



Child's Name: _____

Date of Birth: _____

Florida Diagnostic & Learning Resources System - South (FDLRS-South)

Child Find Referral Packet

Miami Killian Senior High School

10655 S.W. 97th Avenue, Miami, Florida 33176

Office Phone: 305-341-0998 or 305-274-3501

Dear Parent/Guardian,

Your child has been referred to FDLRS-South for a screening to determine if there is a concern of a suspected developmental delay or speech/language delay. If warranted, your child will be referred to Miami-Dade County Public Schools (M-DCPS) for further screening/evaluation. Below is a list of the documents that need to be completed and submitted prior to the scheduled screening.

Please complete this packet and provide the following list of documents to FDLRS-South. The documents with an asterisk are required to open the referral. Check the boxes to the left of the listed documents if you will be submitting that item as part of the referral.

Please submit the following documents:

- Copy of Child's Birth Certificate** * *{If not available, passport or certificate of baptism are acceptable}*
- Custody Documentation*** *(Required only if child is NOT in the custody of a biological parent)*
- Lead Sheet (attached)**
- FDLRS- South Child Find Parent Observation Form (attached)**
- Summary of Student Psychosocial History (attached)**
- Home Language Survey (FM # 5196) (attached)**
- Signed Consent Form for Mutual Exchange of Information (FM # 2128) (attached)**
- Observation of Prekindergarten Student Behaviors (FM# 4140 - For teacher/therapist to complete if child attends an early childhood center or receives therapy) (attached)**
- M-DCPS Hearing and Ear Health History form (attached)**

Additional Important Child Find Referral Documents:

If available, please submit copies of the following records.

- Relevant Medical Records (e. g., neurological, genetics, etc.)**
- Hearing/ Audiological Report (if done within the last year)**
- Vision Report (if done within the last year)**
- Psychological Evaluation Report**
- Speech/Language Evaluation Report**
- Behavioral Evaluation Report**

Documents can be submitted to FDLRS- South using one of the following methods:

- Email: FDLRS-South@dadeschools.net
- U.S. Mail or Drop-off at: 10655 S.W. 97th Avenue, Miami, Florida 33176

If you need assistance in completing these forms or if you have any questions, please call us at 305-341-0998 or 305-274-3501.

Sincerely,
The Child Find Team at FDLRS-South

Child Find Office Use Only
Complete the following if referral is made by an Agency or School:
Contact Person: _____
Agency/School: _____
Phone: _____ **Fax:** _____



FLORIDA DIAGNOSTIC & LEARNING RESOURCES SYSTEM - SOUTH
LEAD SHEET

Pick a service location for the evaluation:

Main Office

Miami Killian Senior High
10655 SW 97th Ave
Miami, FL 33176

Central

Thena C. Crowder Early
Childhood Diagnostic and
Special Education Center
757 NW 66th Street
Miami, FL 33150

North

Robert Renick Educational Center
2201 NW 207 Street
Miami Gardens, FL 33056

South

Center for International Education
900 NE 23 Avenue
Homestead, FL 33033

Date: _____ Referred by (Name) _____

Referral Source Phone: _____ Email: _____

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

Sex: M F Birthplace: _____ Race: _____

Primary Language: _____ Other language spoken at home: _____

Attending Preschool: Y N If yes, name of facility: _____

Parent Foster Guardian name: _____

E-mail: _____ Cell: _____

Home Address: _____

City: _____ Zip Code: _____ Alternate Phone Number: _____

Alternate Contact _____ Number: _____

Name/Relationship to child: _____

Reason for Referral (Mark all that apply)

- Speech** (hard to understand, talking is not clear)
- Expressive Language** (limited spoken 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 Difficulties**
- Hearing Difficulties**

Medical Diagnosis: Y N Specify: _____

Receiving therapies: Speech/Language Occupational Physical Behavior Location: _____

Comments: _____

FOR CHILD FIND USE ONLY:

Language Code: _____ K- _____ Information Rec'd by: _____

Homeschool: _____ Entered in CHRIS by (initials) _____

Screening / Appointment: _____

Email the completed form to FDLRS-South@dadeschools.net

Contact: FDLRS-South at 305-341-0998 or 305-274-3501



Florida Diagnostic & Learning Resources System-South (FDLRS-South)
Child Find Parent Observation Form

Child's Name: _____ Birthdate: _____ Age: _____
Person Completing this Form: _____ Relation to Child: _____ Date: _____

Directions: Please check any behaviors that are a concern (leave boxes blank if there are no concerns).

