JAMES RIVER SPECIAL EDUCATION COOPERATIVE
CHILDCOUNT FORM

NAME OF STUDENT:

DEMOGRAPHIC DATA:

Birthdate:
Sex:
Race:
Grade Level:
Case Manager:
Medicaid Eligible: Yes/No

Parent/Guardian:
Title:
Legal Status:
Home Phone #:
Work Phone #:
Street Address:
City, State, Zip:

PLACEMENT DATA:

Placement Status: Initial ___ New _____ Continued ___
Prgm Entry Date (only if initial/new)
Primary Disability:
Secondary Disability:
LRE Placement or EE:
Home District & Plant:
Serving District & Plant:

IEP Date:
3 Year Evaluation Date:
Exit Date:
Exit Reason
Open-Enr – Same District:
Open-Enr – Diff District:
Home Education:
Agency Placed:

EDUCATIONAL PROVIDERS:

Autism:
Traumatic Brain Injury:
Intellectual Disability:
Deaf:
Deaf/Blind:
Non-Categorical Delay:
Hearing Impaired:
Speech/Language Impaired:
Vision Impaired:
Emotionally Disturbed:
Orthopedically Handicapped:
Other Health Impaired:
Specific Learning Disabilities:

RELATED SERVICE PROVIDERS:

Adaptive Physical Education:
Assistive Technology Services:
Audiological Services:
Counseling Services:
Interpreter Services:
Mobility Training:
Occupational Therapy:
Physical Therapy:
Psychological Services:
Recreation Services:
Rehabilitation Services:
School Health Services:
Social Worker: