Referral for MCOE Special Class Placement

Must be used for pupils referred to Merced County Office of Education

Student's Name:_____

Address:_____

_____

Parent/Guardian:_____
Address (if different):_____

_____

Telephone:_____ _____
Home Work

Primary Language: _____ _____
Student Parent/Guardian

Male ☐ Female ☐

Birthdate:____/____/____

Age:_____

Birthdate verified by:
Birth Certificate ☐
Passport Affidavit by: ☐
Parent/Surrogate ☐
Guardian ☐

Referring District:_____ **Referral Date:**_____

Contact Person:_____ **Title:**_____

Telephone:_____ **Fax:**_____ **E-mail:**_____

Current Placement: Public School ☐ Non-public School ☐ Private School ☐ Not in School ☐

Current Special Education Services: ☐ SDC ☐ RSP ☐ DIS ☐ Home/Hospital Instruction

Current School:_____ Telephone:_____

Current teacher/counselor:_____

Student Disability (if known):_____

Placement to be considered: ☐ ECSC/Preschool ☐ TABS ☐ Sierra ☐ D-HH

Required for All Programs:
All reports must be current, within 6 months of referral.

Comprehensive Multidisciplinary Assessment Report
Current IEP or IFSP (last 2)
Health/Development or Medical Records
Home Language Survey (K-12 only)
English Proficiency Status (K-12 only)
English only *EL* *FEP*

Additional Reports as Needed for Specific Programs:

Ophthalmological/vision
Behavioral related materials
Speech Language Report Profile
Audiological Report
Other (e.g. Mental Health, CVRC, Diagnostic Center of CA, Children's Hospital)_____

_____
Print name of Case Manager

_____ _____ _____
Case Manager's Signature Title/Telephone Date

_____ _____ _____
Administrator's Signature (Sp. Ed. Admin.) Telephone Date

Revised: 10/08/19

MERCED COUNTY CALIFORNIA
DISTRICT SPECIAL EDUCATION
LOCAL PLAN AREA
SCHOOL

HEALTH AND DEVELOPMENTAL HISTORY

1. **Child's name** Birth date ☐Male ☐Female

Parent or Guardian's Name/Relationship No. of children in family:

Household composition This child is number:

2. **Prenatal History**: How did mother feel during pregnancy?

Medications (inc/otc) taken during pregnancy, other than vitamins

How much cigarettes, alcohol or other drugs were used during pregnancy (household exposure)?

Mother's age at time of pregnancy Father's age at time of pregnancy

Any complications/illness during pregnancy? ☐No ☐Yes (describe)

3. **Labor and Delivery**: Where was child born? Birth weight lbs oz

☐Head? ☐Breech? ☐Cesarean section? Reason:

Any difficulty breathing? ☐Yes ☐No Was oxygen used? ☐Yes ☐No How long did baby stay in hospital?

Complications?

4. **Nutrition**: Feeding difficulties

Current Status/Allergies

5. **Developmental Milestones**: (Give approximate age) Crawled Walked

Put words together Bladder control Bowel Control

6. **Illnesses, accidents and hospitalization** (give approximate age)

Head injury Diabetes

Ear infections Meningitis

Eye Problems Heart disease

Seizures Accidents

Allergy or Asthma Fractures

Other illnesses

Has your child been hospitalized? ☐No ☐Yes Why?

E.530.1
11/99

HEALTH HISTORY

Check copies provided: ☐Office/Pupil File ☐Office/Pupil File ☐Parent/Guardian ☐Other_____ ☐Other_____

Child's Name_____ Date ----------_____

7. **Family History**: Is there anyone in the family who had difficulty in school? _____

Is there anyone in the family with serious medical problems (heart, diabetes, cancer, etc)? _____

_____

8. **Behavioral History:** Describe the child's behavior (concerns) _____

_____

Does the child exhibit any of the following? Self-abusive behavior_____ Aggressive behavior _____

Destructive_____ Extreme shyness_____ Temper tantrum_____ Bedwetting _____

9. **Current Medical Status**: Present or chronic health problems/handicaps _____

_____

_____

_____

Who is child's physician(s)? _____

When was child's last medical exam? ---------- ____ Reason/Results: _____

_____

What medication is child taking? _____

_____

Other community agencies: _____

10. Are there other factors that you feel the school should be aware of concerning the child (such as health insurance, divorce, frequent family moves, etc.)? _____

_____

_____

SCHOOL NURSE OBSERVATION: Height_____ Weight _____

Vision_____ Date_____-_____-_____ Hearing_____ Date_____-____-_____

Dental Condition_____ School attendance _____

Immunization status: ☐ Current ☐ Referred _____

Comments _____

_____

Report completed by_____ Date_____-____-____

MERCED COUNTY OFFICE OF EDUCATION
Steve M. Tietjen, Ed. D., County Superintendent of Schools
Susan Coston, Assistant Superintendent, Special Education

REFERRAL RESPONSE

Date:_____

Referring District:_____ FAX #_____

Referring District Contact Person:_____

MCOE Referral Coordinator:

The application for_____, was reviewed by the MCOE

Coordinator on_____. The recommendation is as follows:
Date

☐ ***Maintain District Placement***
☐ Referral does not clearly indicate need for moderate/severe levels of programming.

☐ Coordinator recommends further accommodations and supports to maintain students placement in district of residence.

☐ Student can benefit from access to non-disabled peers and general curriculum.

☐ ***MCOE coordinator will contact district to pursue the following:_____***

_____

☐ ***MCOE Coordinator:_____will contact district to schedule IEP.***