1. Attending Behaviors

- | | | |
|--|--|---|
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Short attention span | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Overly active | <input type="checkbox"/> Difficulty remembering things | <input type="checkbox"/> Needs a lot of attention from adults |

2. Disruptive Behaviors

- | | | |
|---|--|--|
| <input type="checkbox"/> Physically aggressive (hits, pushes, bites, pinches) | <input type="checkbox"/> Hurts himself/herself intentionally | <input type="checkbox"/> Verbally abusive (yells, uses inappropriate language) |
|---|--|--|

3. Social/Emotional Indicators

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxious/nervous | <input type="checkbox"/> Seems unhappy | <input type="checkbox"/> Avoids interaction with other children |
| <input type="checkbox"/> Is easily frustrated | <input type="checkbox"/> Has difficulty taking turns | <input type="checkbox"/> Becomes upset easily |
| <input type="checkbox"/> Repeats behaviors over and over (rocking, pacing, spinning) | <input type="checkbox"/> Plays with one toy over and over again for <u>very</u> long periods | <input type="checkbox"/> Cries frequently |
| <input type="checkbox"/> Does not get along with other children | <input type="checkbox"/> Has frequent temper tantrums | <input type="checkbox"/> Is overly fearful in new situations |
| <input type="checkbox"/> Prefers to play alone | <input type="checkbox"/> Does not get along with adults | <input type="checkbox"/> Does not engage in pretend play (feeding the baby, talking on the phone, etc.) |

4. Speech/Language

- | | | |
|---|---|--|
| <input type="checkbox"/> Does not follow simple directions | <input type="checkbox"/> Still utilizes a pacifier on a regular basis | <input type="checkbox"/> Has difficulty naming basic objects or people |
| <input type="checkbox"/> Speech is not understood by others outside of the family | <input type="checkbox"/> Does not speak in 3 – 4-word sentences | <input type="checkbox"/> Voice sounds different from other children (raspy, nasal, hoarse, high pitched, too soft, too loud) |
| <input type="checkbox"/> Does not engage in conversation | <input type="checkbox"/> Stutters with sounds ("m, m, m, many"), repeats words or phrases, or gets "stuck" on words | <input type="checkbox"/> Has difficulty understanding what is said to him/her |

5. Motor Skills

- | | | |
|---|--|--|
| <input type="checkbox"/> Appears clumsy or uncoordinated | <input type="checkbox"/> Frequently drops, spills, or knocks things over | <input type="checkbox"/> Is unsteady when walking |
| <input type="checkbox"/> Has difficulty turning the pages of a cardboard book | <input type="checkbox"/> Has difficulty holding a bottle or cup by himself/herself | <input type="checkbox"/> Has difficulty holding a thick crayon |

6. Self-Help Skills

- | | | |
|--|--|--|
| <input type="checkbox"/> Cannot feed himself/herself independently | <input type="checkbox"/> Has frequent toileting accidents during the day | <input type="checkbox"/> Needs assistance washing/drying hands |
|--|--|--|

7. Sensory Issues

- | | | |
|---|--|---|
| <input type="checkbox"/> Is a very picky eater | <input type="checkbox"/> Sensitive to wearing certain clothing (e.g., socks, shoes, clothing labels) | <input type="checkbox"/> Does not tolerate large crowds |
| <input type="checkbox"/> Covers ears to loud noises | | |

8. Other

- | | | |
|---|---|---|
| <input type="checkbox"/> Has difficulty with changes in routine | <input type="checkbox"/> Frequently wets the bed | <input type="checkbox"/> Has unusual fears |
| <input type="checkbox"/> Has frequent nightmares | <input type="checkbox"/> Has difficulty learning simple rules | <input type="checkbox"/> Has been asked to leave a preschool or daycare |
| | <input type="checkbox"/> Walks on tiptoes | |
| | <input type="checkbox"/> Does not respond to name when called | |



MIAMI-DADE COUNTY PUBLIC SCHOOLS

CONSENT FORM FOR MUTUAL EXCHANGE OF INFORMATION

Date _____

Student's Name _____

Date of Birth _____ ID# _____

I hereby authorize the mutual exchange of records pertaining to my child or myself, _____, between the MIAMI-DADE COUNTY PUBLIC SCHOOLS and the following agencies (include all schools, physicians, psychologists, hospitals, clinics, etc., that have had significant contact with your child):

Name

Address

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- The specific records to be disclosed pertain to: _____

- The purpose for making these records available is: _____

- The receiving party will not disclose the information to any other party without signed consent.

