Ages and Stages (ASQ-3) Child Monitoring Program Enrollment Form

If you are interested in enrolling in the program fill in the information and mail it to:
Child Development Infoline, 1344 Silas Deane Highway, Rocky Hill, CT 06067
Or fax to: 860-571-6853

□ Yes, I would like my child to participate in the ASQ Child Monitoring Program Date: _____

I would like to receive questionnaires in: **English or Spanish** (circle one).

How did family hear about ASQ program:_____

How would you like to receive the questionnaires? Check one below:
___I would like to complete the questionnaires on-line;
go to: https://cdi.211ct.org/program/ages-and-stages/ to enroll.
___I would like to receive questionnaires in the mail.

Child's First Name: _____**Child's Last Name:** _____

Gender: □ Male □ Female

Date of Birth: _____ If child not born full-term, # of weeks born early:_____

Parent or guardian names:

Parent 1: _____

Parent 2: _____

Street Address: _____

City: _____ State: CT Zip Code: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Email Address: _____

If you would also like your child's primary health care provider to receive your child's ASQ monitoring results, complete this section. **(Parent Signature Required!)**

Primary Health Provider Name: _____

Practice Name:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Parent Signature:_____ Date:_____