Doña Ana County Head Start/Early Head Start

2540 B El Paseo
Las Cruces, NM 88001
575-647-8733

Referral and Release Form

To: _____

_____

_____

Phone:_____

From:_____

Disabilities/Transition Specialist

Phone: 575-647-8733 x113

Child's Name:_____ DOB:_____

Parent's Name:_____ Child's dominant language:_____

Physical Address:_____ Parent's dominant language:_____

_____ Parent's Phone:_____

_____ Message Phone:_____

Mailing Address:_____ DACHS Center:_____

_____ Center Phone:_____

_____ Lead Teacher:_____

E-mail Address:_____

Reason for Referral:

Information accompanying Referral:

- ☐ Denver II
- ☐ Health History
- ☐ Immunization Record
- ☐ Vision Screening
- ☐ Hearing Screening
- ☐ Medical Information
- ☐ Other:_____
- _____
- _____

Received BY:_____ Date:_____

Action/Response:

Parents signed and Received::_____Public Schools Rights/Resp: ___Y ___N

By signing below I give my permission to refer my child to the local education agency or appropriate personnel and for the Doña Ana County Head Start/Early Head Start and the cooperating agency to share information needed to determine the needs of my child and deliver any related services.

Al firmar esta forma doy mi permiso para que mi hijo/a sea recomendado/a a una agencia de educacion local o con personal apropiado y para que Head Start/Early Head Start y la agencia en cooperacion compartan la informacion que sea necesaria para determinar las necesidades de mi nino/a y darle los servicios relacionados.

_____ _____

Parent or Guardian Signaure / Firma del Madre/Padre or Guardian Date / Fecha:

☐ Copy to Parent ☐ Copy to Center Child File ☐ Copy to LEA ☐ Original to Disabilities Specialist