

**East Ramapo Central School District
Committee on PreSchool Special Education**

Referral Form

Committee on PreSchool Special Education

Student Name _____ Date of Birth _____
(Last) (First)

Parent/Guardian _____ School ID # _____

Address _____ SS # _____
City State Zip Medicaid #

Phone # *(Home)* _____ *(Work)* _____ *(Cell)* _____

Parent's Dominant Language _____ Student Ethnicity _____

Student's Dominant Language _____

Referred by: _____ Phone: _____
YES NO

Do you believe your child has special education needs? YES NO
Please describe your educational concerns in detail; _____

Parent Signature _____

What interventions/services have taken place prior to this referral?

Type of Program _____

Related Services _____

Does child presently attend a PreSchool Program? YES NO

Name of School _____

Address _____ Phone _____

City State Zip