



Pre-K Referral Form

Child's Name: _____ Date of Birth: _____

Gender: Male Female

Race / Ethnicity: _____ Social Security Number: _____

Referring Agency / Program / Physician: _____

Mailing Address:

Parent/Guardian: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Reason for Referral: _____

Parent/Legal Guardian Signature: _____

Please return completed forms to:
Griffin-Spalding County Schools
Attn: Margaret Faulk, Special Education
234 E. Taylor Street
Griffin, GA 30224