Preschool Special Education Referral Process Checklist

1. **The following are needed from the parent:**
   - ___ Referral for Preschool School form
   - ___ Developmental History Form
   - ___ Medicaid/Peach Care Letter
   - ___ Student Demographic & Enrollment Form
   - ___ Authorization for Release of Confidential Information, if applicable
     (Release of information for any private therapists the child currently sees or who has previously been evaluated the student.)

2. **The following are needed from the pediatrician**
   - ___ Documentation of Passed ***Vision***
   - ___ GA Health Form 3300 **or**
   - ___ Copy of Eye Exam Results (must document acuity level) **or**
   - ___ Physician's Examination (Medical Doctor signature only)

3. **The following are needed from the pediatrician**
   - ___ Documentation of Passed ***Hearing***
   - ___ GA Health Form 3300 **or**
   - ___ Copy of Audiological Results (Audiogram dated within one year) **or**
   - Physician's Examination (Medical Doctor signature only)

4. ***Required Attachments. Incomplete Referral will be returned within 10 days of receipt***
   - ___ **Medicaid/Peach Care/Well Care Card (if applicable)**
   - ___ **Vision Documents**
   - ___ **Hearing Documents**

5. **Note: All referrals must be completed and submitted prior to February 15th of the current school year**
   Any referral received after this date will be processed during the following school year.

6. Send referral packet to Special Education Department at:
   Camden County Board of Eduction
   311 S. East Street
   Kingsland, GA 31548

   Date sent to Central Office: _____

To be completed by Camden County Schools

1. Referral logged in on _____
2. Referral received from BOE on _____ and sent to _____ _____.

Referral Complete Comments: _____
Sign Date

Referral Incomplete Comments: _____
Sign Date

CAMDEN COUNTY SCHOOLS

311 South East Street
Kingsland, GA 31548

Telephone: (912) 729-5687
Fax: 1-912-289-0244

Dr. Tracolya Green, Superintendent

Referral for Evaluation- Preschool Special Education

Child's Name:_____ Date of Birth_____

Referred by:_____ Child Care Center:_____

GA Pre-K site:_____Teacher:_____

Parent(s) Name:_____

Parent(s) Address_____
Street Address City State Zip

Parent(s) Phone Number(s) _____
Home Work

Email:_____

The above student has difficulties with the following skills:

☐ Speech Intelligibility
☐ Following Directions
☐ Tantrums
☐ Academic Skills
☐ Communicating wants/needs
☐ Social Skills
☐ Toilet Training
☐ Motor Skills

Other:_____

As a part of this referral, I understand that my child must be formally screened in the following areas: cognitive, communication / language, social/emotional / behavioral, adaptive behavior, articulation and achievement.

_____Yes, I do agree

_____No, I do not agree

_____
Parent Signature

Parent Social and Developmental History

Dear Parent: We would appreciate your help in completing this information regarding your child. This information will help us in working more effectively with your child. Information on this form will be treated in a confidential manner.

Name of Child: _____Date of Birth: _____

Address: _____Home Phone: _____

Place of Birth_____ _____

Parent/Guardian Name (1): Name: _____Work or Cell Phone: _____

Parent/Guardian Name (1): Name: _____Work or Cell Phone: _____

Name of parent or guardian with whom child lives _____

Recent Traumatic Events_____

List all people living in household:

Name	*Relationship to Child*	*Age*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐

BIRTH HISTORY

Full Term: Yes No If No, how many weeks gestation? _____ weeks (Typical pregnancy is 40 weeks)

