FULTON CITY SCHOOL DISTRICT
Student Support Services Office
167 South Fourth Street
Fulton, NY 13069
315-593-5520

COMMITTEE ON 504 REFERRAL

Student_____ School_____

Date of Birth_____ Grade_____

Parent/Guardian_____ Teacher/Counselor_____

Relationship to student_____ Emergency Contact_____

Address_____ Mother's Work#_____

_____ Father's Work#_____

Home Phone#_____ Language_____

REASON FOR REFERRAL: (Please describe specific concerns)

FOR NEW REFERRALS/RE-REFERRALS

- List previous programs, accommodations and support services

- Attach documentation of **pre-referral interventions**, including:
  - Intervention team meeting dates, minutes and summaries
  - Nature of interventions
  - Intervention frequency and duration (include specific dates)
  - Intervention data summary
  - Objective measures of progress, response to interventions
    - (e.g. DIBELS, Curriculum-Based Measures)

IF ABOVE ARE NOT APPLICABLE, THE BUILDING ADMINISTRATOR IS TO ATTACH A RATIONALE STATEMENT JUSTIFYING THE ABSENCE OF PRE-REFERRAL INTERVENTIONS.

FOR TRANSFER STUDENTS:

Previous District_____ State_____

Previous Teacher/Counselor_____ Phone_____

Previous Classification_____ Previous Services_____

SIGNATURES – BUILDING INTERVENTION TEAM:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SIGNATURE – BUILDING PRINCIPAL:_____ **DATE**:_____

SIGNATURE – 504 CHAIRPERSON:_____ **DATE:**_____

FOR OFFICE USE ONLY:

_____

Student ID #_____

_____ New Referral

_____ Transfer Student Previous District_____

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RELEASE TO EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize you to exchange all pertinent and confidential information regarding:

Student's Name_____

Date of Birth_____

The information may be exchanged with:

Agency Name: **Committee on 504**
Fulton City School District
167 South Fourth Street
Fulton, NY 13069

This release has been authorized by:

Signed _____

Relationship _____

Date _____

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Confidential Social History Report

Report prepared by_____ Title_____ Date_____

History Obtained During: Home Visit_____ Office Visit_____ Phone Call_____ Other_____

Information Provided by:_____ Relationship to Child_____

Identifying Information:

Student's Name_____ Date of Birth_____ Age_____

School_____ Grade_____ Grade(s) Repeated_____

Address_____ Phone_____

Does your child receive free or reduced lunch? Yes_____ No_____

Parent/Guardian Information:

Mother's Name_____ Age_____ Education Level_____

If deceased_____ Occupation_____
(date) (cause)

Name of Employer_____

Work Phone_____

Father's Name_____ Age_____ Education Level_____

If deceased_____ Occupation_____
(date) (cause)

Name of Employer_____

Work Phone_____

Pregnancy and Birth History:

Were there any significant problems during pregnancy or at birth? _____

_____

Was the child born premature? If so, how early?_____

Developmental History:

When did the child crawl?_____ talk?_____ walk?_____ become toilet trained?_____

speak single words?_____ simple sentences?_____

Have there been any emotional difficulties, traumatic events that the staff should be aware of? (E.g. Separation, divorce, illness, arrest, death) _____

_____

Medical History & Physical Condition:

How is the child's health in general?_____

Does you child have health insurance? _____ Name of provider_____

Does your child wear glasses/contacts? Yes_____ No_____

Is the child currently under medical treatment or on medication? If so, please describe_____

_____

Medication taken at home_____ Dosage_____

Medication taken at school_____ Dosage_____

About how many hours a night does you child sleep?_____ Usual bedtime?_____
Time wake up?_____

Does you child have any problems getting to/or staying asleep, or getting up? If so, please

describe_____

_____

Does your child have any allergies?_____

Describe any accidents, serious injuries, illnesses, head injuries, operations and/or hospitalizations with age of occurrence (date, hospital, doctor)_____

_____

_____

Educational History:

Did your child attend preschool?_____ If so, where and how long?_____

Has your child ever been evaluate?_____ If so, please describe_____

Has you child received any of the following services?

____Early Intervention	_____Preschool Special Education	____Special Education
____Counseling	_____Speech Therapy	____Occupational Therapy
____Physical Therapy	_____Evaluation by an outside source	

Please list previous preschools attended_____

_____

Behavior at Home/School:

Below is a list of common childhood problems. Indicate the occurrences of these problems by **circling the correct response.**

O for Often S for Sometimes N for Never

1. Sleep Disturbances	O	S	N	11. Hurting Pets	O	S	N
2. Bedwetting	O	S	N	12. Setting Fires	O	S	N
3. Shyness	O	S	N	13. Strong Fears	O	S	N
4. Refusal to Obey	O	S	N	14. Fighting	O	S	N
5. Temper Tantrums	O	S	N	15. Stealing	O	S	N
6. Lying	O	S	N	16. Destructiveness	O	S	N
7. Hurts Others	O	S	N	17. Hyperactivity	O	S	N
8. Crying	O	S	N	18. Inattentive	O	S	N
9. Separation Anxiety	O	S	N	19. Bullies Others	O	S	N
10. Refuses to Attend School	O	S	N	20. Is Bullied	O	S	N

Family History:

1. Who does the child live with?_____

   If not the biological parents, what is the relationship?_____

   If the child does not live with the biological parents/legal guardian, who has custody?_____

   _____

2. Primary language spoken in the home_____ Parent needing an interpreter?_____

3. Persons living in the home other than parents and siblings? Their relationship to the child: _____

   _____

4. Brothers and Sister: Name_____ DOB_____
   Name_____ DOB_____
   Name_____ DOB_____
   Name_____ DOB_____

5. Other children in household: Name_____ DOB_____
   Name_____ DOB_____
   Name_____ DOB_____
   Name_____ DOB_____

6 Do any of the children have severe health, physical, or emotional problems?_____

_____

7. Did anyone other than the parents raise the children at any time? (E.g. Grandparents, foster parents, residential
care)_____

8. Are there any family members with a history of (If so, whom?)

Learning Problems, Special Education Support Yes _____No_____ Person_____

Physical Problems? Yes_____ No_____ Person_____

Psychiatric Emotion concerns (e.g. Depression, Bipolar Disorder)
Yes_____ No_____ Person_____

Alcohol Substance Abuse Problems? Yes_____ No_____ Person_____

9. Number of changes in residence since your child's birth?

0_____ 1-2_____ 3-4_____ 5 or more_____

10. Agencies involved (e.g. D.S.S., Fulton Youth & Family, Youth Advocacy Program, etc.)

_____

11. What are the sources of financial support for the family? Please check all that apply:

_____Employment _____SSI
_____Public Assistance _____TANF
_____Food Stamps _____WIC
_____HUD _____HEAP
_____Child Support _____Medicaid

12. Is there anything else you would like the school to be aware of that might help them to better serve your child?_____

_____

_____

_____

_____