CHILD FIND REFERRAL FORM

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|---|---|---|---|
| Name of Child: | Date of Birth: | Age: | Gender: ☐ F ☐ M |
| Ethnicity: | Primary Language: | Today's Date: | |
| Name of Person Making Referral: | Relationship To Child: | | |
| Parent/Guardian Name: | Mailing Address: | Phone Number: | |
| Is the child currently in school: Yes ☐ No ☐ | Is child receiving special education services? Yes ☐ No ☐ | School District: | Grade: |

Please complete each item to the best of your knowledge and do not leave any questions blank.

Reason for Referral (Be very specific and describe child):

Describe child's current academic or pre-academic skills:

Does child have any Medical Diagnoses or Health Issues (including vision and/or hearing):

Describe any evaluations the child has had by other agencies or doctors:

Where can copies or reports be obtained?

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Indicate area(s) of suspected disability:

☐ Intellectual Disability
☐ Hearing Impaired
☐ Deaf
☐ Visually Impaired
☐ Other Health Impaired
☐ Emotionally Disturbed
☐ Autism
☐ Speech and Language Impairment
☐ Orthopedic Impairment
☐ Traumatic Brain Injury
☐ Deaf-Blind
☐ Specific Learning Disability
☐ Established Medical Condition
☐ Other

Referral Taken By: Position:

Please Mail or Fax Copy to KCOE Special Services Office
1144 W. Lacey Blvd. Hanford, CA 93230
Fax: 559 589-9611