CCR&R Parent Referral

Name:_____

Street Address:_____

City, State, Zip:_____

Phone #: _____ Email:_____

Name of child_____ Birth date: _____

Name of child_____ Birth date: _____

Name of child_____ Birth date: _____

Do any children: *(Please Circle)*

- Need medications during time of care Yes No
- Have special needs Yes No

Does your family need: *(Please Circle)*

- Early Care (before 8am)
- Late Care (After 5 pm)
- Weekend Care
- Evening Care

Where does your family need care: *(List cities, towns, or school district)*

Location_____

What is your family size: *(Please state)*

1 2 3 4 5 6 7 8 Other _____

Parents,
Please fill out form, but only give us information you feel comfortable with.
Then you may mail or fax the form to your local CCR&R.

Albion Office
113 E. State St, Albion 14411
Fax: 589-5321

Batavia Office
5073 Clinton St Rd, Batavia 14020
Fax: 343-4063

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