For office use only: Date Sent_____
Date Received_____

Forsyth County School System
Early Childhood Programs
Developmental Evaluation Referral Questionnaire

GENERAL INFORMATION

Child's Name:_____ Date of Birth:_____ Age:_____
(First) (Middle) (Last)
Sex: (circle) Male Female

Home Address:_____
(Street) (City) (Zip Code)
Home Phone Number: _____ Alternate Number:_____

Email Address: _____

Neighborhood Elementary School: _____

Referred By: _____ Relationship: _____
Address: _____ Phone Number: _____

Person completing form: (circle) Mother Father Stepmother Stepfather Other:_____

Qualities and characteristics that please you most about your child: _____
_____

Reason for referral (describe what concerns you most about your child and your reason for referral: ___
_____
_____

How long has the problem(s) been of concern to you? _____
Goals for your child: _____
_____
Describe your child's favorite activities, toys, and interests: _____
_____

Does your child attend: ___Daycare ___ Preschool ___ Governor's Pre-K ___Head Start ___Early Intervention Program
Name/Address of the above:_____

Mother's Name: _____Age: _____ Education: _____
Occupation: _____Home Phone # _____Work Phone # _____
(___ Biological ___Adoptive ___Step ___Foster ___Guardian)

Father's Name: _____Age: _____ Education: _____
Occupation: _____Home Phone # _____Work Phone # _____
(___ Biological ___Adoptive ___Step ___Foster ___Guardian)

Child lives with: (circle) Both Parents Mother Father Other:_____
Marital Status of Parents: (circle) Married Separated Divorced Widowed Single
If parents are separated or divorced, how old was child when this occurred? _____

Primary language spoken at home: _____
Other language spoken in the home: _____

List all siblings/other relatives, foster children, friends currently living in household:

Name	*Relationships to the child*	*Age*

If any brothers or sister are living outside the home, list their names and ages: _____
_____

Has your child been diagnosed with any syndromes or medical conditions? Yes No
If yes, please list or describe: _____

_____

_____

Please check any condition that any member or the immediate family has had. Please not the member's relationship to the child.

Condition:	*Relationship to the child:*
__Learning Problems	_____
__Speech/Language Disorder	_____
__Attention Deficit Disorder	_____
__Hearing or Vision Impairment	_____
__Other ( )	_____

PREGNANCY/BIRTH HISTORY

During pregnancy:
Was mother on medication? YES NO
(If yes, describe:_____)

Did mother smoke? YES NO
Did mother drink alcoholic beverages? YES NO
Did mother use drugs? YES NO
(If yes, list: _____)
Did mother experience problems with: ___chronic disease __poor nutrition __trauma
___ vaginal bleeding __toxemia __viral infection
___premature labor __hypertension
___gestational diabetes ____other _____
Were forceps used during delivery? YES NO
Was vacuum suction used during vaginal delivery? YES NO

PREGNANCY/BIRTH HISTORY (continued)

Was a Cesarean Section performed? YES NO
(If yes, state reason _____)
Was the child breech (feet first)? YES NO
Was the child premature? YES NO
(If so, by how many weeks _____)
Were there any birth complications? YES NO
If yes, please describe: _____
Was there any special care needed following birth? ___incubator ____ oxygen ____monitors ___other
If other, please describe: _____

Birth weight:_____ Was baby discharged with mother? YES NO
If no, how long was the baby hospitalized? _____

Were there any feeding/swallowing problems? YES NO
If yes, please describe: _____
Were there any sleeping problems? YES NO
If yes, please describe: _____
As an infant, was the child more quiet than typical? YES NO
Did the child like to be held? YES NO
Was the child alert? YES NO
Were there any special problems during the first few years of life? YES NO
If yes, please describe: _____

DEVELOPMENTAL HISTORY

The following is a list of infant and preschool behaviors. Please indicate the age at which your child demonstrated each behavior. If you are not certain of the age, but have some idea write the age followed by a question mark.

