Orleans Central Supervisory Union

130 Kinsey Road Barton, VT. 05822
Tel: 525-6255 Fax: 525-6260

Special Education Referral Form

Referral Made By: □ 504 □ EST □ Parent □ Other: _____

Today's Date: _____

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Age: _____

Parents'/Guardians' Name: _____

Home Address: _____

Phone Number: _____

Has child been previously tested for similar concerns? (at school or through outside agencies)

_____

Does the child have any current diagnoses? _____

_____

Date received by district personnel: _____

Signature of person accepting referral for Special Education

_____

(Initial Evaluation Planning meeting required to initiate the Special Education Evaluation process. Meeting must be held within 10 days of receipt of a verbal or written request for a Special Education Evaluation.)

Date Form Last Modified: September 6, 2018