



Early Childhood Intervention Program
Sisseton-Wahpeton Oyate
Mailing: PO Box 509
Physical: 12554 BIA HWY 711
Agency Village, SD 57262
Phone: 605-698-4400 Fax: 605-698-4429



INTAKE FORM

CHILD INFORMATION

Name: _____ **Date of Birth:** _____ **Gender**
Male Female

Weight: _____ **Length:** _____ **Number of Weeks Pregnant:** _____

Type of Birth: Normal Premature

Other medical reasons? Explain: _____

Does your child receive special education services? Yes No

Have any of your children been diagnosed with any physical or medical conditions that could cause a delay in growth or development? Yes No

Explain: _____

PARENT/GUARDIAN INFORMATION

MOTHER

Name: _____

DOB: _____

Address: _____

Phone: _____

Are you a tribal member?

Yes No

Where? _____

FATHER

Name: _____

DOB: _____

Address: _____

Phone: _____

Are you a tribal member?

Yes No

Where? _____

GUARDIAN

Name: _____

DOB: _____

Address: _____

Phone: _____

Are you a tribal member?

Yes No

Where? _____

CONSENT

I, _____, give permission to the Early Childhood Intervention Program (ECIP) for on-going monitoring of my child's development, to include periodic screenings, and data collection. If at any time, ECIP feels that your child is in need of a formal evaluation for possible special education services and supports, we will refer your child to the local school and/or educational cooperative. Further formal testing will not occur without your permission. If my child is placed on an Individual Family Service Plan (IFSP) or an Individual Education Plan (IEP), I am allowing those records to be shared with Early Childhood Intervention Program.

Child's Name: _____ Child's DOB: _____

Parent/Guardian Signature: _____ Date: _____

ECIP Staff Member Signature: _____ Date: _____

Entered in data base by: _____ Date: _____