THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Exceptional Student Learning Support

FDLRS / Child Find Referral Form

Children Ages 3 to 5 Years

Date: _____ Referred By: _____
Individual's Name *Relationship to Child*

Referral Source Phone: _____ Referral Source E-mail: _____

Referring Source: _____ Source is a Child Protection Agency? ☐ **Y** ☐ **N**
Agency Name *Department*

Child's Name: _____ DOB: _____ Age: _____

Sex: ☐ **M** ☐ **F** Birthplace: _____ Race: _____ Hispanic: ☐ **Y** ☐ **N**

Language(s) Spoken at Home: _____ If other than English, please specify: ☐ Minimal ☐ Both ☐ Primary

Receiving protective services: ☐ **Y** ☐ **N** Agency/ChildNet Advocate: _____

Attending preschool: ☐ **Y** ☐ **N** Specify location/program: _____

☐ **Parent** ☐ **Foster Parent** ☐ **Relative** ☐ **Guardian** _____

E-mail: _____

Home Address: _____ APT# _____

City: _____ State: FL Zip Code: _____

Cell: _____ Work: _____ Home: _____

Alternative Contact: _____ Relationship to Child: _____ Phone: _____

Reason for Referral

☐ **Speech** (hard to understand, talking is not clear)

☐ **Expressive Language** (few words in vocabulary)

☐ **Receptive Language (**doesn't seem to understand, difficulty following directions)

☐ **Social-Emotional** (interaction with others, social skills)

☐ **Cognition** (seems behind, difficulty retaining information)

☐ **Behavior (**aggressive, harms self or others, inattentive, active)

☐ **Fine Motor** (holding, drawing, grasping, picking up small objects)

☐ **Gross Motor** (clumsy, falls a lot, poor coordination or balance)

☐ **Self-Help** (independent functioning, toileting, feeding, dressing)

☐ **Vision Diagnosis**

☐ **Hearing Diagnosis**

Medical Diagnosis: ☐ **Y** ☐ **N** Specify:_____

Developmental Services: ☐ **S/L** ☐ **OT** ☐ **PT** ☐ **Behavior** Location:_____

Comments: _____

FOR CHILD FIND USE ONLY: Language Code: _____ K-20: _____ Information Received by: Initials _____

Language Classification Appointment: _____

FDLRS #: _____

Home School: _____

Screening Appointment: _____

Entered in CHRIS/ Online by:
Initials
_____

Email the completed form to: esechildfind@browardschools.com 754-321-7200 -Child Find Referral Line

Welcome to our ASQ Online screening program!

Please click on link to complete

Arabic https://asqonline.com/family/9412ac

Chinese Simplified https://asqonline.com/family/16bcf7

Chinese Traditional https://asqonline.com/family/faed75

English https://www.asqonline.com/family/e7bbfe

French https://asqonline.com/family/d34907

Spanish https://asqonline.com/family/15d264

Vietnamese https://asqonline.com/family/680f81

Because your child's first 5 years of life are so important, we want to help you provide the best start for your child. You've been invited to participate in the *Ages & Stages Questionnaires, Third Edition (ASQ-3)*, to help you keep track of your child's development. The questionnaire may be provided every 2-, 4- or 6-month period. You will be asked to answer questions about some things your child can and cannot do. The questionnaire includes questions about your child's communication, gross motor, fine motor, problem solving, and personal social skills.

We look forward to your participation in ASQ-3!

