

# Child Find Referral Form

Child's Name: \_\_\_\_\_ Date \_\_\_\_\_

Child's Birthdate: \_\_\_\_\_

Primary Language of the Child: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Primary Language of the Parents: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Person Making Referral: \_\_\_\_\_ Phone: \_\_\_\_\_

## What are the primary concerns about the child's development?

Please check those that are applicable to your child's development below:

- Pre-Academic Skills
- Speech/Communication
- Self-care Skills Toilet Training
- Fine Motor/small muscles
- Gross Motor/large muscles
- Visual Perception
- Vision
- Hearing
- Social Skills

Other concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child received a specific medical diagnosis? Please list.

\_\_\_\_\_

Please list any medications your child is currently taking:

\_\_\_\_\_

Has your child had any significant medical concerns?

\_\_\_\_\_

I give my permission to share this information with the Special Education Team at SRSD.

Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_

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To be completed by district staff member.

Date of Inquiry: \_\_\_\_\_ School: \_\_\_\_\_

Staff Member: \_\_\_\_\_ Position: \_\_\_\_\_

Please send referral form to:  
Tonyel M. Berry, Director of Student Services  
Shaker Regional School District  
58 School Street  
Belmont, NH 03220