Birth Weight _____ pounds _____ ounces Complications? Explain _____

Length of Labor_____ Apgar _____ Child's Length of Hospital Stay:_____

DEVELOPMENTAL HISTORY

Does your child have a history of ear infections? ☐ Yes ☐ No

To the best of your memory, when did the following milestones first occur?	Early	Late	On time	Approximate Age
Sat without support (*most children develop this skill between 6-9 months*)	☐	☐	☐	
Crawled (*most children develop this skill between 9-12 months*)	☐	☐	☐	
Stood alone	☐	☐	☐	
Walked without assistance *(most children develop this skill between 12-18 months)*	☐	☐	☐	
Spoke first words(besides ma-ma, da-da) -(*most children develop this skill between 12-18 months)*	☐	☐	☐	
Put several words together *(most children develop this skill between 2- 3 years)*	☐	☐	☐	
Toilet trained during day (*most children develop this skill by 3 years*)	☐	☐	☐	
Toilet trained during night (*most children develop this skill under 5 years*)	☐	☐	☐	
Dressed self except for tying shoes *(most children develop this skill by age 4)*	☐	☐	☐	

CURRENT PHYSICAL CONDITION

My child's general condition is:

☐ Seems to be in good health ☐ Underweight ☐ Overweight
☐ Tires easily, listless, lacks energy ☐ Overly active, always on the move
☐ Sleeps too little ☐ Sleeps too much

MEDICAL HISTORY

Please indicate any illnesses or conditions that your child has had and the age of the child when he / she had the illness or condition.

	Year / Age of Child	
Hospitalization	_____	(Describe) _____
Surgery	_____	(Describe) _____
Allergies	_____	(Describe) _____
Asthma	_____	
Broken bones	_____	(Describe) _____
Chicken Pox	_____	
Epilepsy / Seizures	_____	
Head Injury	_____	(Describe) _____
High fever (above 104 degrees)	_____	
Tonsils or adenoids removed	_____	
Tubes in ears	_____	
Other	_____	(Describe) _____

Is the student currently under a doctor's care? ☐ Yes ☐ No If yes, who is the doctor? _____

What is the diagnosis / medical concern? _____

Is this child currently prescribed any medications? ☐ Yes ☐ No

If yes, what medication and how much? _____

Has your child taken any prescription medications in the past for more than 3 months? ☐ Yes ☐ No

If yes, what medication and how much? _____

Does this student use any of the following adaptive equipment? ☐ Eyeglasses ☐ Hearing Aids ☐ Wheelchair ☐ Leg Braces

Walker/ Gait Trainer Stander Feeding Tube Other: _____

Any other medical diagnosis / diagnoses? _____

SCHOOL HISTORY

Does / Did the student attend preschool / pre-kindergarten? Yes ☐ No ☐ If yes, where? _____

Describe any problems noted in preschool / pre-kindergarten: _____

Other schools attended _____

Does your child currently receive any private speech therapy, occupational therapy or physical therapy? ☐ Yes ☐ No

If yes, what type, where and how long? _____

Other Areas of Concern

1. Describe any concerns with your child's self-help skills (e.g. bathing, toileting, fastening buttons or zippers, dressing appropriate for weather, brushing teeth, washing and brushing hair, caring for minor injuries, etc.). _____

_____

2. Describe any concerns with your child's daily living skills (e.g. feeding self, cleaning up after self, preparing a snack or meal, answering the telephone, following safety rules in public, etc.) _____

_____

_____

3. Describe any concerns with your child's communication skills? _____

_____

5. Describe any concerns with your child's social skills? _____

_____

6. Describe any concerns with your child's fine motor (using fingers) or gross motor (walking / running) skills? _____

_____

ADDITIONAL INFORMATION (All STUDENTS)

Any additional comments or concerns?

_____ _____

Name of person completing this form Date

311 South East Street
Kingsland, GA 31548

Telephone: (912) 729-5687
Fax: 1 - (912) 289-0244

Dr. Tracolya Green, Superintendent

Special Education Department
Parental/Guardian
Medicaid or PeachCare for Kids® Consent Form

Student Name:_____ Date of Birth_____
(Last, First)

Identification Number:_____ Social Security Number:_____

Street Address: _____

City _____ State_____ Zip_____

DR. NAME (student's physician):_____

DR. PHONE NUMBER: _____

DR. ADDRESS:_____CITY:_____

Your Local Education Agency (LEA) is providing health-related services that are medically necessary for your child. These services are identified in his/her Individualized Education Program (IEP), the Letter of Medical Necessity (LMN), or the Plan of Care (POC) that your child's doctor signed. The Medicaid or PeachCare for Kids® program is required to cover the cost of certain services.

