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

CHILD SUCCESS TEAM REQUEST

Identifying Information

Service Options: ____ Center Based ____ Home Based ____ FCCH ❑ Full Day ❑ AM ❑ PM
____ EHS ____ RHS ____ MSHS

Location_____ Teacher/Provider_____ Enrollment Date _____

Child's Name_____ M_____ F_____ DOB_____

Parent/Guardian _____Phone _____

Address _____ City_____ ZIP _____

District of Residence_____ Primary Language _____
(*If Unknown, Leave Blank)*

Contact Made

Parent/Guardian_____ Date_____

Delegate Coordinator/Site Supervisor _____Date _____

COPA Referral Submitted by _____ Date _____

Screening Results

Vision: _____ Hearing: _____ ASQ:SE: _____ ESI: _____ ASQ: _____

Referral Area of Concern

☐ Health/Medical ☐ Speech/Language ☐ Cognitive ☐ Behavioral/Social/Emotional
☐ Individual Social/Emotional Observation requested

Describe specific reasons for referral: _____

_____

_____

Describe pre-referral interventions used (include environmental modifications) and results:_____

_____

_____

_____

Describe child's strengths:_____

_____

Participants

☐ Parent ☐ Head Start Teacher ☐ Child Care Specialist
☐ Site Supervisor ☐ Education Coordinator ☐ Disabilities Coordinator
☐ Family Service Worker ☐ Mental Health Consultant ☐ District/SELPA Staff

Submitted by:_____ **Title:**_____ **Date:**_____

Phone:_____ **E-Mail Address:**_____

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