Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

Tony Jordan, Executive Director
1100 H Street • Modesto CA 95354 • (209) 238-1800 • FAX (209) 238-4217

HEAD START REFERRAL FOR SPECIAL EDUCATION SERVICES

Date Completed:_____ Date Referral Submitted: _____

Child's Name:_____ Date of Birth: ____/____/____ Gender: M F
Last First

Head Start Center: _____ Teacher:_____ Enrollment Date:_____

Parent/Guardian:_____

Address:_____
Street City Zip Code

Mailing Address (if different):_____

Phone (Home):_____ Cell Phone:_____ Email address:_____

Ethnic Background:_____ Primary Language: _____

Screening Results: Vision:_____ Hearing:_____ Developmental:_____

Referral Area of Concern: Speech/Language ☐ Cognitive ☐ Medical Condition ☐

Describe specific reasons for referral? _____

_____

_____

_____

What interventions have you tried to help alleviate the problem(s) and results? _____

_____

_____

_____

_____

_____

Describe child's strengths?_____

_____

_____

_____

Referred by:_____ Position:_____

Distribution: White - Grantee Disabilities Supervisor
White – Delegate Disabilities Coordinator (MHS)
Yellow – Child File
Pink – Parent