Your LEA cannot bill Medicaid or PeachCare for Kids® without your consent. If you will allow your LEA to bill Medicaid or PeachCare for Kids® for these medically necessary services, please check the "YES" Box and sign below.

To comply with the requirements of the Family Educational Rights and Privacy Act (20 U.S.C. §1232g and 34 CFR §99.30), I further consent to the release of my child's education records that contain information about the health-related services provided at school and billed to the Georgia Department of Community Health (DCH). I understand these records may be used, as necessary, to make sure the health services received at school are not an exact copy of health services provided by other healthcare providers. I also understand these records will allow DCH (or its agents) to perform reviews of the Medicaid payments made to the school. I understand that I may request a copy of the records disclosed pursuant to this consent.

☐ **YES** I authorize my LEA to bill Medicaid or PeachCare for Kids® for the health-related services listed in my child's IEP, the Plan of Care, or the Letter of Medical Necessity.

☐ **NO** I do not want Medicaid or PeachCare for Kids® billed for the health-related services my child is receiving.

Parent/Guardian Name (Please print): _____

Parent/Guardian Signature:_____ Date:_____

It is my responsibility as a parent to notify the LEA's Special Education Department in writing if I ever decide to withdraw this consent allowing the LEA to seek reimbursement from Medicaid or PeachCare for Kids®. I understand this consent is for the school lifetime of my child.
If you have any questions, please call Camden County Schools 912-729-5687

CAMDEN COUNTY SCHOOLS

311 South East Street
Kingsland, GA 31548

Telephone: (912) 729-5687
Fax: 1-(912) 289-0244

Dr. Tracolya Green, Superintendent

Physician's Documentation of Passed Hearing

Student Name:_____DOB:_____

Examiner:_____Examiner Title:_____Date of Examination

(within 1 year):_____Today's Date:_____

To whom it may concern:

The above student was seen in our offices on the date above. The student has current medical documentation of passed vision via the following:

- ☐ In clinic screening documented on GA Form 3300 **(attached). Date Completed:_____**
- ☐ Audiological Evaluation from a certified Audiologist **(within one year, results attached) Date Completed: _____**
- ☐ Alternative exam by a medical ***doctor*** below:

Physician's Examination: Date Completed:_____

1.	Does the child have or appear to have delayed speech development?	*Yes	No
2.	Does the child understand simple phrases?	Yes	*No
3.	Is the child able to retrieve everyday familiar objects when they are named?	Yes	*No
4.	Does the child have a spoken vocabulary of 20 to 50 words and short phrases ("all done," "go out," "Mommy up")	Yes	*No
5.	Does the child learn new words every week.	Yes	*No
6.	Does the child seem to hear fine some of the time and then not respond at other times.	*Yes	No
7.	Does the child move one ear forward when listening, or he complains that he can only hear out of his "good ear."	*Yes	No
8.	Does the child have a history of ear infections?	*Yes	No
9.	Otoscope revealed decrease movement in eardrum?	*Yes	No

10. Describe any additional behaviors, with regards to hearing, which should be considered during assessment and educational programming: _____

_____

_____

If any of the above is marked with "*", the student should be referred for audiological exam prior to any educational testing. Otherwise, read and sign the statement below:

The above student was examined in our offices on the date below. It is my sincere medical opinion that the student has no suspected hearing loss that may impair acquisitions of speech or language skills and that educational and/or psychological evaluations may proceed at this time without apparent difficulty.