I certify that I am the parent or legal guardian of the child named above or that I am a student of majority age and have the authority to sign this release.

Name (print) Signature

Address City, State Zip Code

Please return this form to:



**MIAMI-DADE COUNTY PUBLIC SCHOOLS
HOME LANGUAGE SURVEY**

To Be Completed By Parent or Guardian

Student I.D. No. _____

Student Name _____
Last First Middle

Date of Birth _____ / _____ / _____ Grade _____ Parent Language _____ Student Language _____
Month Day Year

Date Entered U.S. School : _____ / _____ / _____ Ethnic _____ (Check all that apply) Race: White Black Asian
Month Day Year Hispanic _____ (Y/N) American Indian Native Pacific Islander

If the answer is "YES" to any of these questions, the student must be tested for English proficiency.

1. Is a language other than English used in the home?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Did the student have a first language other than English?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Does the student most frequently speak a language other than English?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

School _____ Date _____ Parent/Guardian Signature _____

**ESCUELAS PUBLICAS DEL CONDADO DE MIAMI-DADE
ENCUESTA SOBRE EL IDIOMA HABLADO EN EL HOGAR**

Debe ser completado por el/la padre/madre o tutor/a

No. De I.D. _____

Nombre del Estudiante _____
Apellido Nombre Inicial

Fecha de Nacimiento _____ / _____ / _____ Grado _____ Lengua Paterna _____ Idioma del Estudiante _____
Mes Día Año

Fecha de Entrada a la Escuela de los Estados Unidos: _____ / _____ / _____ Origen Etnico (Marque todo lo pertinente) Raza: Blanco Negro
Mes Día Año Asiático Indígena de los EEUU Oriundo de las Islas del Pacífico

Si responde "SI" a alguna de estas preguntas, el estudiante debe tomar un examen para saber cual es su conocimiento del Inglés.

1. ¿Usan en su casa algún otro idioma que no sea el Inglés?	Sí <input type="checkbox"/>	No <input type="checkbox"/>
2. ¿Tuvo el estudiante una lengua materna distinta al Inglés?	Sí <input type="checkbox"/>	No <input type="checkbox"/>
3. ¿Habla el estudiante frecuentemente otro idioma que no sea el Inglés?	Sí <input type="checkbox"/>	No <input type="checkbox"/>

Escuela _____ Fecha _____ Firma del Padre/Madre _____

**MIAMI-DADE COUNTY PUBLIC SCHOOLS
SONDAJ SOU KI LANG TIMOUN NAN PALE**

Pou paran oubyen moun ki responsab timoun nan ranpli

No. I.D. Elèv La _____

Non Elèv la _____
Non fanmi Non

Dat Fèt li _____ / _____ / _____ Klas _____ Lang paran Yo _____ Lang Elèv La _____
Mwa Jou Ane

Dat ou Antre U.S. Lekòl: _____ / _____ / _____ Etnisite (Tcheke tout sa ki aplike) Ras: Blan Nwa Azyatik
Mwa Jou Ane Espayòl _____ (W/N) Amriken Endyen Natif Il Pasifik

Si repons lan se "WI" pou nenpòt nan kesyon anba yo, elèv la dwe pran yon tès Anglè.

1. Eske yo sèvi ak yon lang ki pa Anglè lakay li?	Wi <input type="checkbox"/>	Non <input type="checkbox"/>
2. Eske elèv la te genyen yon premye lang anvan Anglè?	Wi <input type="checkbox"/>	Non <input type="checkbox"/>
3. Eske elèv la abitye pale yon lang ki pa Anglè?	Wi <input type="checkbox"/>	Non <input type="checkbox"/>

Lekòl _____ Dat _____ Siyati Paran _____



Florida Diagnostic & Learning Resources System-South Summary of Student Psychosocial History

			Date:
Child Name:	ID#:	D.O.B:	Age:
Home School:	Person Completing Form:		
Respondent's Name/Relationship:	Signature:		
Home Address:	Rent <input type="checkbox"/>	Own <input type="checkbox"/>	
Telephone:	Email:		

