**Edisto Children's Center**

Strengthening Families Program Referral Form Attention: Site Coordinator

P.O. Box 1568 Orangeburg, SC 29116

Main Office: (803) 534-2448 Fax: (803) 534-2594

Parent/Guardian:_____ Date:_____

Physical Address:_____

Mailing Address: _____

Phone Number: _____ Email Address _____

Age_____ Gender: M or F Primary Language Spoken:_____

Is the parent/guardian named above attending sessions with child yes or no, if no who is the adult authorized to bring child to session and relation: _____

Child lives with: Mother___ Father___ Both Parents___ Other_____

**Child(ren) Being Referred to Strengthening Families Program:**

| | Name | Sex | Age | Food Allergies/dietary restrictions: |
|---|---|---|---|---|
| 1. | _____ | ___ | ____ | _____ |
| 2. | _____ | ___ | ____ | _____ |
| 3. | _____ | ___ | ____ | _____ |
| 4. | _____ | ___ | ____ | _____ |
| 5. | _____ | ___ | ____ | _____ |

**6 and under Child(ren) Attending**

| | Name | Sex | Age | Food Allergies/dietary restrictions: |
|---|---|---|---|---|
| 1. | _____ | ___ | ____ | _____ |
| 2. | _____ | ___ | ____ | _____ |
| 3. | _____ | ___ | ____ | _____ |

Does anyone in the family have any other concerns ex. asthma, seizures, learning disabilities etc.. if so please list and state who?

_____

_____

Reason for referral (please be as specific as possible) _____

_____

_____

Are there any known barriers:_____

_____

_____

**Referral Source Contact Information:** Name _____

Agency_____ Telephone _____