**Child's Name:** _____
**Date of Birth:** _____

**Miami-Dade County Public Schools**
**Florida Diagnostic and Learning Resources System – South (FDLRS-South)**
**Child Find Referral Packet**
**6521 S.W.62nd Avenue, South Miami, Florida 33143**
**Main Office - Phone: (305) 274-3501**

Dear Parent/Guardian,

Your child has been referred to FDLRS-South for a screening and/or evaluation to determine the possible need for special education services from Miami-Dade County Public Schools (M-DCPS). Below is a list of the documents that need to be completed and submitted prior to or at the time of the scheduled screening.

Please complete and provide the following list of documents to FDLRS-South. The documents with an asterisk are required to process the case. Check the boxes to the left of the listed documents if you will be submitting that item as part of the referral.

- ☐ **Copy of Child's Birth Certificate*** (*If not available, passport or certificate of baptism are acceptable*)
- ☐ **Custody Documentation*** (*Required only if child is NOT in the custody of a biological parent*)
- ☐ **FDLRS-South Child Find Parent Observation Form**
- ☐ **Prekindergarten Diagnostic Team Summary of Student Psychosocial History**
- ☐ **Home Language Survey** (FM # 5196)
- ☐ **Signed Consent Form for Mutual Exchange of Information** (FM # 2128)
- ☐ **Observation of Prekindergarten Student Behaviors** (FM # 4140 - *For teacher/therapist to complete if child attends an early childhood center or receives therapy*)

**Additional Important Child Find Referral Documents:**
Please submit copies of the following records, if available.

- ☐ **Relevant Medical Records** (*e.g., neurological, genetics, etc.*)
- ☐ **Hearing/Audiological Report or copy of the State of Florida School Entry Health Examination Form** – (DH 3040 Yellow Form)
- ☐ **Vision Report or copy of the State of Florida School Entry Health Examination Form** – **Part II - Medical Evaluation** (DH 3040 Yellow Form)
- ☐ **Psychological Evaluation Report**
- ☐ **Speech/Language Evaluation Report**
- ☐ **Behavioral Evaluation Report**

Documents can be submitted to FDLRS-South via email: FDLRS-South@dadeschools.net

If you need assistance in completing these forms or if you have any questions, please call us at 305-274-3501.

Sincerely,
The Child Find Team at FDLRS-South

**Complete if the following referral is made by an Agency or School:**
**Contact person:** _____
**Agency/School:** _____
**Phone:** _____ **Fax:** _____

**Miami-Dade County Public Schools**
**Florida Diagnostic and Learning Resources System-South (FDLRS-South)**
**Child Find Parent Observation Form**

**Child's Name:** _____ **Birthdate:** _____ **Age:** _____

**Person Completing this Form:** _____ **Relation to Child:** _____ **Date:** _____

**Directions**: Please check any behaviors that area concern (leave boxes blank if there are no concerns).

**1. Attending Behaviors**

- ☐ Easily distracted
- ☐ Short attention span
- ☐ Impulsive
- ☐ Overly active
- ☐ Difficulty remembering things
- ☐ Needs a lot of attention from adults

**2. Disruptive Behaviors**

- ☐ Physically aggressive (hits, pushes, bites, pinches)
- ☐ Hurts himself/herself intentionally
- ☐ Verbally abusive (yells, uses inappropriate language

**3. Social/Emotional Indicators**

- ☐ Anxious/nervous
- ☐ Easily frustrated
- ☐ Seems unhappy
- ☐ Has difficulty taking turns
- ☐ Avoids interaction with other children
- ☐ Becomes upset easily
- ☐ Repeats behaviors over and over (rocking, pacing, spinning)
- ☐ Does not get along with other children
- ☐ Prefers to play alone
- ☐ Plays with one toy over and over again for very long periods
- ☐ Has frequent temper tantrums
- ☐ Does not get along with adults
- ☐ Cries frequently
- ☐ Is overly fearful in new situations
- ☐ Does not engage in pretend play (feeding the baby, talking on the phone, etc.)