FDLRS Child Find Office (located at the Wingate Oaks Center)
Serving Broward County Public Schools
1211 NW 33rd Terrace
Fort Lauderdale, Florida 33311
754-321-7200
esechildfind@browardschools.com

DATE COMPLETED:_____

COMPLETED BY: _____

REFERRED BY: ☐ Doctor ☐ Teacher

☐ Therapist ☐ Early Steps ☐

FDLRS NO._____

PRE-K INFORMATION SURVEY

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

AGE: _____ **SEX:** ☐ **FEMALE** ☐ **MALE** **SSN#** _____

LANGUAGE SPOKEN IN HOME: _____ **LANGUAGE SPOKEN TO CHILD** _____

Home Address: _____ City: _____ ZIP: _____

Mother's Name: _____ Home #: _____

Cell #: _____ E-MAIL: _____

Mother's Date of Birth: _____ Education: _____ Occupation: _____

Father's Name: _____ Home #: _____

Cell #: _____ E-MAIL: _____

Father's Date of Birth: _____ Education: _____ Occupation: _____

Marital Status of Parents: (Check One) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If the Parents are separated or divorced, how old was the child when the separation occurred? _____

Did you adopt this child? ☐ Yes ☐ No If yes, what was the date of the adoption? _____

COMPLETE THIS SECTION ONLY IF THERE IS CHILD PROTECTIVE SERVICES (CPS) INVOLVEMENT

☐ **CPS Involvement but child remains with Natural Parent(s)**

Address: _____

Street Apt. City Zip

☐ **Out of Home Placement:** ☐ Placed with Relatives ☐ Shelter Care ☐ Foster Care ☐ Skilled Nursing Facility

☐ Other: _____

Identify Contact: ☐ Parent(s) ☐ Foster Parent(s) ☐ Relative Guardian/Caregiver ☐ Agency Caseworker

Caregiver's Name: _____ Home #: _____ Cell #: _____

Address: _____

Street Apt. City Zip

Agency Caseworker's Name: _____ Phone #: _____

Agency Name: _____

LIST EVERYONE WHO LIVES IN THE HOUSEHOLD *Use additional page if necessary*

NAME	AGE	SEX	RELATIONSHIP TO CHILD

PREGNANCY, BIRTH AND DEVELOPMENTAL HISTORY

City of Birth: _____ State: _____

Complications during pregnancy (if any): _____

Weeks/Months Carried: _____ Birth was (Check One) ☐ Normal ☐ Caesarean ☐ Breech

Birth Weight: _____ lb _____ oz

Complications during birth (If any): _____

What was Mother's condition after delivery? _____

What was Baby's condition after delivery? _____

MEDICAL HISTORY

Has your child ever been diagnosed with a medical condition? ☐ Yes ☐ No

Name of condition: _____

Date of last physical exam: _____ Results: _____

Check any illness/conditions that your child has had since birth. Also, note the age when illness/condition occurred

	ILLNESS/CONDITION	AGE		ILLNESS/CONDITION	AGE		ILLNESS/CONDITION	AGE
	Cyanosis (turning blue)			Malformations			Tonsillitis	
	Jaundice (yellow)			Feeding difficulty			Adenoidectomy	
	Convulsions/Seizures			Sleeping difficulties			Measles	
	Hemorrhage			Headaches			Sinusitis	
	Skin Eruption			Excessive crying			Tonsillectomy	
	Asthma			Colic			Head injuries	
	Bronchitis			Mumps			Swallowing/sucking difficulties	
	Scarlet Fever			Meningitis			Rheumatic fever	
	Chicken Pox			Diphtheria			Pneumonia	
	Polio			High Fevers (over 104°)			Diabetes	
	Encephalitis			Ear injuries			Visual problems	
	Frequent colds			Frequent Ear Infection			Excessive Tearing	
	Kidney disease			Draining Ears			Cleft lip/palate	
				Tubes in Ears				

Check	ILLNESS/CONDITION	**PLEASE DESCRIBE**	AGE
	Serious Accident or injuries		
	Surgeries		
	Allergies		
	Other		

LIST PHYSICIANS YOUR CHILD HAS SEEN/IS SEEING

NAME of PRIMARY CARE PHYSICIAN/PEDIATRICIAN	ADDRESS	PHONE NUMBER
NAME and TYPE of SPECIALIST(S)	ADDRESS	PHONE NUMBER

List any assistive/adaptive devices the child uses (ex: prosthetics, mobility devices, communication aids):

