Date Received: \_\_\_\_\_\_\_\_\_\_\_\_

Number:

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

Circle Type:

Early On-B3

Preschool 3-6

6 yrs-26 yrs old

 **IOSCO REGIONAL EDUCATIONAL SERVICE AGENCY**

 **REFERRAL FOR SPECIAL EDUCATION SERVICES**

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|  **STUDENT (first name) Student (middle name) Student (last name) Verifier:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  **ADDRESS: Birthdate: Birth Place:**  |
|  **City/Zip:**  |
| **(CIRCLE ONE) Birth Record Y / N Shot Record Y / N Sex: M / F Hispanic Y/N Race: \_\_\_\_\_Age: Verifier:** |
|  **PARENT/GAURDIAN:**  |
|  **Telephone #: Home: Work: Emergency Contact:** |
|  **Resident School: County: Grade: Attending School:** |
|  **Classroom Teacher(s) including support personnel:** |
|  **Student's Language: Parent(s)Language:** |
| **1. Why do you believe that this student needs to be considered for special education services?** |
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| **2. What regular education or community program options have been exhausted prior to considering this request? What strategies and techniques have been used to try and overcome these concerns; and how long were these different strategies tried and by whom?** |
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| **3. Describe the student’s specific learning, developmental, or behavioral weaknesses, (include the student’s current levels of functioning in these areas and how these weaknesses impact the student’s ability to function in regular education without special education assistance.**  |
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|  |
| **4. Describe the student’s strengths, (including these student current levels of functioning in theses areas and how these strengths enable these student to benefit in regular education with or without special education assistance).**  |
|  |
| **5. Who has discussed these concerns with the parent(s) and when?**  |
| **Referring Persons Signature/Contact Number/Date Administrators Signature/Date** |