CHILD FIND REFERRAL FORM

Today's Date:	

Name of Child:		Date of Birth:	
Ethnicity:		Primary Language:	
Name of Person Making Referral:		Relationship to Child:	
Parent/Guardian Name:		Phone Number:	
Mailing Address:			
Is the child currently in school?	YES ☐ NO ☐	Gender:	
Is the child receiving Special Education Services?	YES ☐	NO ☐	
School District:		Grade:	

PLEASE COMPLETE EACH ITEM TO THE BEST OF YOUR KNOWLEDGE & 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?

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