Alachua County Public Schools
Head Start Program

Observation Request

For: ☐ Disabilities ☐ Education ☐ Health ☐ Nutrition
☐ FCE ☐ Transition ☐ Social/Emotional Support Services

Note: Your Teacher Specialist must sign off and will submit to a coordinator

Child's Name:_____ Center:_____
Date of Birth:_____ Age:_____ Program: Head Start
Parent/Guardian:_____ Telephone:_____
Address:_____ Other:_____
Concern:_____
Referred By:_____ Date:_____
Position/Title:_____
Parent Signature:_____ Date:_____

To Be Completed by Classroom Teacher:

Date Parent Contacted:_____ Date Interventions Attempted:_____
Students Developmental Score:_____
Please attach a copy of the Screening and Assessment results, Anecdotal notes or any other information you have on the child. ***Also, Please attach copies of strategies implemented in collaboration with parents***.
Teacher Specialist Signature:_____ Date Received:_____
Date Submitted to Coordinator:_____

To Be Completed by Content Area coordinator or Designee:

☐ Disabilities ☐ Education ☐ Health ☐ Nutrition
☐ FCE ☐ Transition ☐ Social/Emotional Support Services

Date Received:_____

Action Taken/Strategies Planned:

☐ Provide activities and rescreen in _____ months
☐ Share results with parents and health provider
☐ Refer for: ☐ Hearing ☐ Vision ☐ Behavior
☐ Refer to Florida Diagnostic & Learning System (FDLRS)
☐ Refer to primary health care provider--specify reason:_____
☐ Galileo/Acu Screen
☐ ASQ-SE
☐ No further action taken at this time
☐ Other--specify:_____
Follow-up: