FULTON CITY SCHOOL DISTRICT
Special Education Office
167 South Fourth Street
Fulton, NY 13069
315-593-5520

COMMITTEE ON SPECIAL EDUCATION 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 – C.S.E. CHAIRPERSON:_____ **DATE:**_____

FOR OFFICE USE ONLY:

_____

Student ID #_____

_____ New Referral

_____ Transfer Student Previous District_____

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CONSENT FOR REFERRAL, EVALUATION AND PLACEMENT TRANSFER STUDENT

Dear Parent/Guardian:

In order to conduct a review of your child's special education program the district is requesting your written consent to evaluate your child. Your consent is voluntary and may be reconsidered at any time with your written request.

If you should have any questions or concerns, please do not hesitate to call your child's teacher or the Special Education Office. Your prompt response would be appreciated.

Sincerely,

Katherine Adams
Chairperson on
Committee on Special Education

RE:

I have received and understand the notice that my child has been referred to the Special Education Committee for evaluation and I hereby grant consent for evaluation by the Special Education committee regarding my child. I further consent to my child's placement in a program similar to the program my child was placed in previously.

_____
Student Name

_____
Parent/Guardian Date

FULTON CITY SCHOOL DISTRICT
Special Education Office
167 South Fourth Street
Fulton, NY 13069
315-593-5520

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 Special Education**
Fulton City School District
167 South Fourth Street
Fulton, NY 13069

This release has been authorized by:

Signed _____

Relationship _____

Date _____

FULTON CITY SCHOOL DISTRICT
Special Education Office
167 South Fourth Street
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315-593-5520

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 evaluated?_____ 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?_____

_____

_____

_____

_____

SPECIAL INSTRUCTIONAL PROGRAMS AND PUPIL SERVICES
167 South Fourth Street
Fulton, NY 13069
Phone: 315-593-5520
Fax: 315-593-5519
E-Mail: kadams@fulton.cnyric.org

Dear Parent/Guardian:

Your child currently receives speech, occupational therapy, physical therapy, counseling, psychological testing, nursing services, audiological services, and/or transportation services which are eligible for Medicaid reimbursement. We are required to have a signed "Release of Information" form from you before we can bill Medicaid. Would you please sign and return the enclosed forms, along with the consent form for special education services, in the envelope provided. If the Fulton City School District receives these reimbursement monies, it would help us financially. This in turn would help children and programs. We appreciate your help in this matter.

Sincerely,

Katherine Adams
Director of Special Education