Behavior	Age	Behavior	Age
Showed response to parent	____	Put several words together	____
Rolled over	____	Fed self	____
Sat alone	____	Dressed self	____
Crawled	____	Became toilet trained	____
Walked alone	____	Stayed dry at night	____
Babbled	____	Rode tricycle	____
Spoke first word	____		

MEDICAL/HEALTH INFORMATION

Please specify any of the following that apply to your child's medical history:

Illness/Condition	Age	Illness/Condition	Age
Allergies	____	Cleft Palate/Lip	____
Asthma	____	CMV	____
Bleeding Disorder	____	Concussion	____
Cerebral Hemorrhage	____	Craniofacial Deformities	____
Chronic Colds	____	Diabetes	____

MEDICAL/HEALTH INFORMATION (continued)

Chronic Ear Infections	____	Ear Tubes/Surgery	____
Encephalitis	____	Fragile X	____
Fevers over 104 degrees	____	Genetic Disorders	____
Head Injuries	____	Heart Problems	____
Shunts	____	Sinus	____
Spina Bifida	____	Sickle Cell Anemia	____
Meningitis	____	Tremors (location:_____)	____
Vocal Nodules	____	Tonsillitis	____
Other: _____	____		
_____	____		
_____	____		

List any additional operations, hospitalizations, or injuries your child has had:

	AGE
_____	____
_____	____

Does your child use any assistive/adaptive devices? ___glasses ___braces ___wheelchair ___walker/crutches ___hearing aide ___other: (Please specify _____)

Please list any medication your child is presently taking:

Medication	Dosage	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL/OTHER SERVICE PROVIDERS

Pediatrician _____	Phone: _____	
Cardiologist _____	Phone: _____	
Neurologist _____	Phone: _____	
Gastroenterologist _____	Phone: _____	
ENT _____	Phone: _____	
Orthopedist _____	Phone: _____	
Psychologist/Psychiatrist _____	Phone: _____	
Ophthalmologist _____	Phone: _____	

		Presently Involved	No longer Involved
Physical Therapist _____	Phone: _____	_____	_____
Occupational Therapist _____	Phone: _____	_____	_____
Speech/Language Therapist _____	Phone: _____	_____	_____
Other: _____ (e.g. special Instruction, Music Therapy)	Phone: _____	_____	_____
BCW Service Coordinator _____	Phone: _____	_____	_____

LANGUAGE/MOTOR/BEHAVIOR/COGNITIVE DEVELOPMENT

Please indicate which of the following describes your child and/or concerns you:

___Speech /Language Difficulty

___Gestures/points instead of using words
___ Speech appeared to develop and then stopped
___ Uses babbling (baba, dada)
___ Stuttering
___ Hoarseness

___Uses jargon (unrecognizable words)
___ Inability to produce speech sounds
Specify: _____
___ Inability to follow directions
___ Inability to understand words/sentences
___ Other _____

___Unable to repeat 2, 3, 4 word phrases
___Inability to be understood

___Not combining words into sentences
___ Difficulty answering questions

Please indicate the number of words your child uses spontaneously
__0-10 ___10-20 ___20-50 ___50-100 ___more than 100 ___too many to count How many signs: ___
(If your child uses less than 50 words or signs, it would be helpful if you brought a list of those words to the evaluation.)

Please describe how your child's speech/language difficulties affect his/her daily life:

_____
_____

___ Motor Concerns

___ Difficulty with coordination
___ Difficulty walking, running
___ Clumsiness
___ Difficulty eating

___Inability to sit without support
___ Falls/trips frequently
___ Difficulty dressing, buttoning zipping
___ Difficulty using pencils, crayons, Scissors

___ Difficulty with puzzles/Manipulative toys
___ Difficulty with balance, jumping, hopping
___ Difficulty negotiating stairs, curbs, playground
___ Other _____

___ Behavior/Social Concerns

___Bullies other children
___Prefers to be alone
___Is inattentive
___Is impulsive
___Cries easily
___Is obedient
___Is cruel to animals/people
___Bites nails/fingers
___Easily frustrated
___Is stubborn
___Unusual fears
___Gives up easily
___Doesn't have any friends
___Having behavior difficulty at Preschool/daycare
___Other: _____

___Is shy or timid
___Is aggressive
___Restless/difficulty sitting still
___Has frequent tantrums
___Tells lies
___Worries about many things
___Unhappiness/sadness
___Fussy or over particular
___Difficulty playing with other children
___Is noncompliant
___Does not separate easily
___Kicks, bites, hits others
___Has wet/soiled this year

