St Mary's County
Infants and Toddlers Program
Intake Form

Date: ___________________

Child's name:____

Date of birth:___________________ Race: ______________ Sex: ______________
Month/Date/Year

Address: ____

____

City State Zip

Directions to the home:____

____

____

____

Phone: __________________ __________________ __________________
Home Work/Mother Work/Father

Child's Social Security number: ______________________

Child's Medical Assistance number: _______________________ REM?_______________________

Other Insurance: ____

Mother's name: _____________________________ D.O.B.: ___________________________
Mother's Social Security ______________________ Month/Date/Year

Address: ____

____

Father's name: _____________________________ D.O.B.: ___________________________
Father's Social Security ______________________ Month/Date/Year

Address: ____

____

Hospital where born: _______________________________ Weeks gestation: __________________

Reason for referral: ____

What are the developmental concerns: ____

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Other pertinent information:____

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____

Child's doctor: ____

Caregiver, if other than parent:____

Name of person referring child: __________________________________Parent notified: Y N

Phone: _____________________

Address, if not parent: ____

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