List any medical devices the child uses (ex: respirator, g-tube, oxygen):

LIST ANY MEDICATIONS YOUR CHILD IS TAKING AT THIS TIME AND THE REASON WHY

Name of Medication	Dosage	Time(s) taken	Date prescribed	Reason

PLEASE INDICATE THE AGE AT WHICH YOUR CHILD FIRST DEMONSTRATED EACH OF THE FOLLOWING DEVELOPMENTAL BEHAVIORS

Showed response to mother:		Rolled Over:	
Followed objects with eyes:		Crawled:	
Turned toward noise:		Stood alone:	
Smiled:		Sat alone:	
Held head up:		Walked alone:	
Babbled:		Toilet trained:	
Spoke first words:			

Child's development appeared normal up to age: _____

Check the statement that best describes your child's language development:

☐	Follows simple directions.
☐	Understands everything said to him/her.
☐	Speaks in phrases or short sentences.
☐	Engages in appropriate conversations.

Check any behavior problems your child currently exhibits:

☐	Does not get along with other children.
☐	Does not get along with adults.
☐	Prefers to be alone.
☐	Is too active.
☐	Is physically aggressive.
☐	Is stubborn.
☐	Wets the bed.
☐	Has difficulty with speech/language.
☐	Does your child have a hearing aid?
☐	Has difficulty with vision.
☐	Does your child wear glasses?
☐	Other (Explain/Describe)

Is there any family history of developmental delay? ☐ Yes ☐ No If so, please explain: _____

Do you feel your child is having difficulty at home? ☐ Yes ☐ No If so, please explain: _____

Do you feel your child is having difficulty at school? ☐ Yes ☐ No If so, please explain: _____

Other Concerns: _____

Your observations/knowledge of your child's strengths/weaknesses will prove a useful part of the evaluation process.

My child's favorite activity/toy: _____

My child's least favorite activity/toy: _____

I would describe my child as: _____

My child is good at: _____

Changes/progress I have noticed in my child recently: _____

Some of my hopes for my child are: _____

Information/services that I need to help my child: _____

EDUCATIONAL HISTORY List preschools your child has attended:

Name	Location	Date Started	Reason for leaving

If the child is not in school, who cares for him/her during the day? _____

Has your child ever had any of the following evaluations?

☐ **Psychological/Developmental** Date: _____
Who was the evaluation completed by? _____
Address: _____ Phone #: _____

☐ **Psychiatric** Date: _____
Who was the evaluation completed by? _____
Address: _____ Phone #: _____

☐ **Speech/Language** Date: _____
Who was the evaluation completed by? _____
Address: _____ Phone #: _____

☐ **Hearing** Date: _____
Who was the evaluation completed by? _____
Address: _____ Phone #: _____

☐ **Vision** Date: _____
Who was the evaluation completed by? _____
Address: _____ Phone #: _____

☐ **Occupational Therapy** Date: _____
Who was the evaluation completed by? _____
Address: _____ Phone #: _____

☐ **Physical Therapy** Date: _____
Who was the evaluation completed by? _____
Address: _____ Phone #: _____

☐ **Neurological** Date: _____
Who was the evaluation completed by? _____
Address: _____ Phone #: _____

☐ **Pending Referral** Date: _____
For what type of evaluation? _____

THERAPIES CHILD IS CURRENTLY RECEIVING

☐ PT – Physical Therapy Times per week: _____

What agency: _____

Address: _____ Phone #: _____

☐ OT – Occupational Therapy Times per week: _____

What agency: _____

Address: _____ Phone #: _____

☐ ST – Speech Therapy Times per week: _____

What agency: _____

Address: _____ Phone #: _____

☐ ABA- Behavior Therapy Times per week: _____

What agency: _____

Address: _____ Phone #: _____

OTHER AGENCIES/CLINICS/SOCIAL SERVICES ASSISTING CHILD/FAMILY

Name of Agency/Clinic/Social Service	Contact Person	Services Provided

DIET:

