



COMMITTEE ON PRESCHOOL SPECIAL EDUCATION
DEPARTMENT OF EARLY CHILDHOOD
Rochester City School District
131 West Broad Street
Rochester, New York 14614

Every child is a work of art.
Create a masterpiece.

PARENT REFERRAL

Please Print:

Child's Name _____ Gender _____

Date of Birth _____

Parents Name: _____

Address _____

Childcare/Preschool Location _____

Parent Phone: _____

Email address: _____

I would like to refer my child for an evaluation to determine whether or not he/she needs special education services.

I am concerned about my child having difficulty
with _____

My child has had the following educational experiences/services in the
past: _____

I understand that preschool special education is voluntary, and my consent will be required in writing to perform evaluations to determine whether my child is eligible for services and again to begin providing any recommended services.

_____ **Date:** _____

(Signature of Parent or legal guardian)

Parent Referral