TAYLOR EARLY CHILDHOOD CENTER

400 Joachim Avenue * Herculaneum, MO 63048 Phone: (636) 479-5200 Fax: (636) 479-2053 (Crystal City 47, Dunklin R-5, Festus R-VI, Jefferson County R-VII)

EARLY CHILDHOOD SPECIAL EDUCATION REFERRAL

TAYLOR	OFI	FICE USE ONLY	
Date:			
Referring Agency:			
Referring Name:			
Agency Re	ferral	Parent Referral	

*** Each section <u>MUST</u> be completed; incomplete forms will result in an invalid referral. If you need assistance please contact our office at 636-479-5200, opt. 5. E-mail completed forms to <u>rschuepbach@dunklin.k12.mo.us</u> OR you may bring them to our office at the address listed above.

CHILD INFORMATION:

Child's Legal Name:	Child's Legal Name:			А	.ge:	DOB:	
Nickname or name the child usually goes by:	Firs	irst Name Middle In	nitial Last Nam	e			
Primary language spoken in the home: English Spanish Other: Home School District: Dunklin R-5 Festus R-6 Jefferson R-7 Medicaid Number: Copy of Birth Certificate Attached: Yes No Proof of Residency (i.e. utility bill or real estate/rental contract): Yes No PARENT/GUARDIAN INFORMATION: Parent(s)/Guardian(s):	Nickname or name the child us	usually goes by:					
Home School District: Dunklin R-5 Festus R-6 Jefferson R-7 Medicaid Number:	Ethic Origin: \Box Caucasian \Box] African-American 🗆	American Indian	🗆 Hispanic	\Box Other:		
Medicaid Number:	Primary language spoken in th	he home: 🗆 English	🗆 Spanish	\Box Other:			
Copy of Birth Certificate Attached: Yes No Copy of Immunizations Attached: Yes No Proof of Residency (i.e. utility bill or real estate/rental contract): Yes No PARENT/GUARDIAN INFORMATION: Parent(s)/Guardian(s): Natural Parents Foster Parents Adoptive Parents Guardians Other: Natural Parents Foster Parents Adoptive Parents Guardians Other: City/State/Zip: Mother/Guardian Cell Phone: Father/Guardian Cell Phone: MEDICAL INFORMATION: Physician's Name: Physician's Name: Physician's Name: Physician's Name: Physician's Name: Physician's Phone: Physician's Physician's Phone: Physician's Phone: Physician's Physician's Phone: Physician's	Home School District: Dunl	ıklin R-5 🛛 🗆 Festi	us R-6 🛛 🗆 Jeffer	rson R-7			
Proof of Residency (i.e. utility bill or real estate/rental contract): Yes No PARENT/GUARDIAN INFORMATION: Parent(s)/Guardian(s): Natural Parents Foster Parents Adoptive Parents Guardians Other: E-mail: City/State/Zip: Home Phone: E-mail: City/State/Zip: Home Phone: Work Phone: Mother/Guardian Cell Phone: Work Phone: Mork Phone: Physician's Name: Physician's Name: Physician's Name: Physician's Phone: Physici	Medicaid Number:						
PARENT/GUARDIAN INFORMATION: Parent(s)/Guardian(s): Natural Parents Foster Parents Adoptive Parents Guardians Other: Street Address: E-mail: City/State/Zip: Home Phone: Mother/Guardian Cell Phone: Work Phone: Father/Guardian Cell Phone: Work Phone: MEDICAL INFORMATION: Physician's Name: Physician's Name: Physician's Address:	Copy of Birth Certificate Attac	ached: □ Yes □ No		Copy of Imm	unizations At	tached: □ Yes	□ No
Parent(s)/Guardian(s): Natural Parents Foster Parents Adoptive Parents Guardians Other: Street Address: E-mail: City/State/Zip: Home Phone: Mother/Guardian Cell Phone: Work Phone: Father/Guardian Cell Phone: Work Phone: MEDICAL INFORMATION: Physician's Name: Physician's Name: Physician's Address:	Proof of Residency (i.e. utility	y bill or real estate/rer	ntal contract): 🗆 Ye	es 🗆 No			
Parent(s)/Guardian(s): Natural Parents Foster Parents Adoptive Parents Guardians Other: Street Address: E-mail: City/State/Zip: Home Phone: Mother/Guardian Cell Phone: Work Phone: Father/Guardian Cell Phone: Work Phone: MEDICAL INFORMATION: Physician's Name: Physician's Name: Physician's Address:							
□ Natural Parents □ Foster Parents □ Adoptive Parents □ Guardians □ Other: Street Address: E-mail: City/State/Zip: Home Phone: Mother/Guardian Cell Phone: Work Phone: Father/Guardian Cell Phone: Work Phone: MEDICAL INFORMATION: Physician's Name: Physician's Phone: Physician's Name: Physician's Phone: Physician's Phone:							
Street Address: E-mail: City/State/Zip: Home Phone: Mother/Guardian Cell Phone: Work Phone: Father/Guardian Cell Phone: Work Phone: MEDICAL INFORMATION: Physician's Name: Physician's Name: Physician's Phone:	\Box Natural Parants \Box Easter	r Parante 🗆 Adontiv	ve Perents 🗖 Gu	ardians	Ithor		
City/State/Zip: Home Phone: Mother/Guardian Cell Phone: Work Phone: Father/Guardian Cell Phone: Work Phone: MEDICAL INFORMATION: Physician's Name: Physician's Name: Physician's Phone:	~						
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Father/Guardian Cell Phone: Work Phone: MEDICAL INFORMATION: Physician's Name: Physician's Name: Physician's Phone:	• •			Work Phon	e		
MEDICAL INFORMATION: Physician's Name: Physician's Address:	Fother/Cuardian Cell Phone.	·	<u> </u>	Work Fliun	e		
Physician's Name: Physician's Phone: Physician's Address: Physician's Phone:	Father/Guardian Cen Fhone.			WOIK FIIOII	e		
Physician's Address:	MEDICAL INFORMATION	N:					
Physician's Address:	Physician's Name:		Phy	vsician's Phon	e:		
	Physician's Address:						
List any past and/or current health/medical problems:		ealth/medical problen	ns:				
	51	I I I I I I I I I I I I I I I I I I I					
Currently attends a daycare/preschool: Yes No	Currently attends a daycare/pr	reschool: 🗆 Yes 🗆 N	No				
If yes, where: How long:				How lot	าง		
Has the child been seen by another agency: \Box Yes \Box No If yes, indicate which ones below:		other agency: \Box Yes	□ No If ve			w/•	
\square P.A.T. \square First Steps \square Head Start \square Therapeutic Playtime \square PS Kids	\square P.A.T. \square First	rst Steps	☐ Head Start	□ Therapeu	itic Playtime	\square PS Kids	
P.A.T. First Steps Head Start Therapeutic Playtime PS Kids Dates: Dates: Dates: Dates: Dates:	Dates: Dates:	:I	Dates:	Dates:		Dates:	
PS Kids Mercy Behavioral Clinic Cardinal Glennon Knights of Columbus Walker-Scottish Rite	□ PS Kids □ Me	ercy Behavioral Clinic	Cardinal Gle	nnon Knights of Colu	umbus 🗆 Wa	lker-Scottish Rite	
Dates: Dat	Dates: Dates:		Dates:	-	Dates:		
□ SLCH: □ Other:		ther:					
Dates: Dates:	Dates: Dates:						