**4. Speech/Language**

- ☐ Does not follow simple directions
- ☐ Speech is not understood by others outside of the family
- ☐ Does not engage in conversation
- ☐ Still utilizes a pacifier on a regular basis
- ☐ Does not speak in 3 –4-word sentences
- ☐ Stutters with sounds ("m, m, m, many"), repeats words or phrases, or gets "stuck" on words
- ☐ Has difficulty naming basic objects or people
- ☐ Voice sounds different from other children (raspy, nasal, hoarse, high pitched, too soft, too loud)
- ☐ Has difficulty understanding what is said to him/her

**5. Motor Skills**

- ☐ Appears clumsy or uncoordinated
- ☐ Has difficulty turning the pages of a cardboard book
- ☐ Frequently drops, spills, or knocks things over
- ☐ Has difficulty holding a bottle or cup by himself/herself
- ☐ Is unsteady when walking
- ☐ Has difficulty holding a thick crayon

**6. Self-Help Skills**

- ☐ Cannot feed himself/herself independently
- ☐ Has frequent toileting accidents during the day
- ☐ Needs assistance washing/drying hands

**7. Sensory Issues**

- ☐ Is a very picky eater
- ☐ Covers ears to loud noises
- ☐ Sensitive to wearing certain clothing (e.g., socks, shoes, clothing labels)
- ☐ Does not tolerate large crowds

**8. Other**

- ☐ Has difficulty with changes in routine
- ☐ Has frequent nightmares
- ☐ Frequently wets the bed
- ☐ Has difficulty learning simple rules
- ☐ Walks on tiptoes
- ☐ Does not respond to name when called
- ☐ Has unusual fears
- ☐ Has been asked to leave a preschool or daycare

Clear Form

**MIAMI-DADE COUNTY PUBLIC SCHOOLS**

# CONSENT FORM FOR MUTUAL EXCHANGE OF INFORMATION

Date _____

Student's Name _____

Date of Birth _____ ID# _____

I hereby authorize the mutual exchange of records pertaining to my child or myself, _____ _____ , between the MIAMI-DADE COUNTY PUBLIC SCHOOLS and the following agencies (include all schools, physicians, psychologists, hospitals, clinics, etc., that have had significant contact with your child):

| **Name** | **Address** |
|---|---|
| | |
| | |
| | |
| | |
| | |

- The specific records to be disclosed pertain to: _____

- The purpose for making these records available is: _____

- **The receiving party will not disclose the information to any other party without signed consent.**

I certify that I am the parent or legal guardian of the child named above or that I am a student of majority age and have the authority to sign this release.

_____ _____
Name (print) Signature

_____
Address City, State Zip Code

Please return this form to: _____

_____

_____

_____

Clear Form

MIAMI-DADE COUNTY PUBLIC SCHOOLS

# HOME LANGUAGE SURVEY

To Be Completed By Parent or Guardian

Student I.D. No._____

Student Name _____ _____ _____
Last First Middle

Date of Birth ____/____/____ Grade_____ Parent Language _____ Student Language _____
Month Day Year

Date Entered U.S. School : ____/____/____
Month Day Year

Ethnic Hispanic _____ (Y/N)

(Check all that apply) Race: White ☐ Black ☐ Asian ☐ American Indian ☐ Native Pacific Islander ☐

| If the answer is "YES" to any of these questions, the student must be tested for English proficiency. | |
|---|---|
| 1. Is a language other than English used in the home? | Yes ☐ No ☐ |
| 2. Did the student have a first language other than English? | Yes ☐ No ☐ |
| 3. Does the student most frequently speak a language other than English? | Yes ☐ No ☐ |

