THE SCHOOL BOARD OF BROWARD COUNTY FLORIDA
Exceptional Student Education and Support Services

FDLRS / Child Find Referral Form

Children Ages Birth to 5 Years

Referred By: ________________________________ **Director's Name:** ________________________________
Child Care Facility

Facility E-Mail: ______________________________ **Phone#:** ____________________ **FAX #:**______________

Referring Source: ______________________________ **ASQ3/SE Attached:** ❑ Y ❑ N ❑ New ❑ Annual

Authorization to Refer: ______________________ ____________________ ______________ ______________
Print Parent/Custodial Caregiver's Name *Signature* *Relationship* *Date:*

Child's Name: ____ **DOB:** __________________ **Age:** ________

Sex: ❑ **M** ❑ **F** **Language Spoken at Home:** ______________________ **Family receives SR financial assistance?** ❑ Y ❑ N

❑ **Parent** ❑ **Foster Parent** ❑ **Relative** ❑ **Guardian:** ____

Home Address: ____ **Apt #:** ______________

City:____ **State:** __FL__ **Zip:** ______________

Home Phone: 954/754 ____________________ **Work:** 954/754 ______________ **Cell:** 954/754 __________________

Alternative Contact Name: __________________________ **Relationship:** ______________ **Phone:** ____________

Child Covered by Healthcare Insurance? ❑ Y ❑ N ❑ Unknown **Medicaid #:** ______________________

Private: ❑ Y ❑ N **Name of Insurance Plan:** ____________________________ **Plan #:** __________________

Child is currently receiving protective service: ❑ Y ❑ N **ChildNet Advocate:** ______________________________

Developmental / Educational Concerns: ❑ Communication ❑ Motor ❑ Self-Help ❑ Cognitive ❑ Social/Emotional

❑ Behavioral ❑ Other: ____

Currently Receiving Developmental Services? ❑ Y ❑ N ❑ Physical Therapy ❑ Speech Therapy ❑ Occupational Therapy

❑ Behavioral Services ❑ Unknown **Where?** ____

Child has a Medical Diagnosis ❑ Y ❑ N **What:** ____

Comments ____

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FOR CHILD FIND USE ONLY	FOR CDTC USE ONLY / PART C STATUS
FDLRS #: ______________________	Part C Eligible ❑ Y ❑ N Date: ____________
Date of Referral: ______________________	Service Coordinator: ____________________
Home School: ______________________	Initial IFSP: ____________________
Screening Appointment: ______________________	Transition IFSP Mtg.: ____________________

STATE OF FLORIDA, DEPARTMENT OF HEALTH
CHILDREN'S MEDICAL SERVICES

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
Form Control # 2980 I *Revised 9/13*

Fax to FDLRS / Child Find at: 754 - 321 – 7217
Phone: 754 – 321 - 7200