***** REASON FOR REFERRAL:** Summarize concerns by indicating specific reasons and/or situations that make you feel **a referral is necessary:**

	I CAN	I CANNOT	Γ INTERVENTIONS / STRATEGIES	INTERVENTION OUTCOMES
FINE MOTOR SKILLS	 Stack blocks Scribble Use utensils Puzzles Cut with scissors Button/unbutton Finger/thumb pickup Write - fist closed Write - 3 finger grip Draw a line Draw a closed circle 	Stack blocks Scribble Use utensils Puzzles Cut with scissors Button/unbutton Finger/thumb pic Write - fist close Write - 3 finger g Draw a line Draw a closed ci	ckup d grip	
GROSS MOTOR SKILLS	 □ Walk □ Run □ Jump □ Climb □ Walk up/down steps □ Independently □ With assistance 	☐ Walk ☐ Run ☐ Jump ☐ Climb ☐ Walk up/down si ☐ Independently ☐ With assistance	7	
SOCIAL / EMOTIONAL	 Transition Control emotions Play with peers Share/take turns Pretend play Follow directions Attend to task 	 Transition Control emotions Play with peers Share/take turns Pretend play Follow direction Attend to task 		
ACADEMICS / GENERAL INTELIGENCE	 Count to Match colors Name colors Match shapes Name shapes Say ABC's Sing songs 	Count to Match colors Name colors Match shapes Name shapes Say ABC's Sing songs	-	
Do you have con			your concerns?	
VISION	Yes No Pass			
HEARING HEALTH	☐ Yes No ☐ Pass ☐ Yes ☐ No			
ΠΕΑΓΙΠ				

COMMUNICATION / LANGUAGE:

1) My child uses the following forms of communication to make his/her needs and wants known: (check all that apply)
\Box Cries \Box Eye Contact \Box Gestures \Box Words
2) Number or words used: (check one) $\Box 0-10$ $\Box 10-30$ $\Box 30-50$ $\Box 50-99$ $\Box 100+$
3) My child understands the following: (check all that apply) 🗌 Many words 🔹 One-step directions 🔅 Two-step directions
COMMUNICATION / SPEECH:
1) My child can make the following sounds: $\Box p \Box b \Box m \Box t \Box n \Box d \Box k \Box g \Box f$
2) Family and individuals <i>familiar</i> with my child understands his/her speech: $\Box 0.25\% \Box 25.50\% \Box 50.75\% \Box 75.100\%$
3) New people/individuals <i>unfamiliar</i> with my child understand his/her speech: 0-25% 25-50% 50-75% 75-100%
Additional comments on
communication:

Parent / Guardian Signature

Date