ARLINGTON PUBLIC SCHOOLS
EDUCATE • PREPARE • INSPIRE

Child Find Referral for Special Education Evaluation

Student's First Name | Middle Name | Last Name | Date of Birth | Gender

Ethnicity/Race | Primary Language | Language spoken at home (if different)

Parent/Guardian #1 Legal Name | Primary Phone | Cell Phone

Parent/Guardian #2 Legal Name | Primary Phone | Cell Phone

Address | City | State | Zip

Mailing Address (if different) | City | State | Zip

Email Address | Preschool/Daycare

Siblings (Please include age and school attending)

Has your child ever received services? ☐ Yes ☐ No

If yes, when & where?

Areas of concern:
☐ Cognitive/Pre-Academic ☐ Medical/Physical ☐ Behavior ☐ Vision/Mobility ☐ Motor
☐ Adaptive ☐ Social/Emotional ☐ Communication ☐ Sensory
☐ Other _____

Comments:

Office use only

Person making request | Relationship to student

Date referral discussed with parent:

Phone call | In person | Written | Email | Appointment date & time

Received by | Title | Date

Entered by | Date | ☐ Address verified | School