Child Find Referral

Florida Diagnostic and Learning Resources System

www.fdlrsnefec.org; 386-329-3684 (FAX)

County _____ Date of Referral_____

Child's Name _____
(First) (Middle) (Last)

DOB _____ ___ Male ___Female _____
(check one) Primary Language Spoken at Home

Mother's Name _____
Child lives with? Y/N

Father's Name _____
Child lives with? Y/N

Legal Guardian _____
(if not mother or father) Relationship to Child

Mailing Address _____

Physical/911 Address _____
(If different from mailing)

Best Phone Numbers _____
Mom Dad Guardian (if different)

Email Address _____

Child's Primary Care Physician _____
Phone Number

Child Care/Preschool program your child attends _____

Head Start? _____ Early Steps? _____
Location Location

Other Therapists or Agencies Involved _____

Previous Testing _____
By Whom? Date of Testing

Reason(s) for Referral _____

_____

Referred by: _____ (**Continued on the other side of this page)**

Child Find - Permission to Screen/Share Information

I hereby grant permission for my child, _____, to be screened by competent personnel and release them from liability for any mishap to my child. I understand this is a screening and the results do not indicate the presence of a problem, only the need for further evaluation.

_____ _____

Signature of Parent or Guardian Date

I am authorizing the following people to exchange information in verbal, written, facsimile, or digital formats for the purposes of developing a thorough and optimal educational plan for my child. (*Check all that apply)*

____ Baker County School District
____ Bradford County School District
____ Columbia County School District
____ Hamilton County School District
____ Flagler County School District
____ Lafayette County School District
____ Madison County School District
____ Putnam County School District
____ St. Johns County School District
____ Suwannee County School District
____ Union County School District
____ Local Early Steps Program
____ Medical or therapy providers serving my child
____ Child Care/Preschool/Head Start programs serving my child

The following records may be exchanged (*check all that apply*):

___ Developmental Screening and/or Evaluation Results
___ Psychological Testing, Behavioral Screening Checklists/Reports
___ Social/Developmental History
___ Health/Medical Records, Hearing/Vision Reports
___ Speech and Language Reports
___ Occupational/Physical Therapy Reports
___ Staffing Reports/IFSPs/IEPs
___ School Records
___ Other _____

Parent/Guardian Signature _____

Date

Printed name of Parent/Guardian _____

(BELOW FOR FDLRS' USE ONLY)

SPEECH: A/P/F HEARING: A/P/F SOCIAL/EMOTIONAL: A/P/F DEVELOPMENTAL: A/P/F
LANG: A/P/F VISION: A/P/F MOTOR: A/P/F OTHER: _____A/P/F

Screening Instrument Used	Date of Screening	Specialist Name	Closed/Inactive Date	Reason

Social Developmental History

Child's Name: _____DOB: ____/____/____

Sex: _____Male _____Female Ethnicity: ___Hispanic ___Not Hispanic

Race:___White/Caucasian ___Black/African American ___Native American

___ Asian ___Native Hawaiian/Other Pacific Islander

Home Address: _____

Mother's Name: _____ Legal Guardian? ___Y ___N

Father's Name: _____ Legal Guardian? ___Y ___N

Contact Information for Caseworker and Foster Parent (if applicable): _____

_____

Primary Language(s) Spoken at home: _____

Medical Information:

Primary care physician name: _____ Phone: _____

Specialist physician(s) name(s): _____ Phone: _____

Briefly describe this child's general health: _____

_____

Please check all that apply. Does this child have a history of:

___Head Injury? ___Hospitalization? ___Ear Infections? ___Major Illness/Accident?

If you checked any of the above, please explain: _____

_____

Pregnancy History:

This child was born at _____ weeks, weighing _____ pounds _____ ounces.

Briefly describe any complications during or immediately after birth: _____

_____

Was Mom sick during this pregnancy? If so, please describe: _____

_____

While pregnant, did Mom: __Smoke? ___ Packs/day __Drink alcohol ____ drinks/day

___Take prescribed medications? Which ones: _____

___Take non-prescribed medications? Which ones: _____

Developmental History:

At what age did this child: Sit up _____ Walk _____ Say first word _____

At what age did potty training: Begin _____ Was completed: _____

Please describe any developmental concerns, including challenges with reaching

milestones such as talking, walking, and potty training. _____

_____

Has this child received: ____ Speech Therapy ___Occupational Therapy

____ Physical Therapy ____ Early Steps Services

Currently Attending Childcare or VPK? ____Yes ____ No

If so, where?_____