

Doña Ana County Head Start/Early Head Start

1335 International Mall Drive Rm 332

Las Cruces, NM 88003-8001

575-646-8910

Referral and Release Form

To: _____ _____ _____ Phone: _____	From: _____ Disabilities Specialist Phone: 575-639-5147 Email: rachruiz@nmsu.edu
Child's Name: _____ Parent's Name: _____ Physical Address: _____ _____ Mailing Address: _____ _____ E-mail Address: _____	DOB: _____ Child's dominant language: _____ Parent's dominant language: _____ Parent's Phone: _____ Message Phone: _____ DACHS Center: _____ Center Phone: _____ Lead Teacher: _____
Reason for Referral: 	
Information accompanying Referral: ____ ASQ-3 ASQ-SE Other: _____ Healt Hearing Screening GISD Child Find Referral Intake form _____ ____ Vision Screening Medical Information _____	
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 cooperación compartan la informacion que sea necesaria para determinar las necesidades de mi niño/a y darle los servicios relacionados. _____ Parent or Guardian Signaure / Firma del Madre/Padre or Guardian Date / Fecha: _____	