

Connecticut Center for Child Development Student Application

Please complete this application and return it, along with a copy of your child's current IEP, evaluations and/or other relevant documents to Admissions at **95 Wolf Harbor Road, Milford, CT 06461**.

Student Personal Information
Name (last,first,middle):
Sex:
Date of Birth (month/date/year):
Current Age:
Current Address:

Mother's Personal Information
Name: (last,first,middle)
Home Phone:
Cell Phone:
E-Mail Address:
Home Address (if different from above):
Occupation:
Work Phone:
Business Name and Address :

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CCCD Wolf Harbor Location

95 Wolf Harbor Rd
Milford, CT 06461
Phone: (203) 882-8810
Fax: (203) 878-9468

CCCD Bridgeport Ave. Location

925 Bridgeport Ave.
Milford, CT 06460
Phone: (203) 306-0005
Fax: (203) 306-0006

CCCD, Inc. admits students of any race, color, and national ethnic origin.

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Father's Personal Information
Name: (last,first,middle)
Home Phone:
Cell Phone:
E- Mail Address:
Home Address (if different from above):
Occupation:
Work Phone:
Business Name and Address:

Languages spoken in the home
Primary Language:
Other Languages:

Other people living in same household as child			
Name	Sex	Age	Permanently living at home?

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How did you hear about CCCD? If referred, please state by whom.

Information about Student Diagnosis:

Diagnosis Performed by:

Primary Clinical Diagnosis:

Date of Diagnosis:

Allergies (including food) and/or food restrictions:

Additional Diagnoses / Medical Conditions:

DDS/ DCF Services

Is your child receiving any DDS/ DCF services:

If yes, what services:

Name of case manager:

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District Information

Name of District:

Special Education Director:

Director of Outplacement:

Does the District know you are looking at out of district placements?

May we contact the district?

If yes, name and contact information:

Current Educational Placement

Current Placement:

Is this an in district program/school?

If not, is it a district approved outplacement or private placement?

Please provide a brief description of your child's current program*

*(If more space is needed, please use back of this paper.)

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Related Services	
If your child is receiving any of the following services, please complete this section. If not, please mark the non-relevant sections as n/a.	Speech (SLP):
	Name of Provider:
	Number of hours a week:
	Occupational Therapy (OT)
	Name of Provider:
	Number of hours a week:
	Applied Behavior Analysis (ABA)
	Name of Provider:
	Number of hours a week:
	Other (please specify type of service):
	Name of Provider:
	Number of hours a week:
	Description of Services:
	Other (please specify type of service):
Name of Provider:	
Number of hours a week:	
Description of Services:	

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Are you currently considering other programs? (If yes, please list)

Do you anticipate securing funding for services, or will services be funded privately?

Preferred start date

Provided by District	The following materials will help us better understand your child's strengths and areas of deficit. Please include them with this application, if applicable.
	Current IEP/ IFSP
	Most Recent Evaluation(s)*
	Progress Report(s)*
	Behavior Intervention Plan
	DVD or Video Footage of child*
	Other Materials

*Please place a check in the box to the right of each item that will be or has been provided by the district.
These items are optional, but helpful.

Signature of Parent/Guardian: _____ Date: _____

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