**DISTRICT:**

**CHILD’S INFORMATION**

NAME:       ID NUMBER:

STREET:       GENDER:       GRADE:

CITY:       STATE: OH ZIP:

DATE OF BIRTH:

**PARENT/GUARDIAN INFORMATION**

NAME:

STREET:

CITY:       STATE: OH ZIP:

HOME PHONE:       WORK PHONE:

CELL PHONE:       EMAIL:

NAME:

STREET:

CITY:       STATE: OH ZIP:

HOME PHONE:       WORK PHONE:

CELL PHONE:       EMAIL:

**BUILDING OF CURRENT ATTENDANCE:**

|  |
| --- |
|       |

**TEACHER(S):**

|  |
| --- |
|       |

**STUDENT’S NATIVE LANGUAGE (If Not English):**

|  |
| --- |
|       |

**PARENT’S NATIVE LANGUAGE (If Not English):**

|  |
| --- |
|       |

**Reason for Referral:**

|  |
| --- |
|       |

**EDUCATIONAL HISTORY**

Provide data about the child’s progress in the general curriculum or, for the preschool-age child, data pertaining to the child’s growth and development:

|  |
| --- |
|       |

Provide data from previous interventions, including interventions required by Rule 3301-35-06 or; for the preschool child, data from early intervention, community or preschool providers:

|  |
| --- |
|       |

Provide any relevant trend data beyond the past twelve months, including the review of current and previous IEPs:

|  |
| --- |
|       |

Number of school districts attended:

Years at present school building:

List schools/early childhood programs and dates:

|  |
| --- |
|       |

**ATTENDANCE:**

 [ ]  Regular [ ]  Irregular

Is this student age-appropriate for grade level? [ ]  Yes [ ]  No

**BACKGROUND INFORMATION**

 **A. Health Data**

 Do you suspect problems with [ ]  Vision [ ]  Hearing

 Does the student [ ]  Wear Glasses [ ]  Use Hearing Aid(s)

 Does the student take medication [ ]  Yes [ ]  No

 If yes, specify type and purpose:

|  |
| --- |
|       |

 Does the student have any health/developmental/physical problems of which you are aware? [ ]  Yes [ ]  No

 If yes, please explain:

|  |
| --- |
|       |

 **B. Environmental Factors**

 Describe any specific home factors that might affect the student’s performance in school:

|  |
| --- |
|       |

**For Preschool Children Only *(please check the area(s) of concern):***

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Eating[ ]  Receptive Communication [ ]  Cognitive[ ]  Vision[ ]  Other | [ ]  Dressing[ ]  Expressive Communication[ ]  Fine Motor[ ]  Social/Emotional Behavior | [ ]  Toileting[ ]  Hearing[ ]  Play | [ ]  Attention[ ]  Gross Motor |

Describe any other pertinent information not previously described:

|  |
| --- |
|       |

**SIGNATURES**

|  |  |  |
| --- | --- | --- |
|       |  |       |
| Signature of Person Initiating the Referral |  | Signature of Person Receiving the Referral |
|       |  |       |
| Position or Relationship to Student |  | Title |
|       |  |       |
| Date |  | Date Received |
|  |  |       |
|  |  | Date District Suspects a Disability |