Margaretville Central School
PO Box 319, 415 Main Street
Margaretville, NY 12455

CHILD FIND FORM

I have reason to believe that _____may possess a disabling condition. I am making this referral for an individual evaluation and a determination of eligibility for special education programs and services.

Name of Child:	Date of Birth:	Age:
Ethnicity:	Primary Language:	Gender: ☐ F ☐M
Is the child currently in school? If yes, level? ☐Preschool ☐ Grade _____		Is the child receiving special education services? ☐ Yes☐No
Name of Person Making Referral:		Relationship to child:
Parent/Guardian Name:	Mailing Address:	Phone Number:

Reason for referral (Be very specific and describe the child.):

Describe the child's current academic or pre-academic skills:

Does the child have any medical diagnoses or health issues (including vision and/or hearing)?

Describe any evaluations the child has had by other agencies or doctors:

Where can copies or reports be obtained?

_____ _____

Signature Date

DATE WHEN RECEIVED BY CHAIRPERSON OR BUILDING ADMINISTRATOR:_____

cc: **CSE Chair**
Building Administrator