**Inform parents they must send a copy of their child's birth certificate, social security card, and immunization records at the same time they return the release form(s).

RAPIDES PARISH SCHOOL BOARD
PUPIL APPRAISAL SERVICES
CHILD SEARCH REFERRAL INTERVIEW

REFERRAL SOURCE: Hospital / Physician / Day Care / Pub. Health Facility / Parent / Social Services / Private School

NAME_____ **DATE OF INTERVIEW**_____

(HAVE PARENTS VERIFY ALL INFORMATION - SPELLING, DATES, ETC.)

CHILD'S FULL NAME_____ **M / F DOB:**_____

CHILD'S ETHNICITY: 1 – American Indian 2 – Asian 3 – Black 4 – Hispanic 5 - White

BIRTH CERTIFICATE #_____ **SS #**_____ **MEDICAID #**_____

PARENT'S NAME & ADDRESS (Include Street, P. O. Box, City, and Zip Code) **TELEPHONE CONTACT #s:**

_____ (C)_____

_____ (H)_____

_____ (W)_____

1. **HAS YOUR CHILD BEEN TESTED BEFORE BECAUSE OF CONCERNS** (i.e., through Cabrini Pediatric Therapy, MB Therapy, ABA Center, Beyond A Spectrum, speech therapist, psychologist/psychiatrist/, behavioral specialist, hearing/vision specialist, or some other source?)
   YES NO If yes, where (agency)? :_____
   When?_____ **Why?**_____

2. **DOES YOUR CHILD ATTEND DAYCARE/HEADSTART?** **YES** **NO**
   DAYCARE NAME_____ **HEADSTART CENTER NAME**_____
   (**If child attends Headstart, complete normal referral process ***AND*** also notify Marian Price, HS Disability Mgr.)

3. a.) **HAS YOUR CHILD BEEN MEDICALLY DIAGNOSED / EVALUATED?** **YES** **NO**
   (If yes, by whom?_____ **What was the diagnosis?**
   (Ex: premature birth, Brittle Bone, heart/respiratory problems (including Asthma / severe allergies,) Spina Bifida, seizures, hearing (including: tubes inserted and tonsils and/or adenoids removed), vision, Cerebral Palsy, surgeries, etc.)
   _____
   _____
   _____
   _____

   b.) **ARE THERE ANY RESTRICTIONS/LIMITATIONS PLACED ON YOUR CHILD BY HIS/HER DOCTOR?**
   YES NO _____

   c.) **WHO IS YOUR CHILD'S PEDIATRICIAN?**_____

4. **TO YOUR KNOWLEDGE, IS YOUR CHILD FREE OF COMMUNICABLE DISEASE?** **YES** **NO**
   (**Children diagnosed with CMV (cytomegalovirus) or HIV, please note carefully and give referral to Mr. Yoist.)
   [redacted] _____

5. **WHAT ARE YOUR SPECIFIC CONCERNS REGARDING YOUR CHILD?**_____
   _____
   _____
   _____
   _____

6. **DO YOU FEEL YOUR CHILD IS DELAYED IN?**
   ____ Speech (describe)_____
   ____ Sensory Processing _____
   ____ Fine Motor (using his/her hands)
   ____ Gross Motor (using big muscles; like throwing, running)
   ____ Social Skills (relating to others - adults/other children)
   ____ Behavior (listening, following directions, attending stories, games, T.V.)
   ____ Medical (Autism, ADHD, Asthma, Diabetes, etc.)

7. **AT WHAT AGE DID YOUR CHILD SIT ALONE?**_____ **WALK?**_____ **TALK?**_____
   TOILET TRAINED?_____

DATE RELEASE(S) SENT TO PARENT_____ **REC'D FROM PARENT**_____