

Candler County School System
Program for Exceptional Children

Referral for Preschool Special Education Services

Student Name: _____

Circle here for Speech Services Only : SPEECH SERVICES ONLY

Pre-K HeadStart Babies Can't Wait or Other _____

Address: _____

Race _____ Sex _____ Phone# _____

Birthdate: _____ Primary Language: _____

SSN# _____ GTID# _____

CASE HISTORY:

Reason for referral: _____

Has the child attended any other programs or daycare? _____, If yes, please name the program. _____

Is this child age appropriate for grade level? Yes No

If no, please check all of the following that apply:

_____ Retained _____ Started school late _____ Held out of school by parents

Is the child's hearing and vision within normal limits? _____ Yes _____ No

Attach hearing and vision documentation

Does the child have significant health concerns, major childhood illness/disease or a diagnosed syndrome? _____ Yes _____ No

If yes, please explain: _____

Does the child take medication on a regular basis? _____yes _____No

If yes, please explain:_____

Does the child have motor/coordination/mobility needs? _____Yes _____No

If yes, please explain:_____

Does the child have adaptive medical needs such as glasses, wheelchair, walker, hearing aids, leg braces, feeding tube, etc. _____Yes _____No

Does the child have other significant issues not covered in the previous questions?

_____Yes _____No

If yes, please explain:_____

THE FOLLOWING DOCUMENTS MUST BE ATTACHED TO THIS REFERRAL

- * Hearing Results
- * Vision Results
- * Birth Certificate
- * Social Security Number

IF CHILD IS ENROLLED IN PRE-K OR HEADSTART INTERVENTIONS AND STRATEGIES MUST BE DOCUMENTED FOR SIX WEEKS AND ATTACHED TO REFERRAL AS WELL

_____ Date:_____

Parent Signature

_____ Date:_____

Teacher Signature (If Pre-k or HeadStart student)