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***
   - ___ **Birth Certificate**
   - ___ **Social Security Card**
   - ___ **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 _____ and sent to _____
2. Referral received from BOE on _____.

Referral Complete Comments: _____	Referral Incomplete Comments: _____
Sign Date	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

PLEASE PRINT

Official Use Only
_____
Entry Date
_____
School Entry Code

CAMDEN COUNTY SCHOOLS
STUDENT DEMOGRAPHIC
AND ENROLLMENT INFORMATION

Official Use Only
_____
Homeroom
Revised 11/22

_____
(School)

Student Social Security # _____ **Grade**_____ **Age**_____

Student's Name (Legal Name)_____
(Last) (First) (Middle)

Gender : _____ **Date of Birth** _____ **Place of Birth**: City _____ State _____

Ethnicity: 1. **Is the student Hispanic/Latino?** (Check only one) ☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino

2. **Please select race(s) from list below. (Check all that apply) At least one must be checked.**

☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

☐ Asian ☐ White

Physical Address _____
House # Street Name Apt. # Subdivision

_____ _____ _____
City State Zip Code

Mailing Address _____
Mailing Address Street Apt. #/Route/MHP/Lot P.O.

_____
City State Zip Code

****

Parent/Guardian (P/G) #1 _____ Relationship _____ Last 6 Digits of SSN _____

(P/G) #1 Home Address _____ _____ _____ _____
House # Street Name City State Zip

(P/G) #1 Home Phone # _____ Cell Phone # _____

(P/G) #1 Parent Home Email Address _____

(P/G) #1 Employer _____ If Military-Command _____

(P/G) #1 Employer Work Address _____
Mailing Address City State Zip

(P/G) #1 Work Phone _____ Parent Work Email Address _____

Parent/Guardian (P/G) #2 _____ Relationship _____ Last 6 Digits of SSN _____

(P/G) #2 Home Address _____ _____ _____ _____
House # Street Name City State Zip

(P/G) #2 Home Phone # _____ Cell Phone # _____

(P/G) #2 Parent Home Email Address _____

(P/G) #2 Employer _____ If Military-Command _____

(P/G) #2 Employer Work Address _____
Mailing Address City State Zip

(P/G) #2 Work Phone _____ Parent Work Email Address _____

PLEASE PRINT

****

Marital Status of Parents _____ (S=Single, M=Married, D=Divorced)

If Divorced, list the Custodial Parent _____

****

****

** List All Siblings (Brothers and Sisters Attending Public School)	Name	Grade	Gender	School
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

****

Is the student a dependent of an active member of the Armed Forces? (Circle one) ☐ **Yes** ☐ **No**

Name_____ Relationship_____

MILITARY BRANCH _____ RANK _____

Do you live on Federal Property? ☐ YES ☐ NO If yes, Property _____

Are you a civilian employee working on Federal Property? YES ☐ NO ☐

If yes: NAME_____ OFFICE or AGENCY_____

****

Is student classified as a migrant? ☐ YES ☐ NO If yes, List Migrant # _____

Is this your first year in a school in the United States? Yes_____ No _____

Is the student classified as an immigrant? ☐ **Yes** ☐ **No** **(an immigrant student was not born in any US state, Puerto Rico, or the District of Columbia AND has not been attending one or more schools in any one or more states for more than 3 full academic years)**

****

The purpose of the following questions is to determine if your child might be eligible for additional services under the McKinney-Vento Homeless Assistance Act of 2001.

1. Is the student currently living in a fixed, regular, and adequate nighttime residence**?** ☐ YES ☐ NO

2. If the student's residence is only temporary please explain the circumstances**.**

If you answered NO to question l, please contact the clerk or counselor at the neighborhood elementary school for more information to determine if your child is eligible for additional services under the Homeless Act.

****

As the parent/guardian completing this enrollment form, please list any other person(s) legally authorized to make changes on this form.

Name _____ Relationship _____

Name _____ Relationship _____

****

I understand that my signature below certifies that all information that I have provided on the enrollment form is accurate.

_____ _____

Signature of Parent/Guardian **Date**

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

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)

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

Things I have tried at home to address my child's areas of concern (Please check all that apply):

Area of Concern: Speech Intelligibility
Beginning Date:_____End Date:_____

	Learning in Action:
	Private Speech therapy at_____
	Repeated words correctly, stressing the correct sound
	Praise child's attempts at producing sound correctly.
	Other:

Area of Concern: Expressive Language
Beginning Date:_____End Date:_____

	Learning in Action:
	Private Speech therapy at_____
	Asked child to name objects in the environment ("What is this____?") Provided corrected response as needed.
	Used pictures depicting actions (for example, playing, cooking, sleeping, etc). Asked child to name the action ("What is this girl doing?") Provided corrected response as needed.
	Used a children's book with objects/actions. Asked child to name the object/action ("What is this____?") Provided corrected response as needed.
	Other:

Area of Concern: Receptive Vocabulary
Beginning Date:_____End Date:_____

	Learning in Action:
	Private Speech therapy at_____
	Name objects in the environment, asked child to find the named objects. Provided corrected response as needed.
	Used a children's book, targeted key vocabulary by labeling objects. Asked the child to point to object as it was named.
	Other:

Area of Concern: Following Directions
Beginning Date:_____End Date:_____

	Learning in Action:
	Private Speech therapy at_____
	Broke down instructions into small, manageable parts.
	Repeated/rephrased directions. Provided physical assistance. Repeated the direction again.
	Other:

Area of Concern: Communicating Wants and Needs.
Beginning Date:_____End Date:_____

	Learning in Action:
	Took pictures of common actions (eating, drinking) and food items. Asked "What do you want?" Provided assistance in selecting needed item. Repeated word or action. Gave the child the requested item.

Things I have tried at home to address my child's areas of concern (Please check all that apply):

	Provided praise for child's attempts at labeling.
	Other:

Area of Concern: Toilet Training.
Beginning Date:_____End Date:_____

	Learning in Action:
	Set timer for every 30 minutes. Reminded child to go to the restroom.
	Provide hand over hand assistance with clothing. Assist child to sit on the toilet. Allow to child to leave restroom after 2 minutes of sitting or voiding.
	Other:

Area of Concern: Academic Skills.
Beginning Date:_____End Date:_____

	Learning in Action:
	Targeted letter identification through use of flash cards/ games/ activity books.
	Used a variety of objects, practiced counting out loud from 1- 10
	Other:

Area of Concern: Behavioral Skills
Beginning Date:_____End Date:_____

	Learning in Action:
	Behavior therapy at:
	Counseling at:
	Have a regular schedule in place
	Set a timer for 30 minutes. Provide reinforcement through stickers or verbal praise for appropriate behavior.
	Make pictures of scheduled activities so the child can reasonably be assured of what happens next in order to aid in transitions.
	Time-out from reinforcement: Provided a time out area. Set a timer for 2 minutes. Reset timer if child left the time out area.
	Other:

Other Area of Concern. Describe:_____

	Learning in Action:

Reminders!

1. Complete All Forms enclosed.
2. Attach all Required Documents:
    - Birth Certificate
    - Social Security Card
    - Medicaid/Peach Care/Well Care Card (if applicable)
    - Vision Documents
    - Hearing Documents
    - Interventions
3. Submit all documents prior to the 02/15/2023
4. Per GA regulations, no evaluations are conducted after the end of the current school year.