**Jackson Public School District**

**Office of Exceptional Education Services**

621 South State Street

Jackson, MS 39201

**Child Find Referral to Multidisciplinary Evaluation Team                    Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Within 2 Calendar Days of Parent and/or TST Request)

The Teacher Support Team at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is requesting a Multidisciplinary Evaluation Team review for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

This request is being made due to:

                        { } Lack of Response to Intervention

                        { } Parent Request

 { } Current 504 Plan

                        { } Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Complete the Following Information:

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\*\*To Be Completed by the Child Find/Eligibility Division\*\*

Date of Receipt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of MET:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Decision:

     { } Refer for Comprehensive Evaluation

     { } Refer to TST for Continued Interventions

     { } Refer for 504 Plan