Head Start

"Building partnerships, changing lives"

Child Find

Child Plus ID # _____

Campus_____Date_____

Student_____ _DOB_____

Parent/Guardian: _____Telephone:_____

Address: _____City:_____

School District:_____County:_____

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

_____ECI ____IFSP (If Yes, where)_____

_____Spec Ed. ISD (If Yes, where)_____

Primary concern or area(s) of delay

_____Behavior _____Gross or Fine Motor Skills

_____Hearing _____Vision _____Speech/Language

_____Significant Health Problems (tubes in ears, asthma, etc.)

_____Other_____

Attachments: _____Assessment Information_____

_____IFSP/IEP_____

_____Other_____

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OUTCOME

_____Did not qualify for service ____See Child Plus

_____Declined services

_____Referred to Outside Agency for Services_____

_____Interventions

_____Team Meeting ____CIT Forms Completed _____10 days

_____Given to ISD / SpEd CoOp_____

_____Enrolled receiving services from ISD / Other Provider_____

_____ IEP Date_____

_____Other: _____

Contact Person:_____

Agency: CSNT Head Start

Date: _____Phone#_____

Revised 3/22/17