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:

_____

Name of person making referral: _____

Please attach a copy of 504/EST plans

Today's Date: _____

Student's Name: _____ Date of Birth: _____ Age: _____

School: _____ Grade: _____ Teachers Name: _____

Parents'/Guardians' Name: _____

Home Address: _____

Phone Number: _____

Parents Email: _____

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

YES NO

Are there any suspected disabilities? _____

_____

Does the child have any current diagnoses? _____

_____

_____ _____

Signature of person accepting referral for Special Education Date Received

(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.)