

NEW STUDENT

Special Education Information Form

Please return completed form to:

Yellowstone-West/Carbon County Special Services Cooperative

2016 Grand Ave, Suite C

Billings MT 59102

FAX: 406-839-2345

STUDENT'S NAME: _____ SEX: _____
(First) (Middle Initial) (Last)

BIRTHDATE: _____

RACE/ETHNICITY (circle one): 01 American Indian or Alaskan Native
02 Asian or Pacific Islander
03 Hispanic or Latino
04 Black or African American (not Hispanic)
05 White (not Hispanic)

HOME ADDRESS: _____

PARENT/GUARDIAN: _____

TELEPHONE: _____

SCHOOL ATTENDING: _____ GRADE: _____

DISABILITY CATEGORY:

- | | |
|--|--|
| <input type="checkbox"/> AU (Autism) | <input type="checkbox"/> DD (Developmental Delay ages 3-5) |
| <input type="checkbox"/> CD (Cognitive Delay) | <input type="checkbox"/> DB (Deaf/Blindness) |
| <input type="checkbox"/> DE (Deafness) | <input type="checkbox"/> HI (Hearing Impairment) |
| <input type="checkbox"/> ED (Emotional Disturbance) | <input type="checkbox"/> OI (Orthopedic Impairment) |
| <input type="checkbox"/> LD (Specific Learning Disability) | <input type="checkbox"/> SL (Speech/Language Impairment) |
| <input type="checkbox"/> OH (Other Health Impairment) | <input type="checkbox"/> VI (Visual Impairment) |
| <input type="checkbox"/> TB (Traumatic Brain Injury) | |

RELATED SERVICE(S): ☐ Speech/Language Therapy ☐ Physical Therapy ☐ Occupational Therapy

TEACHER SIGNATURE: _____