School _____ Date _____ Parent/Guardian Signature_____

ESCUELAS PUBLICAS DEL CONDADO DE MIAMI-DADE

# ENCUESTA SOBRE EL IDIOMA HABLADO EN EL HOGAR

Debe ser completado por el/la padre/madre o tutor/a

No. De I.D. _____

Nombre del Estudiante _____ _____ _____
Apellido Nombre Inicial

Fecha de Nacimiento ____/____/____ Grado _____ Lengua Paterna _____ Idioma del Estudiante _____
Mes Día Año

Fecha de Entrada a la Escuela de los Estados Unidos: ____/____/____
Mes Dia Año

Origen Etnico Hispano _____ (S/N)

(Marque todo lo pertinente) Raza: Blanco ☐ Negro ☐ Asiático ☐ Indígena de los EEUU ☐ Oriundo de las Islas del Pacífico ☐

| Si responde "Sí" a alguna de estas preguntas, el estudiante debe tomar un examen para saber cual es su conocimiento del Inglés. | |
|---|---|
| 1. ¿Usan en su casa algún otro idioma que no sea el Inglés? | Sí ☐ No ☐ |
| 2. ¿Tuvo el estudiante una lengua materna distinta al Inglés? | Sí ☐ No ☐ |
| 3. ¿Habla el estudiante frecuentemente otro idioma que no sea el Inglés? | Sí ☐ No ☐ |

Escuela _____ Fecha _____ Firma del Padre/Madre _____

MIAMI-DADE COUNTY PUBLIC SCHOOLS

# SONDAJ SOU KI LANG TIMOUN NAN PALE

Pou paran oubyen moun ki responsab timoun nan ranpli

No. I.D. Elèv La _____

Non Elèv la _____ _____
Non fanmi Non

Dat Fèt li ____/____/____ Klas _____ Lang paran Yo _____ Lang Elèv La _____
Mwa Jou Ane

Dat ou Antre U.S. Lekòl: ____/____/____
Mwa Jou Ane

Etnisite Espayòl _____ (W/N)

(Tcheke tout sa ki aplike) Ras: Blan ☐ Nwa ☐ Azyatik ☐ Amriken Endyen ☐ Natif Il Pasifik ☐

| Si repons lan se "WI" pou nenpòt nan kesyon anba yo, elèv la dwe pran yon tès Anglè. | |
|---|---|
| 1. Eske yo sèvi ak yon lang ki pa Anglè lakay li? | Wi ☐ Non ☐ |
| 2. Eske elèv la te genyen yon premye lang anvan Anglè? | Wi ☐ Non ☐ |
| 3. Eske elèv la abitye pale yon lang ki pa Anglè? | Wi ☐ Non ☐ |

Lekòl _____ Dat _____ Siyati Paran _____

**CC: FILE IN CUMULATIVE FOLDER**
**TO STAFF FOR TESTING**

**Miami-Dade County Public Schools**
**Pre-K Diagnostic Team**
**Summary of Student Psychosocial History**

| | | | |
|---|---|---|---|
| | | | **Date**: |
| **Child Name**: | **ID#**: | **D.O.B**: | **Age**: |
| **Home School**: | **Person Completing Form**: | | |
| **Respondent's Name/Relationship**: | **Signature**: | | |
| **Home Address**: | **Rent** ☐ **Own** ☐ | | |
| **Telephone**: | **Email**: | | |

## FAMILY COMPOSITION

| Name | Relationship | Lives with Child | Age | Occupation |
|---|---|---|---|---|
| | Mother | Yes / No | | |
| | Father | Yes / No | | |
| | | Yes / No | | |
| | | Yes / No | | |
| | | Yes / No | | |

Child's place of birth: _____ Family's cultural origin: _____
Primary language spoken in the home: _____
Other languages child is exposed to: _____
Parents/Guardian's marital status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed
Reason for referral/parent concerns:_____
_____

## EDUCATIONAL HISTORY

Is the child currently attending school: Yes ☐ No ☐ If yes, Name/Date entered: _____
_____

