

WALTON COUNTY BOARD OF EDUCATION

200 Double Springs Church Road, Monroe, Georgia 30656, Telephone 770-266-4520, Fax 770-266-4415

www.walton.k12.ga.us

Dear Parent or Guardian(s),

Enclosed is a referral packet for the Special Needs Preschool evaluation process. Please complete the following steps to initiate the referral process.

- Special Needs Preschool Referral
- Developmental and Social History
- Proof of Residency – current utility bill and lease/rental/mortgage statement
- Certified Birth Certificate
- Parent or Guardian's Driver's License
- Social Security Card for your child
- Forms 3231 and 3300, if available from child's physician
- Proof of Guardianship, if applicable
- Daycare Input Form, if applicable
- Copy of previous evaluation(s), if applicable

Please complete all information listed above and return the packet to the Special Education Office. The referral packet can be submitted in the following ways:

- Mail or drop off: 200 Double Springs Church Rd, Monroe, GA 30656
- FAX: 770-266-4499
- Email: melanie.cooksey@walton.k12.ga.us

Upon the receipt of the completed referral, the Special Education Office will contact you to schedule a screening appointment. Once the screening is completed, we will schedule an evaluation with a school psychologist and speech/language pathologist. If an emergency arises, please contact the office as soon as possible so that another evaluation may be scheduled. Due to the high demand of Preschool Evaluations, a cancellation may delay the referral process.

Please arrive a few minutes prior to the scheduled evaluation. Arrangements should be made for the care of other children during the evaluation. As the parent/guardian, you will be actively involved in the evaluation. We ask that one parent/guardian accompany the child to the evaluation.

If you have any questions, please contact our office at 770-266-4502. We look forward to working with your family.

Walton County Special Education

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Special Needs Preschool Program Referral Form

The following documents should accompany this form (if applicable): psychological reports, behavior checklists, disciplinary reports, current developmental reports, medical reports, occupational therapy, or speech reports.

Child's Name _____ Date of Birth _____

Age at Time of Referral _____ Primary Language in Home _____

Parent(s) Name _____

Home Address _____ City _____ Zip _____

Email address _____

Elementary School district in which you reside _____

Home Phone _____ Cell Phone _____

Referred by _____ Phone # _____

Child's Disability and/or Diagnosis _____

Describe in detail all areas of concern: (attach additional page if more space is needed)

Preschool or Day Care _____

Phone Number _____ Teacher's Name _____

Days/Times Attending _____

Address _____

Street Address

City

Zip Code

Child's Physician _____ Phone Number _____

Parent or Guardian Signature

Date

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Developmental and Social History

Student Name: _____

Preferred name to be called: _____

Birth Date: _____ Gender: Male Female

Person completing this form: _____

Child's Current Address: _____

Street

City

State

Zip Code

	Mother	Father
Address (if different from child's)		
E-mail		
Home Phone		
Cell Phone		
Occupation		

Do you share responsibility for raising your child with anyone else? _____

Does this person live in your home? _____

If yes, what is their relationship to the child? _____

Please list any other siblings that may or may not live in the home with the child and please list other children or adults that are living in the home with the child:

Name	Age	Gender	Lives in home with child	Relationship
		M or F	Y or N	
		M or F	Y or N	
		M or F	Y or N	
		M or F	Y or N	
		M or F	Y or N	

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Language(s) spoken in the home: _____ Language spoken most frequently to the child: _____

Pregnancy and Birth History

Complications / Illness during Pregnancy:

_____ Gestational Diabetes _____ High Blood Pressure _____ Bed Rest

Other / Comments:

Did you see a prenatal specialist during pregnancy? Y or N

If so, who and for what purpose?

What were the results or findings?

What drugs was the baby exposed to during pregnancy?

Baby was born: Feet first _____ Head first _____ Breech _____ C-Section

Emergency delivery: _____ Yes _____ No

Describe any complications during labor or delivery:

Baby was: _____ Full Term _____ Premature

_____ Weeks of Gestation

Birth Weight: _____ lbs. _____ oz.

Were any of these present during pregnancy, labor, or delivery:

Illicit /street drug exposure	Yes	No	Alcohol exposure	Yes	No
Toxemia	Yes	No	Smoking	Yes	No
Diabetes	Yes	No	Prescription Drugs	Yes	No
High blood pressure	Yes	No	Preterm labor	Yes	No
Excessive bleeding	Yes	No	Significant illness	Yes	No
Born with cord around neck	Yes	No	Injured during birth	Yes	No
Had trouble breathing	Yes	No	Yellow coloring (jaundice)	Yes	No
Turned blue (cyanosis)	Yes	No	Was in Hospital more than 7 Days	Yes	No
Needed oxygen	Yes	No	Seizures	Yes	No
Born with a heart defect	Yes	No	Born with other defect	Yes	No

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Please describe any "yes" answers:

Please describe any other aspects of the pregnancy and/or birth that were unusual or exceptional:

Did your child spend time in the NICU? ____Yes ____ No

If yes, how long?

Reason for NICU stay?

Health and development

At what age did your child meet these milestones?

	Age in months
Crawl	
Walk	
Started talking	
Bladder trained	
Bowel trained	

Did your child pass a newborn hearing screening: __Yes __No __I don't know

Do you think your child hears okay? ____Yes ____No

If no, please explain:

Does your child have a history of ear infections? ____Yes ____No

If yes, please state the number of ear infections he/she has had in the past 12 months: _____

Does your child have tubes in his/her ears (pressure equalizing tubes, tubes for drainage, etc.)?

If so, for how long and how many sets over time?

Has your child ever had a hearing evaluation? ____Yes ____No

If yes, please state the following: Place: _____ Date: _____

Please note the results of the test: _____

How does your child play? What do they enjoy doing?

