

Morgan County Schools

Parent Referral Questionnaire

With the exception of questions 14 and 15, which should be completed by the classroom teacher, this form should be completed by the parent/guardian requesting a referral for a special education evaluation. After questionnaire is completed, return the form to the classroom teacher who will forward it to the Response to Intervention chairperson for review. The form will then be forwarded to the special education department once form's completeness and accuracy is determined by the RtI chairperson.

Child's Name: _____

Address: _____

Birthdate: _____ Social Security Number: _____

Gender: Male Female Race: _____

Mother's Name: _____

Father's Name: _____

Phone Number: _____ Secondary Phone Number: _____

Please fill out this form as completely as you can. Use additional pages if needed. All information will be kept confidential.

Primary Concerns of Child/Reason for referral (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Reading Fluency | <input type="checkbox"/> Reading Decoding | <input type="checkbox"/> Reading Comprehension |
| <input type="checkbox"/> Math Fluency | <input type="checkbox"/> Math Calculations | <input type="checkbox"/> Math Applications |
| <input type="checkbox"/> Oral Communication | <input type="checkbox"/> Written Communication | <input type="checkbox"/> Handwriting |
| <input type="checkbox"/> Processing Information | <input type="checkbox"/> Recall of Information | <input type="checkbox"/> Understanding Directions |
| <input type="checkbox"/> Attention/Concentration | <input type="checkbox"/> Compliance | <input type="checkbox"/> Following Directions |
| <input type="checkbox"/> Social Skills | <input type="checkbox"/> Study Skills | <input type="checkbox"/> Easily Frustrated |

Describe your child's difficulty in the areas checked above (be specific):

1. _____
2. _____
3. _____
4. _____
5. _____

Please list what you perceive to be your child's strengths and weaknesses.

STRENGTHS: _____

WEAKNESSES: _____

Please answer the following questions:

1. Your child's grades have:

Improved each year Stayed about the same each year Declined each year Dropped suddenly Not applicable

2. Your child's grades in the indicated area(s) of concern are: Above average

Average Below average Not applicable

3. Compared to last year, your child has been absent: More Less

About the same Not applicable

4. Has your child ever repeated a grade? Yes No If yes, which one(s)/how many times? _____

5. Has your child been previously referred for special education services?

Yes No If yes, note previous referral date: _____

6. Did your child qualify for special education services? Yes No

Not applicable

7. Has your child received other services such as, Title I, 504, ESL, Migrant, etc.?

If yes, which ones? _____

8. Does your child take medication at home or at school? Yes No

If yes, please state whether the child takes it at home, school, or both, the name of the medication, the dosage, and the medication's purpose. _____

9. Is there other relevant information you would like to share (i.e., medical, social, emotional, etc.)?

Yes No If yes, please explain. _____

10. What is the date your child participated in the school's vision and hearing screening? _____

11. What were the results of the vision and hearing screening?

Passed Failed

TO BE COMPLETED BY THE CLASSROOM TEACHER.

14. Explain in detail interventions, strategies, or programs that have been utilized at SCHOOL in the area(s) he/she is experiencing difficulty. Use back if additional space is needed.

15. Did any of the interventions, strategies, or programs utilized at SCHOOL appear to be helpful? If so, please list which ones and explain how they helped?

THANK YOU FOR TAKING TIME TO COMPLETE THE QUESTIONNAIRE.

Signature of Individual Completing Form

Date Submitted to Teacher

Relationship to the Child

Date Received @ Central Office
