EASTHAMPTON PUBLIC SCHOOLS

EASTHAMPTON MUNICIPAL BUILDING

50 Payson Avenue, 2nd Floor
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Referral from Parent/Guardian for a Special Education Evaluation

Student (first, middle, last):____

School/Teacher:____ Grade: _____ DOB: _______

Place of Birth:__________________________ Primary Language: ______________________________

Parent(s)/Guardian(s):____

Address:____

Phone Number(s):____

Email Address(es):____

Primary Language:______________________________________

Would you like documents translated into your primary language?__________

Would you like a translator for school meetings?__________

Please answer all questions.

1. Describe your academic concerns for your child.

2. Describe social/emotional or behavioral concerns for your child.

3. Describe any concerns related to your child's ability to communicate.

4. Describe any concerns related to your child's ability to focus and pay attention.

5. Does your child have any diagnoses? If so, please list.

6. Has your child been evaluated by a community-based agency? If so, please explain.

7. Have you spoken to your child's teacher about your concerns? Please describe.

8. Describe your child's strengths.

9. Are there additional concerns you would like the district to know?

____ ____________________

Parent/Guardian Signature Date