Republic of Palau Ministry of Education

Hospital #: _____

CHILD IDENTIFICATION INTAKE FORM

This form is to be used to initiate the review of a child's progress and any difficulties that the child may be having in school. The completed form should be returned to the child's school principal. After a review by the school Child Study Team, you will be informed of its disposition.

Instructions for completing this form

For Parent: Fill in items 1, 2, and 3. This referral will be reviewed
For School Personnel, Health Services, Head Start, or other agency personnel: Fill in items 1, 2, and 3 below.

1. **Name of person submitting this referral**: _____
   Relationship to child or Agency/Position: _____

2. **Name of Child being referred**: _____
   First Middle Last
   Sex: _____ Age: _____ Birthdate: _____/_____/_____ Hospital #: _____
   Enrolled in school: ☐ YES ☐ NO Name of School: _____
   Grade: _____ Currently receiving special education services: ☐ YES ☐ NO
   Village: _____ Island: _____
   Father's Name: _____ Mother's Name: _____
   Primary Language: _____

3. **Reason for Referral - Please check the child's problem area (s)**:
☐ Vision ☐ Hearing ☐ Physical ☐ Behavior ☐ Speech ☐ Language ☐ Medical
☐Learning in subject areas ☐Attendance ☐Other (please state)_____

What is the specific problem and what kind of help do you think this child needs:

For School Use Only:

Date referral received _____ Date referred to child study team _____
Date of team recommendation _____ Disposition _____
Date of Prior Written Notice to Parent _____ Date of Notice to agency rep _____