DORCHESTER SCHOOL DISTRICT FOUR
Department of Exceptional Children

CHILD FIND REFERRAL FORM

Please complete and return this form if you know or suspect a child with a disability or a child that may need further assessment by the Student Assistance Team, School Psychologist, or Speech Pathologist.

CHILD'S NAME:		AGE:
GRADE (If applicable):	DATE OF BIRTH:	RACE:
SCHOOL (If applicable):		GENDER:
PARENT/GUARDIAN:		
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME TELEPHONE:	WORK TELEPHONE:	
SUSPECTED PROBLEM/DISABILITY:		
ADDITIONAL COMMENTS:		

REFERRED BY: _____

DATE: _____