



**CHILD  
CARE  
CHOICES OF  
BOSTON**

Affiliated with Action for Boston Community Development, Inc.  
105 Chauncy Street \* Boston, MA.02111 \* 617-357-6000 \* fax 617-292-4629

*Please Print*

**Family Authorization**  
*To be completed by the family.  
Complete form in full.*

I, (parent/guardian's name) \_\_\_\_\_, give my permission for **Child Care Choices (CCCB)** to provide support for (child's name) \_\_\_\_\_, whose date of birth is \_\_\_\_/\_\_\_\_/\_\_\_\_\_.

I understand that in order to help determine and accommodate my child's needs, they may observe my child at (name of child care provider) \_\_\_\_\_. If necessary, they may obtain outside supports to conduct an assessment, and to provide consultation and therapeutic services. Any plans for services for my child will be discussed with me. In addition, I give my permission for CCCB support services staff to discuss/share written information about my child's needs with any outside vendor, representatives from the Boston Public Schools, staff at the child care program and/or any other professionals involved with my child. Professionals serving my child may also communicate with each other to better meet my child's needs.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ and Zip Code: \_\_\_\_\_

Phone Number: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Please indicate name(s) of Guardians not listed above: \_\_\_\_\_

***\*Please indicate programs that your child has attended and if we may contact them.***

1. \_\_\_\_\_ contact? \_\_\_\_ yes \_\_\_\_ no
2. \_\_\_\_\_ contact? \_\_\_\_ yes \_\_\_\_ no
3. \_\_\_\_\_ contact? \_\_\_\_ yes \_\_\_\_ no

*In cases where we hire outside supports to work with the child, the childcare provider, and the child's family, CCCB Support Services will cover short-term services. In some cases, longer-term services are needed for the child and family. Therefore, please provide us with this information below to aid us in selecting a provider that will best suit your families needs.*

Health Insurance Co. Name: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Health Center: \_\_\_\_\_

Phone Number: \_\_\_\_\_

*A copy of this document is as good as the original and is valid for one year.*