REFERRAL TO PAUL BUNYAN HELP ME GROW

For children birth to kindergarten
Aitkin, Brainerd, Crosby-Ironton, Pequot Lakes, Pillager, Pine River-Backus

Please provide all information and send referral to the Paul Bunyan Education Cooperative at:
FAX: 218-454-6958 SCAN & EMAIL: helpmegrow@pbcoop.org PHONE: 218-454-5534

Date of Referral ______________________ Is Parent/Guardian aware of Referral? ▢ Yes ▢ No

Child __________________ __________________ __________________ Date of Birth______________ ▢ Female ▢ Male
Last First Middle

Child Resides With: ▢ Father ▢ Mother ▢ Grandparent ▢ Foster Parent ▢ Guardian

Name ____

Address____

Phone____
(Cell Phone - Text: ▢ Yes ▢ No) (Home Phone) (Work Phone) (Email)

▢ Father ▢ Mother ▢ Grandparent ▢ Foster Parent ▢ Guardian

Name ____

Address ____

Phone____
(Cell Phone - Text: ▢ Yes ▢ No) (Home Phone) (Work Phone) (Email)

REASON FOR REFERRAL

▢ Health Concern/Condition/Syndrome/Diagnosis ____
▢ Vision - Results of Vision Screening ____
▢ Hearing - Results of Newborn or Other Hearing Screening ____
▢ Motor ▢ Cognitive ▢ Communication ▢ Social/Emotional/Behavioral ▢ Adaptive

Additional Information ____
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____(Please add additional pages if necessary)

Person Making Referral: ______________________________Agency ______________________________

Contact Information____

______________________**FOR OFFICE USE - Paul Bunyan Education Cooperative**______________________

Central Referral Intake ______________________ School District ______________________ ▢ Address was checked