Favorite characters or shows (e.g. Mickey Mouse, Paw Patrol):

How often is your child read to?

Favorite books:

Does your child have a strong interest in certain objects or topics? __Yes __No

If yes, please explain:

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What diagnoses does your child have (e.g. asthma, seizures, autism, eczema, concussions/head injury, etc.):

Diagnosis	When diagnosed	By whom

List any diseases, serious illnesses, operations, chronic physical problems, or any history of hospitalizations the child has had:

Please list any medications (prescription and/or over the counter medications), vitamin, or nutritional supplements your child takes:

Medication/Supplement:	Dosage:	To treat:

Does your child:

Mostly use single words, e.g. "ball"	Yes	No
Mostly use simple sentences, e.g. "see doggie"	Yes	No
Mostly use long sentences, e.g. "Mommy sit at the table with me"	Yes	No
Use gestures more than words to communicate	Yes	No
Instead of asking, take your hand to guide you to what they are wanting	Yes	No

If your child uses words to communicate:

What percentage can you understand your child's speech? 10 20 50 75 90 100

What percentage would a stranger understand your child's speech? 10 20 50 75 90 100

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Which describes your child:

Has trouble walking	Yes	No
Appears clumsy, often bumping into things, trip and/or falling down often	Yes	No
React negatively to the feel of new clothes	Yes	No
Covers eyes or complains of brightness when lights are not viewed as bright by others (e.g. sensitive to light)	Yes	No
Did not enjoy being cuddled as a baby	Yes	No
Frequently enjoys making loud or strange noises	Yes	No
Stares at lights	Yes	No
Stares at spinning objects	Yes	No
Displays repetitive behavior, e.g. lines up cars, waves hands in front of face, etc.	Yes	No
Picky eater	Yes	No
Does not eat variety of soft foods	Yes	No
Does not eat a variety of crunchy foods	Yes	No
Is not able to chew and swallow meats	Yes	No
Mouths toys or other objects (e.g. puts toys in mouth when playing, sucks on shirt, etc)	Yes	No
Covers ears or complains of loudness when sounds are not viewed as loud by others (e.g. sensitive to sound)	Yes	No
Objects to being touched	Yes	No
Prefers to play alone	Yes	No
Restless, runs about or jumps up and down, cannot sit still.	Yes	No

Describe how your child acts when he/she gets angry or frustrated:

Does your child have or use any equipment (AFO's, wheelchair, walker, feeding tube, etc.). Yes No

If yes, please explain: _____

Bedtime at: _____ and wakes at: _____

Does your child take daily naps? Yes No

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Does the child sleep through the night? ____Yes ____No

Does the child sleep alone? ____Yes ____No

Please describe the concerns you have for your child regarding their development and/or behavior?

Has your child lost any developmental skills, or does he/she seem to not be progressing in any developmental areas? Yes or No

If yes, in what way?

Do you feel as though your child is different from his/her siblings or other children their age? Yes or No

If yes, in what way?

Has this child been tested or evaluated before about these or other concerns? ____Yes ____No_____

If yes, where and when, and what were the results?

Do you have any medical reports, evaluations, or other papers you feel are important to share with the evaluation team?

Are there any other public or private agencies providing services to the child or family (including speech, feeding, physical, or occupational therapy)? Yes or No

If yes, please provide information below:

Agency and/or Therapist Name

_____	Dates of service:	Purpose:
_____	Dates of service:	Purpose:
_____	Dates of service:	Purpose:
_____	Dates of service:	Purpose:

How was that experience for you and/or your child?

Has your child ever received early childhood services from another agency such as Babies Can't Wait? Y N

Please list: _____

How was that experience for you and/or your child?

Does your child regularly attend any other settings outside of the home now or in the past, such as daycares, mother's morning out programs, etc.? __Yes or __No

If yes, describe your child's experiences:

Is there anything else that you would like us to know regarding your child's health, behavior, or development?

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Daycare Input Form

Child's Name _____ D.O.B. _____

Center/Preschool Name _____ Teacher _____

Contact Phone Number _____

Classroom Age Group _____ Ratio of Children to Adults _____

List the number of days and hours child attends your program _____

Check the routines in which child participates and list level of support required:

	Independently Participates	Participates with some assistance	Full Assistance required	Comments
Circle Time				
Free Play				
Movement/Outdoor				
Centers				
Transitions				
Bathroom				
Snacks/Lunch				
Communication - Peers & Teachers				
Fine Motor/ Art Activities				
Small Group/ Pre-Academic Skills				

Please make a statement concerning progress of the child based on goals and/or curriculum of your program

Teacher Signature _____ Date _____

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Authorization to Release Confidential Information (This document serves as a RECIPROCAL release of information.)

TO:

Agency _____

Contact Personal _____

Address _____

City _____ State _____ Zip _____

Phone _____ FAX _____

Email address _____

RE:

Student _____

Birth Date _____

Former School _____

Current School _____

Grade _____

INFORMATION TO BE RELEASED: Psychological Report/Date Educational Evaluation Hearing/Vision Screening
Results and Dates Eligibility Report IEP Analyzed Work Samples Speech/Language Records Other, Specify: _____ Classroom Observation Social History Anecdotal Records Medical Records Discipline Reports Psychiatric Eval/summary Due Process Checklist SST/RTI Records**REASON FOR RELEASE** Educational Planning Two-way communication Proof of Disability Medical Issues Related to Learning**Please forward records to:**

Walton County School District
Special Education Office
200 Double Springs Church Road
Monroe, GA 30656

FAX: 770.266.4499 Telephone: 770.266.4502

I authorize the release of the above confidential information:

Signature _____ Date _____