



**LANGUAGE OF SERVICE AND
COMMUNICATION FORM**

INFORMATION – CHILD

Name of child: _____ Date of birth: _____

Language of service for the child’s intervention: ___ English ___ French

INFORMATION - PARENTS

Name of parent (1): _____ **Address:** _____
(Suite, number, building, street)

(City/town/village) (Province) (Postal Code) Telephone: _____

Language of choice for communication: ___ English ___ French

Parent signature: _____ Email: _____

Name of parent (2): _____ **Address:** _____
(Suite, number, building, street)

(City/town/village) (Province) (Postal Code) Telephone: _____

Language of choice for communication: ___ English ___ French

Parent signature: _____ Email: _____

Please send completed and signed form to autism.autisme@gnb.ca or fax to 506-462-2104 or mail to:

Education and Early Childhood Development
Preschool Autism Program
Place 2000, 250 King Street
Fredericton, NB
E3B 9M9