



# Michigan City Area Schools

408 S. Carroll Avenue  
Michigan City, Indiana 46360  
Special Education Services  
219/873-2000 ext. 8335 Fax: 219/877-3548

## REFERRAL FOR SPECIAL EDUCATION or 504 CONSIDERATION

Circle: Special Education 504

### Personal Data:

Student's Name: \_\_\_\_\_ STN # \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F

Ethnic Background: Hispanic/Latino (4) American Indian or Alaska Native (1) Asian (3)  
Black/African-American (2) Native Hawaiian or Pacific Islander (7) Multiracial (6) White (5)

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_ Room # \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Reason for the Referral:** Reading: \_\_\_\_\_ Language Arts: \_\_\_\_\_ Mathematics: \_\_\_\_\_  
Emotional/Behavioral: \_\_\_\_\_ other: Please specify below:

\_\_\_\_\_  
\_\_\_\_\_

Parent Referral: Yes / No If yes, please explain the reason in detail:

\_\_\_\_\_  
\_\_\_\_\_

**History:** Last Hearing Screening \_\_\_\_\_ Last Vision Screening \_\_\_\_\_  
(must be within one year of referral date)

- |  |  |
|--|--|
| ❖ Social and Developmental/Medical History (Please attach)                         | ❖ State and Local Assessment Record (Please attach)      |
| ❖ School History (Please attach copy of front of permanent record)                 | ❖ Behavior Record, including FBA and BIP (Please attach) |
| ❖ Response to Instruction (Please attach RTI plan and data that supports the plan) | ❖ Outside Services Record (Please attach)                |
|  | ❖ Current Gradebook Information                          |

### Special Education Office Use Only

Date the Referral was Received: \_\_\_\_\_ Data Complete: Yes/No

If no, referred back to Principal on: \_\_\_\_\_

Reason: \_\_\_\_\_

Beginning Date of Referral: \_\_\_\_\_ Timeline Date: \_\_\_\_\_

Psychologist Assigned: \_\_\_\_\_ Date: \_\_\_\_\_