Describe the student's current school experience, strengths and challenges: _____
_____

## DEVELOPMENTAL HISTORY

Describe pregnancy and delivery of child, risk factors and/or difficulties: _____
_____
Gestation (months): _____ Birth Weight: _____ Postnatal Difficulties: _____
_____
Developmental Milestones (Age) Walked: _____ First Words: _____ Phrases: _____ Toilet Training: _____
Bedwetting: Yes ☐ No ☐ Explain:_____

## MEDICAL/MENTAL HEALTH HISTORY

Describe history of illness, chronic health problems, syndromes: _____

_____

_____

Allergies to food, medication:_____

Injuries, surgeries, accidents, hospitalizations: Yes ☐ No ☐ If yes, date/explain: _____

_____

Current medications: _____

Eating problems: Yes ☐ No ☐ Difficulty sleeping: Yes ☐ No ☐ Speech/language problems: Yes ☐ No ☐

Vision impairment: Yes ☐ No ☐ Wears glasses: Yes ☐ No ☐ Hearing impairment: Yes ☐ No ☐

Has the child been seen by a neurologist, psychologist, or other professional? Yes ☐ No ☐ If yes, explain: _____

_____

_____

Has the child had any diagnostic testing such as MRI, EEG, etc.? Yes ☐ No ☐ If yes, explain: _____

_____

_____

Has the child received speech/language therapy? Yes ☐ No ☐ If yes, place of service and dates: _____

_____

Has the child received occupational therapy, physical therapy or behavioral therapy? Yes ☐ No ☐

If yes, place of service and dates: _____

_____

Family history of learning, medical, or mental health problems: _____

_____

## INTERPERSONAL RELATIONSHIPS/BEHAVIOR

Describe the student's overall behavior at home: _____

_____

Discipline measures used in the home: _____

Describe child's peer relationships: _____

Student's interests and strengths: _____

Behaviors: Easily Distracted: Yes ☐ No ☐ Easily Frustrated: Yes ☐ No ☐ Aggressive: Yes ☐ No ☐

Independent: Yes ☐ No ☐ Impulsive: Yes ☐ No ☐ Temper Tantrums: Yes ☐ No ☐

If yes, explain: _____

_____

## TRAUMATIC EVENTS/PSYCHOLOGICAL STRESSORS

Has the child been exposed to or affected by: Separation/Divorce: Yes ☐ No ☐ Serious family illness/death: Yes ☐ No ☐

Police or Department of Children and Families involvement: Yes ☐ No ☐ Catastrophic events: Yes ☐ No ☐

Homelessness: Yes ☐ No ☐ If yes, explain: _____

_____

**Additional Information:** _____

_____

_____

Clear Form

**Miami-Dade County Public Schools**
**OBSERVATION OF PREKINDERGARTEN STUDENT BEHAVIORS**

**Child's Name**_____ **Birthdate**_____ **Age**_____

**Observer**_____ **School**_____

***To be completed by child's teacher(s) and/or therapist(s).*** **Please check the behaviors that occur more frequently than is typical for same-age peers. If no concerns, check the box marked age appropriate.**

## I. Attending Behaviors

- ☐ Easily distracted
- ☐ Has short attention span
- ☐ Impulsive
- ☐ Needs help from adult to stay on task
- ☐ Needs excessive attention from teacher
- ☐ Acts upset by a change in plans
- ☐ Over-active/hyperactive
- ☐ Has difficulty remembering things
- ☐ Appears to daydream
- ☐ Age appropriate

## II. Disruptive Behaviors

- ☐ Argumentative
- ☐ Physically aggressive (hits, kicks, destructive etc.)
- ☐ Self-injurious behavior e.g._____
- ☐ Verbally abusive
- ☐ Bullies peers
- ☐ Age appropriate

