _____

Agency Name: _____

Is there signed parental consent attached? ☐ Yes ☐ No

Child's Name: _____ Child's Date of Birth: _____

Parents/Guardians Name: _____

Address: _____

City/Town: _____

Province: _____ Postal Code: _____

Home Phone Number: _____

Other Phone Number: _____

Email: _____

Is the Child in a Licensed Program? Example: Child Care Centre, Early On, Licensed Home

☐ Yes ☐ No

Please list your concerns below:

Office Use Only:

Date:	
Referral Received by:	
Parent Contact Date:	

The personal information collected on this form is collected by The Corporation of the City of Stratford under the authority of the Child Care and Early Years Act, 2014 and will be used by Social Services staff for the purpose of reviewing the application and other administrative purposes. Questions regarding the collection and use of this information may be made to the City Clerk, P.O. Box 818, Stratford, ON, N5A 6W1 or by telephone 519-271-0250 extension 5329 during business hours. If you require this document in an alternate format, please contact the Clerk's office at 519-271-0250 extension 5237 or clerks@stratford.ca.

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Authorization to Obtain and Release Information

Full Name of Parent: _____

Address: _____

Child's Name: _____ Child's Date of birth: _____

I do hereby authorize the City of Stratford Children's Resource Consultant Program to obtain and release all pertinent records, medical and educational history on the above-named child to/from:

- ☐ Thames Valley Children's Centre
- ☐ CPRI
- ☐ Children's Aid Society
- ☐ Huron Perth Public Health
- ☐ Huron Perth Centre
- ☐ Child Care Centre: _____
- ☐ Pediatrician (name): _____
- ☐ Other: _____
- ☐ Huron & Perth Separate School Board
- ☐ Avon Maitland District School Board
- ☐ Small Talk/Speech Therapy
- ☐ Family Services Perth Huron

It is acknowledged that the exchange of such information shall not be regarded as a breach of confidentiality and it is understood that the information shared will be used to serve my child's health care and education needs.

This authorization may be terminated at any time by the undersigned by submitting a written request to the City of Stratford Children's Resource Consultant Program.

Signature of Parent or Guardian: _____

Signature of Witness: _____

Date: _____

Expiry Date of Authorization (Completion of Child Care Program): _____

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