FAMILY COMPOSITION

Name	Relationship	Lives with Child	Age	Occupation
	Mother	Yes / No		
	Father	Yes / No		
		Yes / No		
		Yes / No		
		Yes / No		

Child's place of birth: _____ Family's cultural origin: _____

Primary language spoken in the home: _____

Other languages child is exposed to: _____

Parents/Guardian's marital status: Single Married Separated/Divorced Widowed

Reason for referral/parent concerns: _____

EDUCATIONAL HISTORY

Is the child currently attending school: Yes No If yes, Name/Date entered: _____

Describe the student's current school experience, strengths and challenges: _____

DEVELOPMENTAL HISTORY

Describe pregnancy and delivery of child, risk factors and/or difficulties: _____

Gestation (months): _____ Birth Weight: _____ Postnatal Difficulties: _____

Developmental Milestones (Age) Walked: _____ First Words: _____ Phrases: _____ Toilet Training: _____

Bedwetting: Yes No Explain: _____

MEDICAL/MENTAL HEALTH HISTORY

Describe history of illness, chronic health problems, syndromes: _____

Allergies to food, medication: _____

Injuries, surgeries, accidents, hospitalizations: Yes No **If yes, date/explain:** _____

Current medications: _____

Eating problems: Yes No **Difficulty sleeping:** Yes No **Speech/language problems:** Yes No

Vision impairment: Yes or No **Wears glasses:** Yes No **Hearing impairment:** Yes No

Has the child been seen by a neurologist, psychologist, or other professional? Yes or No **If yes, explain:** _____

Has the child had any diagnostic testing such as MRI, EEG, etc.? Yes or No **If yes, explain:** _____

Has the child received speech/language therapy? Yes or No **If yes, provide us with the place of service and dates:** _____

Has the child received occupational therapy, physical therapy or behavioral therapy? Yes or No

If yes, provide us with the place of service and dates: _____

Family history of learning, medical, or mental health problems: _____

INTERPERSONAL RELATIONSHIPS/BEHAVIOR

Describe the student's overall behavior at home: _____

Discipline measures used in the home: _____

Describe child's peer relationships: _____

Student's interests and strengths: _____

Behaviors: Easily Distracted Yes or No **Easily Frustrated:** Yes No **Aggressive** Yes No

Independent: Yes or No **Impulsive:** Yes or No **Temper Tantrum:** Yes or No

TRAUMATIC EVENTS/PSYCHOLOGICAL STRESSORS

Has the child been exposed to or affected by: Separation/Divorce: Yes No

Serious family illness/death: Yes No

Police or Department of Children and Families involvement: Yes No

Catastrophic events: Yes No **Homelessness:** Yes No

If yes, explain: _____

Additional Information: _____



**Miami-Dade County Public Schools
OBSERVATION OF PREKINDERGARTEN STUDENT BEHAVIORS**

Child's Name _____	Birthdate _____	Age _____
Observer _____	School _____	

To be completed by child's teacher(s) and/or therapist(s). Please check the behaviors that occur more frequently than is typical for same-age peers. If no concerns, check the box marked age appropriate.

I. Attending Behaviors

- | | |
|--|--|
| <input type="checkbox"/> Easily distracted
<input type="checkbox"/> Has short attention span
<input type="checkbox"/> Impulsive
<input type="checkbox"/> Needs help from adult to stay on task
<input type="checkbox"/> Needs excessive attention from teacher | <input type="checkbox"/> Acts upset by a change in plans
<input type="checkbox"/> Over-active/hyperactive
<input type="checkbox"/> Has difficulty remembering things
<input type="checkbox"/> Appears to daydream
<input type="checkbox"/> Age appropriate |
|--|--|

II. Disruptive Behaviors

- | | |
|---|---|
| <input type="checkbox"/> Argumentative
<input type="checkbox"/> Physically aggressive (hits, kicks, destructive etc.)
<input type="checkbox"/> Self-injurious behavior e.g. _____ | <input type="checkbox"/> Verbally abusive
<input type="checkbox"/> Bullies peers
<input type="checkbox"/> Age appropriate |
|---|---|

