Oconee County Schools

Preschool Special Education Referral

Please mail, fax or email the completed referral to:
Paula Bargfrede
Colham Ferry Elementary
191 Colham Ferry Rd Road
Watkinsville, GA 30677
Phone: 706-769-7764, 1105
Fax: 706-310-1997
pbargfrede@oconeeschools.org

The enclosed information is required prior to consideration of eligibility for special education services (including speech and language services, special education preschool services, occupational or physical therapy services or vision impaired services.) This information is also required for those children transitioning from *Babies Can't Wait.* Please complete the required referral and you will be contacted to schedule an appointment for a free hearing/vision vision, speech/language and developmental screening. Screenings are conducted on the first Friday of each month at Oconee Primary School by appointment as well as on a as needed basis in order to implement interventions and to plan for an appropriate evaluation.

1. Child Find Referral form: To be completed by child's parents or guardian, teacher or outside agency to obtain general information.
2. Student History form: To be completed by the child's parent or guardian to provide information to be used during the evaluation process.
3. Outside Evaluations or medical reports: Documentation or reports from any outside agency (including private Speech Therapy, Occupational Therapy, Physical Therapy, hearing or audiological reports, private Psychological evaluations for Autism evaluation reports.)
4. Completion of Online Enrollment Process: To be completed by the child's parent or guardian. Go to \https://www.oconeeschools.org/ then select PARENT, then select STUDENT ENROLLMENT, then select NEW STUDENT REGISTRATION, then select CREATE ACCOUNT

   The following documents are **required** for online enrollment:
   -*Birth Certificate*
   -*Proof of Residency* showing residency in Oconee County (copy of current utility bill, purchase of lease agreement or *residency affidavit* if living at another resident
   -*Social Security card*
   -*Immunization form 3231* (if available)

The parent guardian will be contacted by the appropriate school system personnel upon receipt of the preschool special education referral.

OCONEE COUNTY SCHOOLS
34 SCHOOL STREET, P.O. BOX 146
WATKINSVILLE, GA 30677
(706) 769-5130
(706) 310-2022 FAX

Dr. Jason L. Branch, Superintendent

CHILD FIND REFERRAL

Date of Referral: _____, 20____

Child's Name: _____ Date of Birth: _____

Social Security Number: _____ School Attending: _____

Name of Parent/Guardian: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

Cell Phone: _____

Please explain reason for referral: _____

_____

_____

Person Making Referral: _____

Address: _____

Phone: _____

Office Use Only

Received on: _____, 20____

Staff Member Responsible: _____

Parent Contacted On: _____, 20____

Oconee County School System
Student Support Services
34 School Street P.O. Box 146
Watkinsville, Georgia 30677
Phone: 706-769-3506 Fax: 706-769-3513

STUDENT HISTORY

Completion Format: ☐ Questionnaire ☐ Interview

Directions: Please complete this form as accurately as possible and return it to the school as soon as is practical. If you need more room to answer any question(s) please use extra paper and/or the extra space provided on the last page.

Child's name: _____ Birth date: _____ Age: _____

Address: _____ Sex: ____ Male ____ Female

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____ School: _____ Grade: _____

Person Answering Questions: _____ Relationship to child: _____

Best Way to Reach You: ___home phone ___email ___work phone Today's date: _____

Parent(s) With Whom The Child Lives

Please provide the following information for each parent, step-parent, and/or caregiver **with whom the child lives.**

Name: _____ Name: _____

Relationship to child: _____ Relationship to child: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Work Phone: _____ Work Phone: _____

Highest level of education: _____ Highest level of education: _____

Other Parent(s) / Caregivers

If the child has parent(s), step-parent(s), and/or caregivers **other than the ones listed above**, please provide the following information for each.

Name: _____ Name: _____

Relationship to child: _____ Relationship to child: _____

How often does he/she see this individual? _____ How often does he/she see this individual? _____

Does the child attend after-school day-care? _____ Where? _____ Hours per day? _____

Family Information

Is this child adopted? _____ If yes, at what age? _____ Please explain the circumstances. _____

_____

Has the child experienced parental separation, divorce, or other possibly traumatic childhood experiences? _____ If yes, how old was the child at the time? _____ Please describe the situation.