Signature of Medical Doctor	Date

CAMDEN COUNTY SCHOOLS

311 South East Street
Kingsland, GA 31548

Telephone: (912) 729-5687
Fax: 1-(912) 289-0244

Dr. Tracolya Green, Superintendent

Physician's Documentation of Passed Vision

Student Name:_____DOB:_____

Examiner:_____Examiner Title:_____Date of Examination

(within 1 year):_____Today's Date:_____

To whom it may concern:

The above student was seen in our offices on the date above. The student has current medical documentation of passed vision via the following:

- ☐ In clinic screening documented on GA Form 3300 **(attached). Date Completed:_____**
- ☐ Eye Exam from a doctor of Ophthalmology **(within one year, results attached) Date Completed: _____**
- ☐ Alternative exam by a medical ***doctor*** below:

Physician's Examination: Date Completed:_____

1. There is a single position which appears to maximize the student's ability to process visual stimuli? (for example: student sees materials better up close, in the periphery, or at the midline better than other positions. If yes, please explain: _____	*Yes	No
2. Does the child display a behavioral response (eye blink, change in breathing/activity levels, etc.) to the presentation of visual stimuli?	Yes	*No
3. Does the child focus both eyes on visual stimuli?	Yes	*No
4. Does the child fixate his/her gaze on visual stimuli for at least three seconds?	Yes	*No
5. Does the child track visual stimuli horizontally?	Yes	*No
6. Does the child track visual stimuli vertically?	Yes	*No
7. During tracking, are eye movements smooth?	*Yes	No
8. The child loses the visual stimuli at midline or have difficulty following the stimulus across midline?	*Yes	No
9. There is evidence of nystagmus present (jerky eye movement)?	*Yes	No

10. There is evidence strabismus present (eyes move in different directions)?

Yes *No

11. Does child look at objects introduced into his/her visual field?

Yes *No

12. Does the child reach for/pick up objects?

Yes *No

13. Does the child look at pictures?

14. Describe any additional behaviors, with regards to vision, which should be considered during assessment and educational programming: _____

_____

_____

If any of the above is marked with "*", the student should be referred for an eye exam prior to any educational testing. Otherwise, read and sign the statement below:

The above student was examined in our offices on the date below. It is my sincere medical opinion that the student has no vision loss that may impair functioning of daily life skills and that educational and/or psychological evaluations may proceed at this time without apparent difficulty.

_____ _____

Signature of Medical Doctor Date

CAMDEN COUNTY SCHOOLS
311 South East Street
Kingsland, GA 31548
Telephone: (912) 729-5687
Fax: 1-(912) 289-0244
Dr. Tracolya Green, Superintendent

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO: _____

_____

_____

RE: _____ _____
(Birthdate)

I hereby authorize you to release the following documents:

_____ Placement Committee Minutes
_____ Parental Consent for Placement
_____ Educational Screening
_____ Medical and Social History
_____ Psychological Reports
_____ Speech and Language Evaluation
_____ Current IEP
_____ OTHER _____

PLEASE FORWARD THIS INFORMATION TO THE FOLLOWING ADDRESS:

311 South East Street
Kingsland, Georgia 31548
FAX: 1-912-289-0244

This information will be used in the placement and planning of my child's educational program. I understand that granting this consent is voluntary on my part. It is understood that the party to whom this information is released may release it to a third party, if that party has written consent. This authorization will expire 60 days from the date below. I understand that I may revoke this authorization at anytime by contacting the Camden County Schools special education department at 729-5687.

_____
(Parent of Legal Guardian)

_____ _____
Date Records Mailed (Date)

Georgia Department of Public Health
Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

Parent/ Guardian Name:_____
first middle last

Parent/ Guardian Contact Information:

Daytime phone number:_____

Evening phone number:_____

Cell phone number:_____

Child's Name:_____
first middle last

Date of Birth: _____/_____/_____ **Gender:** ❑**Male** ❑**Female**

Child's Home Address:

_____
street city state zip code county

VISION

❑ Unable to screen (explain why below)
❑ Uses corrective lenses
❑ Worn for testing

❑ Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6)
❑ Needs further evaluation
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Local Health Department
❑ Optometrist
❑ "Prevent Blindness Georgia" employee
❑ School Registered Nurse

