Office Use Only
Date:_____
Appointment Date:_____
ADP:_____
Access:_____
Service:_____
Start Date:_____

Sarah Ashe, Director
(706 437-0505

P.O. Box 1066
Waynesboro, Ga. 30830

INQUIRY FORM:
(The parent or guardian should complete this form)

I. General Information

Child's Name: _____
Date of Birth: _____ **Age:** _____ **Gender: Female Male**
Parent/Guardian: _____
Address: _____ **City/Zip:** _____
County child lives in: _____
Phone: Home: _____ **Work:** _____
Cell: _____
May we leave a message regarding your services at CFNB? Yes/No
May we text/email regarding your services at CFNB? Yes/No
Emergency Contact: _____ **Phone:** _____
Relationship to child: _____

Additional Information

Email address: _____
Would you like to receive email updates from CFNB? Yes/No
Who referred the child to CFNB: _____
Current Custody Status: **_ Parents _ Sole Parental Custody _ Joint Legal Custody**
_ DSS Custody _ Other: _____

Child Lives with: **Mother Father Both Parents**
Other_____
List anyone who may be bringing/picking up your child: _____
_____
List anyone who may NOT pick up your child: _____
_____

School Information:

School/Daycare: _____ **Grade:** _____
Teacher's Name: _____
Does the child have an IEP or 504 Plan in place: Yes/No

II. Check from the list of Services that you are interested in:

___Play Group (Ages 2-5) **___ Intensive Autism Training**
___Social Group (Grades K-12) **___Individual Counseling**
___After School Tutoring **___Family Counseling**
___ Life Skills Group **___Consultation: Behavior/Educational**
Private Therapy Services: Speech Occupational Physical

Primary Areas of Concerns:

_____
_____
_____