_____

_____

Please list **all** brothers, sisters, and **any others living in the home.**

Name	Age	Relationship to child	Living at home (yes/no)

What language(s) are spoken in the home? _____

What was this child's first language? _____

What are this child's most positive qualities? _____

_____

What are the biggest challenges of being a parent to this child? _____

_____

How often is discipline required? _____ What method of discipline works the best ? _____

List some things your child does that require discipline. _____

_____

What is the **highest** level of education that you expect this child will complete? (Check one) ____ High School

____ Vocational school ____ Two year college ____ Four year college ____ Graduate, medical, or law school

Please explain any special situations **currently occurring** within the family that might be impacting this child's school performance? _____

_____

Have any family members ever received special education services or had difficulties in school? _____ Explain: _____

_____

Has the child experienced any of the following? (Check all that apply)

_____ Death of Parent _____ Jail Sentence of Parent _____ Marriage of Parent to Stepparent
_____ Moves _____ Illness Requiring Hospitalization _____ Death of Family Member
_____ Illness of Parent Requiring Hospitalization _____ Death of Close Friend

Check the activities in which this child often participates with the family:

_____ Movies _____ Meals _____ Games _____ Sports
_____ Visits with Relatives _____ Television _____ Trips _____ Church

Medical History

Pregnancy: Were any of the following complications present **during** the pregnancy with this child? (Check all that apply)

_____ Lack of medical care _____ Measles _____ Gestational Diabetes
_____ High blood pressure _____ Toxemia _____ Drug use, Frequency _____ Type_____
_____ Maternal injury _____ Alcohol use, Frequency _____
_____ Cigarette use, Frequency _____
_____ Hospitalization : Please Explain:_____

_____ Medication(s) used: Please Explain: _____

_____ Other complication: Please Explain:_____

Birth: Check all of the following complications that were present during or soon after this child's birth.

_____ Forceps used _____ Breech birth _____ Labor induced _____ Caesarian delivery _____ Jaundiced
_____ Incubator used _____ Breathing problems: Was supplemental Oxygen used? _____ How long? _____
_____ Other complications: Explain: _____

Length of pregnancy: _____ wks. Length of labor: _____ hrs. Mother's condition at birth: _____

Child's condition at birth: _____ Birth weight: ____ lbs. ____ oz.

Mother's age at birth: _____ Length of hospital stay: Mother: _____ Child: _____

Childhood Medical History: Check the illnesses and/or conditions that apply to this child.

_____ Asthma _____ Frequent stomachaches _____ Frequent headaches _____ Heart condition
_____ Anemia _____ Meningitis _____ Seizures/Epilepsy _____ Eating disorder
_____ Awkward walk _____ Poor posture _____ Diagnosed attention problems and/or hyperactivity
_____ Chicken pox _____ Measles _____ Scarlet Fever _____ Strep Infection
_____ Food allergies: List: _____
_____ Allergy to medicine(s): Explain: _____
_____ Other allergies: List: _____
_____ Head Injury: Describe: _____
_____ Coma or loss of consciousness: Describe: _____
_____ Prolonged high fever(s): Explain: _____
_____ Operation(s): Explain: _____
_____ Hospitalization(s): Explain: _____
_____ Long-term medications in the past (at least one month): Please List: _____
_____ Current medications: Please List:_____
_____ Frequent ear infections: Have ear tubes been inserted? _____ When? _____
_____ Hearing problem: Explain: _____
_____ Vision problem: Explain: _____ Wears glasses or contacts? _____
_____ Other health problem or condition: Explain: _____

Family History: Have any family members had or have been considered to have the following? Check all that apply **and** indicate in the blank the relationship of the family member to the child.