_____
Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

HEARING

❑ Unable to screen (explain why below)
❑ Uses hearing aid / assistive device

❑ Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB
❑ Needs further evaluation
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Local Health Department
❑ Audiologist
❑ Speech-Language Pathologist
❑ School Registered Nurse

_____
Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

DENTAL

❑ Unable to screen (explain why below)

❑ Normal appearance
❑ Needs further evaluation
❑ Emergency problem observed
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Dentist
❑ Local Health Department Registered Nurse
❑ Registered Dental Hygienist
❑ School Registered Nurse

_____
Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

NUTRITION

❑ Unable to screen (explain why below)

Height: _____ Weight: _____
BMI: _____ BMI%: _____

❑ 5th to 84th percentile - Appropriate for age
❑ < 5th percentile - Needs further evaluation
❑ ≥ 85th percentile - Needs further evaluation
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Local Health Department
❑ Registered Dietician
❑ School Registered Nurse

_____
Screener's Signature Date

I certify that this child has received the above screening.

Contact Information:

FOR SCHOOL SYSTEM ONLY Follow up for further evaluation

	1st attempt	2nd attempt	Actions reported (if any)
Vision			
Hearing			
Dental			
Nutrition			

Student support services initiated on:

Screeners' Comments:

DPH Form 3300 Rev. 2013

Documentation of Interventions Prior to Referral for Special Education Services.
Interventions should be implemented for a Minimum of 2 weeks. A minimum of 4 data points should be collected.

Intervention Implementation and Documentation- (Speech and/or Language)

Student Name:_____ **DOB:**_____
Teacher Name:_____ **Room #:**_____

Area of Concern:

___**Speech/Language:** The above student was unsuccessful on the speech and language screening administered by Camden County Schools on _____(baseline date) in the following area (s).

_____Articulation (speech sounds)
_____Expressive Skills (communicating wants/needs; labeling pictures/objects; answering questions)
_____Receptive Skills (understanding directions; understanding words)

Intervention Recommended: The following intervention (s) were selected in conjunction with the SLP from Camden County Schools:

Articulation:

___Targeted Individual Drill and Practice on the following sound (s)
_____Initial Position_____
_____Medial Position_____
_____Final_____

Expressive Skills:

___Targeted Individual Drill and Practice in the following area (s)
_____Yes/No Questions _____Labeling Pictures
_____Answering "Wh" Questions _____Other:_____

Receptive Skills:

___Targeted Individual Drill and Practice in the following area (s)
_____One-Step Directions _____Two Step Directions
_____Point to Pictures (named by the teacher) _____Other:_____

The teacher evaluated the student on the following dates. Results are as follows:

Date:	***Results***										***Percentage***
Example: 8/26/19	+	-	+	-	+	-	-	-	+	-	*40%*

I, _____, certify that the above interventions have been implemented for a period no less than two weeks prior to referral for special education services.

_____
Signature

Documentation of Interventions Prior to Referral for Special Education Services.
Interventions should be implemented for a Minimum of 2 weeks. A minimum of 4 data points should be collected.

Area of Concern	**Intervention Name (What I did to correct behavior or increase skill)**	**Date:**	***Opportunities***										***Percentage***
	Targeted Individual Instruction: Worked with Matthew one on one using pictures with objects beginning and ending with the / b / sound. Repeated words correctly, stressing the correct sound.	*3-22-14*	+	-	+	-	+	-	-	-	+	-	*40%*
		3-27-14	-	-	-	-	-	-	+	+	-	-	*20%*
		4-1-14	+	+	+	+	-	-	-	-	+	-	*50%*
		4-4-14	+	+	+	+	-	-	-	-	-	-	*40%*
Toileting	Individual Toileting Schedule implemented every 30 minutes	*3-22-14*	-	-	-	-	+	+	+	+	-	-	*40%*
		3-27-14	+	+	+	+	+	-	-	-	-		*60%*
		4-1-14	+	+	+	+	+	-	+	+	+	+	*90%*
		4-4-14	+	+	+	+	+	+	+	+	+	+	*100%*

I, _____, certify that the above interventions have been implemented for a period no less than two weeks prior to referral for special education services.