## III. Indicators of Anxiety/Sadness

- ☐ Withdrawn
- ☐ Anxious/nervous
- ☐ Seems unhappy
- ☐ Becomes ill when upset or frustrated
- ☐ Easily overwhelmed
- ☐ Cries easily/inappropriately
- ☐ Exhibits inappropriate mood changes
- ☐ Age appropriate

## IV. Language/Speech

- ☐ Has difficulty understanding instructions or directions
- ☐ Has difficulty naming people or objects
- ☐ Has difficulty speaking in sentences
- ☐ Has difficulty staying on topic
- ☐ Speech is difficult to understand
- ☐ Frequently stutters (e.g: m,m,m,many), repeats words, whole phrases or "gets stuck" while trying to say a word
- ☐ Voice is hoarse, raspy or nasal
- ☐ Age appropriate

## V. Social/Emotional

- ☐ Has difficulty with self-control when frustrated
- ☐ Has difficulty sharing with other children
- ☐ Exhibits repetitive behavior e.g._____
- ☐ Becomes easily upset
- ☐ Displays unusual reactions to sensory stimulation (e.g. lights, sounds, smells, tastes, touch, etc.)
- ☐ Has difficulty joining in peer group play
- ☐ Avoids interaction with other children
- ☐ Has temper tantrums (length of tantrums _____ )
- ☐ Has difficulty taking turns
- ☐ Lacks imaginative play
- ☐ Age appropriate

## VI. Gross and Fine Motor Skills

- ☐ Has unsteady gait
- ☐ Appears clumsy or uncoordinated
- ☐ Has difficulty using a pencil or crayon
- ☐ Frequently drops, spills or knocks things over
- ☐ Age appropriate

## VII. Adaptive/Self-Help Skills

- ☐ Has frequent toileting accidents
- ☐ Needs assistance washing and drying hands
- ☐ Needs assistance with eating e.g._____
- ☐ Age appropriate

**Comments/Concerns:**_____

_____

_____

**Signature**_____ **Date**_____

# Parent Completed Vision and Hearing Checklist

Child's name:_____ D.O.B_____

Today's Date:_____ Parent/Guardian:_____

**Vision**

Does your child wear glasses? ____ yes ____ no

Do you have any concerns about your child's ability to see? ____ yes ____ maybe ____ no

Has your child been referred to an eye doctor? ____ yes ____ no

Has your child been tested by an eye doctor? ____ yes ____ no

Diagnosis/recommendations for follow up: _____

Doctor's name: _____ Date Tested: _____

Comments:_____

Please complete if your child has not had a formal vision evaluation:

| | Yes | No |
|---|---|---|
| Does one or both eyes turn in or out? | | |
| Does your child point to pictures in a book? | | |
| Can your child do a simple puzzle? (locate where pieces go/match) | | |
| Can your child track and pop bubbles when you play with bubbles? | | |
| Can your child find/pick up small objects from a floor and/or surface? | | |
| Does your child point out things in his/her environment? | | |
| Does your child reach for objects? | | |

## Hearing

Does your child have P.E. tubes? _____ yes _____ no

Do you have any concerns about your child's ability to hear? ___yes ___maybe ___no

Has your child been referred to an audiologist? ___yes ___no

Has your child been tested by an audiologist? ___yes ___no

Audiologist name: _____ Date: _____

Pediatrician name (if completed by pediatrician):_____

Comments: _____

Please complete if your child has not had a formal evaluation:

| | Yes | No |
|---|---|---|
| Does your child fail to respond to typical sounds in his/her environment? (i.e.- dog bark, doorbell, item dropped behind) | | |
| Does your child often fail to respond to his name or a noise that you would expect him to hear? (i.e., a loud bang, something dropping) | | |
| Does your child respond when you call his/her name? | | |
| Will your child repeat words that you say? | | |
| Does your child point to things that you verbally point out? (i.e.- oh look at the bird in the sky, oh look at that dog, etc.) | | |
| Does your child engage in back and forth conversations? | | |