_____ Physical disability _____
_____ Seizures or epilepsy _____
_____ Drug abuse _____
_____ Alcohol abuse _____
_____ Autism Spectrum Disorder_____
_____ Bipolar Disorder_____
_____ Behavior disorder _____
_____ Depression _____
_____ Learning disability _____
_____ Math problem _____
_____ Reading problem _____
_____ Speech or language problem _____
_____ Attention Problems /Hyperactivity _____
_____ Cognitive delay/Intellectual Disability_____
_____ Tourette's Syndrome _____
_____ Other: Explain: _____

Child Development

At what age did this child do the following:

_____ Sit unsupported _____ Walk Alone _____ Speak first words

_____ Speak in two-word sentences

At what age was the child successfully toilet trained? Days: _____ Nights: _____

Did bed wetting occur after toilet training? _____ How often? _____ Until what age? _____

Were there any medical reasons for bed wetting? _____ Explain: _____

Does or did this child experience any of the following difficulties **during the first four years**: (Check all that apply)

_____ Feeding/Eating problem
_____ Colic
_____ Underweight
_____ Overweight
_____ Failure to thrive
_____ Malnutrition
_____ Delayed language development
_____ Unclear speech
_____ Difficulty separating from parent(s)
_____ Tempter Tantrums
_____ Sleeping too little
_____ Sleeping too much
_____ Walking difficulty
_____ Difficulty learning to throw or catch

Educational History

Is this child frequently absent from school? _____ If yes, explain? _____

Other than for reasons of typical grade promotion, has this child changed schools? _____ If yes, explain. _____

Has this child been retained in any grade? _____ If yes, which grade? _____ Why? _____

Has this child skipped a grade in school? _____ If yes, which grade? _____ Why? _____

Has this child ever been tested for special education? _____ When? _____ Where? _____

Is this child currently receiving special education services? _____ If yes, what type of class _____

Does this child like going to school? _____

Does or did this child attend preschool? _____ Where? _____ At what age? _____

Amount of time per day _____ Days per week _____

Please describe any problems that your child has had in school in the past. _____

_____

_____

Please describe your child's current school difficulties. _____

_____

_____

Behavioral/Social/Emotional Development

Friendships:

How does this child get along with other children? _____

How many friends does this child have? (Check one) _____ None _____ Few _____ Some _____ Many

Does this child have difficulty making friends? _____ Does this child prefer to play alone? _____

With what age individuals does this child prefer to play/associate? (circle one) Younger Same age Older/adults

Outside Interests:

What activities does this child enjoy? _____

Please list after school activities in which your child participates _____

Has this child's interest or participation in these activities decreased lately? _____ Explain: _____

_____

Behavior/Temperament: Please indicate whether your child **currently** exhibits any of the following behaviors, emotions, or personality traits. Check all that apply.

_____ Accident prone	_____ Forgetful	_____ Easily upset/Irritable
_____ Over-stimulation in play	_____ Unreasonable fears	_____ Thumb sucking
_____ Short attention span	_____ Worries excessively	_____ Has many physical complaints
_____ Tics/twitches	_____ Impulsiveness	_____ Lack of self-control
_____ Over-activity	_____ Unhappiness	_____ Does not want to come to school

Does this child have a history of:

_____ alcohol use	_____ drug use	_____ running away from home
_____ stealing	_____ setting fires	_____ vandalism
_____ threatening others	_____ gang involvement	_____ fighting
_____ cruelty to animals	_____ bullying	_____ being bullied

What is this child's bedtime: weekdays? _____ weekends? _____

How long does this child generally sleep? _____ Does this child have difficulty sleeping? _____

Explain _____

Has this child ever undergone psychological or psychiatric evaluation? _____ Date(s) of exam(s): _____

By Whom? _____ Reason(s): _____

_____

Has this child ever received counseling or therapy? _____ From whom? _____

Reason(s): _____

Is this child currently receiving counseling or therapy? _____ From whom? _____

Reason(s): _____

Has this child ever received speech/language therapy, occupational therapy, and/or physical therapy services? _____

When? _____ Where? _____

Additional Information/Comments

Use the space below to expand upon your previous responses or to provide information that you have not previously provided but you feel is important in helping us understand your child. Please sign and date this form below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I understand that the Tier III/ Student Support Team (SST) will meet to develop alternative strategies and interventions for my child. I ☐ give ☐ do not give consent (check one) for the Oconee County School System to perform vision and hearing screenings. I also give consent for individually administered assessments with my child to assist with progress monitoring of interventions.

Signature: _____ Date: _____