_____

Signature

Documentation of Interventions Prior to Referral for Special Education Services.
Interventions should be implemented for a Minimum of 2 weeks. A minimum of 4 data points should be collected.

Area of Concern	**Intervention Name (What I did to correct behavior or increase skill)**	**Date:**	***Opportunities***										***Percentage***

I, ____________________________, certify that the above interventions have been implemented for a period no less than two weeks prior to referral for special education services.

____

Signature

BEHAVIOR INTERVENTION DOCUMENTATION

Student Name (D. O.B.) : _____ **Activity:** _____

Date	Time	Antecedent What was happening JUST prior to the behavior occuring?	Behavior	Consequence What happened after the behavio to resolve the problem?	Duration How long did the behavior last?	Intensity
		___ Alone ___ With peers ___ Riding in bus/van ___ Preparing for outing ___ Just ending an activity ___ Participating in group ___ Asked to do something ___ Asked/told "not to" ___ Transitioning ___ Working on academics (which one(s)?_____) ___ At recess ___ Being ignored ___ At lunch ___ Given a warning ___ About to begin new activity ___ Other (describe)	___ Refusing to follow instructions ___ Disrupting class (describe) ___ Making verbal threats ___ Hurting self ___ Destroying property ___ Screaming/yelling ___ Biting ___ Throwing ___ Kicking ___ Running away ___ Grabbing/pulling ___ Crying Loudly ___ OTHER (describe	___ Planned Ignoring ___ Used proximity control ___ Gave a nonverbal cue ___ Gave a verbal warning ___ Changed assignment ___ Redirected ___ Student lost privilege ___ Sent to office ___ Suspended ___ Gave detention ___ Gave a time out ___ Physical assist/prompt ___ Physical escort ___ Physical management ___ Parent Conference ___ Parent Phone Call ___ OTHER	___ <1 minute ___ 1-5 minutes ___ 5-10 minutes ___ 10-30 minutes ___ 1/2-1 hour ___ 1-2 hours ___ 2-3 hours ___ 3+ hours	1 LOW 2 3 4 5 HIGH

NOTES/Description of Incident:

Activity:

Date	Time	Antecedent What was happening JUST prior to the behavior occuring?	Behavior	Consequence What happened after the behavio to resolve the problem?	Duration How long did the behavior last?	Intensity
		___ Alone ___ With peers ___ Riding in bus/van ___ Preparing for outing ___ Just ending an activity ___ Participating in group ___ Asked to do something ___ Asked/told "not to" ___ Transitioning ___ Working on academics (which one(s)?_____) ___ At recess ___ Being ignored ___ At lunch ___ Given a warning ___ About to begin new activity ___ Other (describe)	___ Refusing to follow instructions ___ Disrupting class (describe) ___ Making verbal threats ___ Hurting self ___ Destroying property ___ Screaming/yelling ___ Biting ___ Throwing ___ Kicking ___ Running away ___ Grabbing/pulling ___ Crying Loudly ___ OTHER (describe	___ Student ignored ___ Used proximity control ___ Gave a nonverbal cue ___ Gave a verbal warning ___ Changed assignment ___ Redirected ___ Student lost privilege ___ Sent to office ___ Suspended ___ Gave detention ___ Gave a time out ___ Physical assist/prompt ___ Physical escort ___ Physical management ___ OTHER	___ <1 minute ___ 1-5 minutes ___ 5-10 minutes ___ 10-30 minutes ___ 1/2-1 hour ___ 1-2 hours ___ 2-3 hours ___ 3+ hours	1 LOW 2 3 4 5 HIGH

NOTES/Description of Incident:

I, _____, certify that the above interventions have been implemented for a period no less than two weeks prior to referral for special education services.

Make copies as needed

_____
Signature