Type: ☐ Regular ☐ Pureed ☐ Ground ☐ Chopped

Food Preferences: _____

Food Dislikes: _____

SELF-CARE:

Eating: ☐ Dependent ☐ Hand-over-hand ☐ Finger-feed ☐ Independent

Adaptive Equipment: _____

Dressing: ☐ Dependent ☐ Needs Some Assistance ☐ Independent

Needs help with: _____

Toileting: ☐ Diapers ☐ Training Pants ☐ Independent

Needs help with: _____

Sleeping Habits: _____

Rest Times: _____

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

EARLY CHILDHOOD PARENT QUESTIONNAIRE FDLRS#_____

Name of Child: _____ Child's Age _____ Date: _____

Completed by: (Last Name)_____ (First Name)_____

Check (√) all the items that best describe this child

Social and Emotional

√ 'YES'	Description	Comments
	Affectionate, loving	
	Appears to enjoy school	
	Plays appropriately with toys	
	Plays appropriately with other children	
	Has a few friends	
	Has no friends	
	Avoids or is uncomfortable with other children	
	Unwilling to share toys	
	Does not want to participate in activities	
	Seeks attention ("Watch me!")	
	Usually is happy	
	Shows little emotion	
	Too much emotion	___Upset ____Fearful ____Angry ____Cries
	Difficulty separating from parent	
	Withdraws, likes to be left alone	
	Hurts others	___ On purpose ____ Without meaning to
	Shows remorse; is sorry	

Sensory and Motor

√ 'YES'	Description	Comments
	Often does not respond to sounds	___ Diagnosed with hearing loss
	Overly sensitive to sounds/smells/touch/textures	___ Sounds ___ Smells ___Touch ___Textures
	Often bumps into things	
	Falls frequently	
	Unusual behaviors. Example: rocks, bangs head, flaps hands	

Self -Help

√ 'YES'	Description	Comments
	Feeds self	
	Washes hands	
	Helps with simple chores	
	Avoids common dangers. Example: hot stove, broken glass	
	Dresses self	____with help _____independently
	Wears diapers or pull-ups	____ And tells an adult when needs changing
	Uses toilet with help	____ And tells an adult when needs to go
	Uses toilet independently	

(over)

Communication

√ **'YES'**	**Description**	**Comments**
	Makes and maintains eye contact	
	Uses gestures. Example: points, waves goodbye	
	Uses facial expressions. Example: smiles, frowns	
	Understands your gestures. Example: looks where you point	
	Vocalizes, uses sounds	
	Repeats words to learn them	
	Uses words to communicate	
	Uses sentences to communicate	
	Follows simple directions	
	Repeats words and phrases for no clear reason	___"Echoes what he hears ___ Repeats commercials, videos, etc.
	Uses jargon or gibberish	
	Uses words but does not speak clearly	
	Has difficulty answering simple questions	

Compliance

√ **'YES'**	**Description**	**Comments**
	Seeks to please	
	Usually is cooperative	
	Difficulty following directions	___Doesn't understand ____Doesn't want to
	Difficulty changing from one activity to another	
	Difficulty handling a change in the usual routine	
	Insists on having his/her way	
	Resists behavioral limits	

Self-Control

√ **'YES'**	**Description**	**Comments**
	Shows good self-control	
	Poor focus and control	___distracted ___impulsive ____can't be still
	Does not stick with an activity or finish tasks	
	Often has tantrums	
	Loses control; has a "meltdown"	
	Requires supervision most of the time	
	Aggressive words Examples: calls people names, bad language	
	Aggressive actions. Examples: hits, kicks, throws	To ___ objects ___children ___ adults___ self