III. Indicators of Anxiety/Sadness

- | | |
|---|--|
| <input type="checkbox"/> Withdrawn
<input type="checkbox"/> Anxious/nervous
<input type="checkbox"/> Seems unhappy
<input type="checkbox"/> Becomes ill when upset or frustrated | <input type="checkbox"/> Easily overwhelmed
<input type="checkbox"/> Cries easily/inappropriately
<input type="checkbox"/> Exhibits inappropriate mood changes
<input type="checkbox"/> Age appropriate |
|---|--|

IV. Language/Speech

- | | |
|---|---|
| <input type="checkbox"/> Has difficulty understanding instructions or directions
<input type="checkbox"/> Has difficulty naming people or objects
<input type="checkbox"/> Has difficulty speaking in sentences
<input type="checkbox"/> Has difficulty staying on topic
<input type="checkbox"/> Speech is difficult to understand | <input type="checkbox"/> Frequently stutters (e.g: m,m,m,many), repeats words, whole phrases or "gets stuck" while trying to say a word
<input type="checkbox"/> Voice is hoarse, raspy or nasal
<input type="checkbox"/> Age appropriate |
|---|---|

V. Social/Emotional

- | | |
|--|---|
| <input type="checkbox"/> Has difficulty with self-control when frustrated
<input type="checkbox"/> Has difficulty sharing with other children
<input type="checkbox"/> Exhibits repetitive behavior e.g. _____
<input type="checkbox"/> Becomes easily upset
<input type="checkbox"/> Displays unusual reactions to sensory stimulation (e.g. lights, sounds, smells, tastes, touch, etc.) | <input type="checkbox"/> Has difficulty joining in peer group play
<input type="checkbox"/> Avoids interaction with other children
<input type="checkbox"/> Has temper tantrums (length of tantrums _____)
<input type="checkbox"/> Has difficulty taking turns
<input type="checkbox"/> Lacks imaginative play
<input type="checkbox"/> Age appropriate |
|--|---|

VI. Gross and Fine Motor Skills

- | | |
|--|---|
| <input type="checkbox"/> Has unsteady gait
<input type="checkbox"/> Appears clumsy or uncoordinated
<input type="checkbox"/> Has difficulty using a pencil or crayon | <input type="checkbox"/> Frequently drops, spills or knocks things over
<input type="checkbox"/> Age appropriate |
|--|---|

VII. Adaptive/Self-Help Skills

- | | |
|---|--|
| <input type="checkbox"/> Has frequent toileting accidents
<input type="checkbox"/> Needs assistance washing and drying hands | <input type="checkbox"/> Needs assistance with eating e.g. _____
<input type="checkbox"/> Age appropriate |
|---|--|

Comments/Concerns: _____

Signature _____ **Date** _____

**Miami-Dade County Public Schools
Hearing and Ear Health History**

OTOLOGIC HISTORY: (Ear problems include but are not limited to ear infection, earaches, draining ears, medicine taken for an ear problem, the doctor noticed fluid behind the eardrum, hole in the eardrum, etc.)

1. How many ear problems has your child had?

None ____ 1-2 ____ 3-5 ____ 6-10 ____ 10 or more ____

2. Has your child had an ear problem in the last 6 months? YES NO

If yes, when? _____ What type of ear problem? _____

Was medication given: YES NO

3. Does your child have any of the following?

• Frequent runny nose: YES NO

• Ringing or buzzing in the ear(s): YES NO

• Frequent colds or sinus infections: YES NO

• Dizziness: YES NO

• Allergies: YES NO

4. Has anyone related to the child had any ear problems? YES NO

Who? (parent, brother, sister, cousin, etc.) _____

What type of ear problem?

5. Has your child ever been seen by an Ear, Nose & Throat (ENT) doctor? YES NO

If yes, which doctor? _____ When? _____

6. Has your child ever had any ear surgery? YES NO

If yes, describe:

7. Has your child previously had his/her hearing tested by an audiologist? YES NO

If yes, by whom? _____ When? _____

What were the results?

8. Does your child have any permanent hearing loss? YES NO

If yes, describe:

Has your child ever used amplification? YES NO

If yes, is it current use or when were they last used?

****IF YOU HAVE A PREVIOUS AUDIOLOGICAL EVALUATION WITHIN ONE YEAR, PLEASE SUBMIT IT TO THE AUDIOLOGY DEPARTMENT FOR REVIEW PRIOR TO YOUR APPOINTMENT****