**DeSoto Glades Hendry Highlands Child Find Specialist:**

**Fax: 863-531-0425** **______________ 531-0444 ext. _____**

**Toll Free: 1-800-316-7057 Local: 1-863-531-0444 ext 234**

Child's Name ________________________ Language Spoken _________ School Zone _______ Child Care Provider ______________

Birth Date ______________ Birthplace ______________________ Sex _______ Race ____________ Ethnicity _______ Referred By ______________

Mailing Address ________________________________________ City __________________________ Zip ___________________

Residence address ______________________________________ City __________________________ Zip ___________________

Area of Concern ___________________________ Phone Number ________________________________ Other Contact Information ______________

*I would like for my child to participate in the screening activities conducted by the public schools and the Florida Diagnostic and Learning Resources System.*

Parent's Name (Print) ___________________________________ Parent's Signature ____________________________________ Date ______________

**SPACE BELOW IS FOR FDLRS OFFICE USE ONLY**

**VISION**: Could Not Test Pass Refer

Screener ______________________

Comments ______________________

______________________________

**HEARING**:

LEFT EAR: Could Not Test Pass Refer

RIGHT EAR: Could Not Test Pass Refer

Screener ______________________

Comments ______________________

______________________________

**Developmental Indicators for the Assessment of Learning 4**

| Screener | | | | |
|---|---|---|---|---|
| Motor Screener | ________________ | Pass | Potential Delay | Rescreen |
| Concepts Screener | ________________ | Pass | Potential Delay | Rescreen |
| Speech Screener | ________________ | Pass | Potential Delay | Rescreen |
| Language Screener | ________________ | Pass | Potential Delay | Rescreen |
| Behavior Screener | ________________ | Pass | Potential Delay | Rescreen |

COMMENTS: ____________________________________________

______________________________________________________

______________________________________________________

Child Find Specialist _________________________________ Date ______________

DBN # ______________________________ Referral Date __________________ Referral Taken By ________________________________

Date Screened _______________________ Age at Screening _______________ Screening Site ___________________________________