

# 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: \_\_\_\_\_