___Difficulty with changes or routines
___Highly sensitive to sounds
___Highly sensitive to textures
___Distracted by lights or visual stimuli
___Insensitive to pain
___Plays repetitively with certain toys
___Mouths toys frequently
___Seeks out rocking, spinning, swinging
___Head banging
___Biting
___Twitches/mannerisms/tics of face or body
___Will not work in a group
___Destroys others' belongings

___Cognitive Concerns

___Inability to imitate simple games (pat-a-cake, peek a boo)
___Difficulty ___learning ABC's___ rote counting___ matching/naming: ___colors ___shapes
___Difficulty understanding a variety of concepts such as "big/small", "same/different", etc.
___Difficulty following instructions related to daily routines
___Difficulty following simple directions
___Does not seem to understand well
___Does not appear to be learning as well as other children
___Other: _____

___**Hearing Concerns**

Does the child display an awareness of noisemaker/speech (such as eye widening, eye blink, smiling, laughing, assuming a listening posture, cessation of activity, etc.)? If yes please elaborate. _____	Yes	No
Does the child respond to a sound outside his field of vision? (e.g. turns head or eyes in the General direction of the sound)	Yes	No
Does the child directly localize the source of sound from a noisemaker or person	Yes	No
Does the child respond to or imitate babbling/nonsense syllables?	Yes	No
Does the child respond auditorily to his/her name?	Yes	No
Does the child point to specific people, objects, or pictures when asked?	Yes	No
Do you have any vision concerns? If yes, explain: _____ _____ _____	Yes	No

- **Please include copies of any reports or evaluations that might be helpful in our evaluation of your child.**

If you have any questions or need assistance in any way, please call Kristi Quinn at 770-887-2461 ext. 310138

Forsyth County School System

CHILD STUDY TEAM

PARENT CONSENT FOR SCREENING

Date: _____

Dear Parent/Guardian:

Your child, _____, has been referred for a classroom observation or a school screening that will be helpful in determining specific problem areas. Test results will be used by the Child Study Team to plan remedial help, assist the teacher in designing alternative teaching techniques, or in determining the need for more comprehensive evaluation.

****

_____ I agree for my child to be screened/observed

_____ I do not agree

Child's name _____ DOB _____

Parent's name_____ Parent's phone #_____

Parent's email_____

_____ Date _____
Parent's Signature

Preschool/Day care _____ Days and times attending_____

Revised 10/26/17

Forsyth County School System
Parent/Guardian
Medicaid and or PeachCare Consent Form

Student Name _____ DOB _____
Last First Middle

Phone Number_____

Medicaid Number _____ Peach Care Number _____

Address_____

City_____ State _____Zip Code_____

Health Insurance Company Name_____ Policy No. _____

Health Insurance Address_____

Primary Care Physician Name _____

Physician Address _____
Street City State Zip

_____Copy of Medicaid Card Attached _____Copy of Peach Care Card Attached

The School System is providing the health-related services to your child in accordance with his/her Individual Education Program or Physician Plan of Care. Medicaid and or PeachCare are required to cover the cost of certain services to eligible students.

Changes in state Medicaid and or PeachCare policy allow school systems to be reimbursed for some of the cost of rehabilitative services provided by the school. The School System can not provide these services to your child or bill Medicaid/PeachCare without your consent. If you allow the school system to bill Medicaid or PeachCare for the health related services that your child is receiving in accordance with his/her IEP or Physician Plan of Care, please check the "Yes" boxes and sign below.

☐ YES I authorize the School System to bill Medicaid and or PeachCare for the health related services listed in my child's IEP or Physician Plan of Care and to send the appropriate IEP Documentation to the physician allowing the physician to give the school system the necessary referral or script for treatment as per IEP.

☐ NO I do not want Medicaid and or PeachCare billed for the health related services my child is receiving.

☐ My child does not qualify for Medicaid or PeachCare.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

It is my responsibility as a parent to notify the school system's special education department in writing if I ever decide to withdraw this consent allowing the school to seek reimbursement from Medicaid and or PeachCare. I understand this consent is for the school lifetime of my child.

If you have any questions, please call: Tricia McCraw @ 770-887-2461 ext. 202324 or email pmccraw@forsyth.k12.ga.us