



Preschool Referral Form

1. Child's Name: _____

Birthdate: _____ Referral date: _____

2. Parent/Caregiver Name: _____

Address w/Zip Code: _____

Email for enrollment packet: _____

Best phone to contact: _____ 2nd best phone: _____

3. Date of last physical: _____ Medical Provider: _____

4. District and County: _____

Preferred Preschool location: _____

5. Referral Source: _____

Contact Information: _____

6. Child currently in foster care: YES _____ NO _____ Case worker: _____

Case Worker contact information/email: _____ phone #: _____

7. Current Services/Supports (please include frequency and group or individual): _____

8. **Preschool Services/Supports (Per IEP):** _____

Skilled Nursing on IEP: YES _____ NO _____

1 on 1 Aide on IEP: YES _____ NO _____

Special Health Care Needs/GTube/Medications, etc. : YES _____ NO _____

*****If Yes, please explain:** _____

Meeting Date: _____ Desired Start Date: _____ BOE Date: _____

CPSE Chairperson Signature: _____

For Office Use:

- Date Referral Received: _____
 - Tour Date: _____
 - Parent Packet: Provided _____ Received: _____
 - Medical Clearance Received: _____
 - Transportation arranged: _____
 - Classroom: _____
- Start Date: _____