



# Head Start

"Building partnerships, changing lives"



## Child Find

Student \_\_\_\_\_ Date Of Birth \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 School District: \_\_\_\_\_ County: \_\_\_\_\_

Check services the child is currently receiving or has previously received:

\_\_\_\_ ECI \_\_\_\_ IFSP (If Yes, where) \_\_\_\_\_  
 \_\_\_\_ Special Education (If Yes, where) \_\_\_\_\_

Primary concern or area(s) of delay: \_\_\_\_ Gross or Fine Motor Skills \_\_\_\_ Hearing \_\_\_\_ Vision  
 \_\_\_\_ Speech/Language \_\_\_\_ Significant Health Problems (tubes in ears, asthma, etc.)  
 \_\_\_\_ Other \_\_\_\_\_

### OUTCOME

\_\_\_\_ Did not qualify for service  
 \_\_\_\_ Declined services  
 \_\_\_\_ Referred to Outside Agency for Services \_\_\_\_\_  
 \_\_\_\_ Interventions  
     \_\_\_\_ Team Meeting \_\_\_\_ CIT Forms Completed \_\_\_\_ 10 days  
     \_\_\_\_ Given to ISD / Special Education Department \_\_\_\_\_  
 \_\_\_\_ Enrolled receiving services from ISD / Other Provider \_\_\_\_\_  
     \_\_\_\_ IEP Date \_\_\_\_\_  
     \_\_\_\_ Other: \_\_\_\_\_

I authorize CSNT Head Start to share the following information with the referring practice/agency listed above.

- Eligibility outcome information (eligible/not eligible)
- Evaluation/Assessment results (range of delay for each developmental domain)
- Ongoing Early Intervention Services included on the Individualized Family Service Plan for the purpose of care coordination

I understand that I may withdraw this consent by written request to CSNT Head Start Program. If consent is revoked it does not apply to any actions that occurred before consent was revoked.

I certify that this authorization to release this information has been given freely and voluntarily. Information collected related to early intervention services may not be shared unless the person who consented to sharing this information specifically consents to it and or the sharing information is allowed by law. I understand I have a right to inspect and copy the information to be disclosed.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (child's parent or legal guardian)

\*Authorization is effective for a period of 24 months from this date

Contact Person: \_\_\_\_\_ Date: \_\_\_\_\_