MIAMI - DADE COUNTY PUBLIC SCHOOLS
FLORIDA DIAGNOSTIC AND LEARNING RESOURCES SYSTEM-SOUTH
CHILD FIND
5555 S.W. 93rd Avenue, Miami, Florida 33165
Main Office: Phone: (305) 274-3501 / Fax: (305) 598-7752
North Satellite Office: Phone: (305) 626-3970 Fax: (305) 626-3972

Dear Parent:

Your child has been referred to us for a screening and/or evaluation to determine the possible need for Special Education services from the Miami-Dade County Public Schools (M-DCPS) Special Education Program.

Enclosed you will find forms to fill out and sign. Please **complete and return the forms** to us as soon as possible in order to process your child's case.

Checklist for Referral to FDLRS / Child Find

The following documents should be completed and submitted with the referral.
Those with an asterisk (*) are required: ***(please check the items that you are submitting)***

____ **Child/Family Questionnaire***

____ **New Student Information Survey***

____ **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)*

____ Copy of Child's Social Security Card *(if available)*

____ Observation of Prekindergarten Student Behaviors (*for teacher to complete if child attends a preschool / childcare center)*

____ **Signed** Consent Form for Mutual Exchange of Information *(if your child has seen any specialists, please state each person's specialty and phone number beside his/her name)*

If you have or can obtain copies of the following records, please submit them to expedite the process:

____ Relevant Medical Records (ex: ENT, psychiatric, neurological, genetics, etc.)

____ Psychological Evaluations ____ Social History Reports

____ Screenings and/or Evaluations in the following areas:

____ Hearing ____ Vision ____ Speech/Language ____ Development ____ Behavior

Once we have gathered and reviewed all of the information, we will forward your child's file to the appropriate **M-DCPS Pre-K Diagnostic Team.** A team member will then contact you to schedule a screening and/or an evaluation.

If you need assistance in completing these forms, please call the **Child Find Department** at **305-274-3501**.
Thank you for your cooperation.

Sincerely,

M. Cristina Peña, M.A.
School Psychologist-Child Find Specialist

If referral is made by an Agency or School:
Contact Person: ______________________________
Agency/School: ______________________________
Phone: _________________ Fax: _______________

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CHILD/FAMILY QUESTIONNAIRE

Child's Name____ Sex: **M F**
First Middle Last

Date of Birth______________________Age_________Place of Birth______________________________

Child lives with: Name(s)____
Relationship(s) to child ____

Address_________________________Apt.______City__________________Zip Code___________

Home Phone____________________Cell Phone____________________Work Phone__________________

What concerns you about your child?____

How did you find out about FDLRS/South?____

What languages are spoken in the home?____

PERSONS WHO MAY BE CONTACTED ABOUT THE CHILD

Name	Relationship to Child	Lives With Child	Age	Occupation	Phones
		yes / no			
		yes / no			
		yes / no			
		yes / no			

If the child is under the custody of the Department of Children & Families (DCF), give name of DCF worker:

Name:____________________________Agency:______________________Phone Numbers:__________________

MOTHER'S PREGNANCY *(for this child only)*

Did you or the baby have any problems before, during or after birth?_____If yes, explain__________________________
____

Did the baby weigh less than 5½ pounds? **Yes / No**

DEVELOPMENTAL HISTORY

Please check the appropriate boxes to indicate when your child achieved the following milestones:

Milestones	Typically achieved at:	Achieved on time	Delayed
Walking	9 to 15 months	☐	☐
Saying single words	12 to 15 months	☐	☐
Using 2-word to 3-word sentences	1½ to 2 years	☐	☐
Toilet training	1½ to 3½ years	☐	☐

Can people outside the family understand him/her clearly when he/she speaks? **Yes / No**

MEDICAL HISTORY (Please attach additional pages if necessary)

Has your child had any of the following: (please **circle**) major illnesses, surgeries, hospitalizations, medical problems, traumatic brain injury? If yes, explain____

Has your child been diagnosed with a syndrome? If yes, explain ____

Does your child take any medication(s)?_____If yes, give name and reason ___________________________________

Does your child require special equipment, such as a wheelchair, braces, etc.?______If yes, explain___________________

Does your child have frequent ear infections?______Does he/she have hearing problems?____ If yes, explain___________

Does your child have any of the following (please **circle**): PE tubes/hearing aids/ cochlear implant?

Does your child have vision problems?_____If yes, explain________________________Does he/she wear glasses?_______

Has your child been evaluated by a specialist in addition to the pediatrician?______If yes, **circle**: ear doctor, audiologist, speech/language pathologist, neurologist, geneticist, psychologist, psychiatrist, other:_______________________________

Is your child receiving any type of therapy?_________If yes, **circle**: physical, occupational, speech/language, psychological, other:____

EDUCATIONAL HISTORY

Is your child attending a child care facility or school program?_________ If yes, list below:

Name___________________________________Phone_____________________________Since when_________________

Has he/she had any difficulties in this or any other program? ______ If yes, explain _________________________________

____

If an agency is helping you pay for child care, please **circle**: CDS, Head Start, RCMA, VPK, DCF, other:______________

CURRENT FUNCTIONING

How long is he/she able to focus on one activity?____

Can your child follow simple directions?____

Do you feel your child has any behavioral/emotional problems?_____If yes, describe_________________________________

____

PARENTS' COMMENTS

How do you view your child's development compared to other children the same age?______________________________

____

How would you describe your child?____

Questionnaire Completed by__________________________Relationship to Child_________________Date___________

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305-274-3501 / 305-598-7752 - FAX

NEW STUDENT INFORMATION SURVEY

____
Date

Child's Name____**Date of Birth**________________
First *Middle* *Last*

Home Language Survey

1. Is a language other than English used in the home? Yes ☐ No ☐
2. Did the child have a first language other than English? Yes ☐ No ☐
3. Does the child most frequently speak a language other than English? Yes ☐ No ☐

   Language(s) spoken by mother:________________________________
   Language(s) spoken by father:________________________________
   Language(s) spoken by other caretakers:________________________

4. Is the child Hispanic? Yes ☐ No ☐

Ethnicity/Race Survey

Please check ***all*** options that best describe the child's race:

☐ **W**-White ☐ **B**-Black ☐ **N**-Native Pacific Islander ☐ **A**-Asian ☐ **I**-Indian *(American)*

Supplemental Survey

Hurricane Affected Student? Yes ☐ No ☐
If yes, in Miami-Dade ☐ **or** outside Miami-Dade ☐

Military Family? Yes ☐ No ☐

Haitian Earthquake? Yes ☐ No ☐

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:

MIAMI-DADE COUNTY PUBLIC SCHOOLS
FDLRS-SOUTH
5555 S.W. 93 AVENUE
MIAMI, FLORIDA 33165

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