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 location/Classroom:_____

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:_____

3/3/2022