Telephone: 906-863-5665

MENOMINEE COUNTY ISD
Intermediate School District

Fax: 906-863-7776

1201- 41st Avenue
Menominee MI 49858
http://mc-isd.org

EARLY ON REFERRAL FORM

Date of Referral:	Child's Name:	
Date of Birth:	Sex:	Race:
Mother/Guardian:		Father/Guardian:
Mother Address:		Father Address:
City, State, Zip:		City, State, Zip:
Mother Phone:		Father Phone:
Mother Email:		Father Email:
Student's Primary Residence: □ Mother's Address □ Father's Address □ Shared Equally/Live Together		
Primary Health Care Provider Name & Agency:		
Primary Health Care Provider Phone:		
Referring Person/Agency:		
Concerns/Reason for Early On Referral:		

PARENT/GUARDIAN CONSENT:
I am aware of this Referral to Early On and give my consent for evaluation.

_____ _____
Parent/Guardian(s) Signature Date Signed

Return completed form to:

Early On Coordinator
Menominee County ISD
1201 41st Avenue
Menominee MI 49858

Fax: (906)863-7776
Phone: (906)863-5665 x-1029

Health and Developmental History

Child's Name _____ Date of Birth _____

Primary Physician/phone number _____

Date of last physician visit _____ Any health concerns? _____

Is the child taking any prescribed medication? _____ Yes _____ No
If yes, what medication?

Child's birth weight _____ Height _____ Weeks gestation _____

Any complications with pregnancy or delivery? _____ Yes _____ No
If yes, what complications?

Are child's immunization up to date? _____ Yes _____ No

Has child been hospitalized? _____ Yes _____ No
If yes, for what? How long?

Has child had any accidental injuries requiring medical assistance? _____ Yes _____ No
If yes, what type?

Information about child's development to date

Information about child's sleep/feeding schedule

Do you have any concerns about the child's hearing? _____ Yes _____ No
Do you have any concerns about the child's vision? _____ Yes _____ No
Have there been any significant changes with the child's health or social situation (death, divorce, move, etc)?
Do you have any concerns about your child's health or development?

Who lives in the home with the child? Who is the primary caregiver?

DOCUMENTS FOR THE DISCLOSURE STUDENT INFORMATION
TO
MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES

_____ SCHOOL DISTRICT (the School District) currently provides necessary school-based health services to your child at no cost to you, the parent/guardian. The School District is participating in a Michigan Department of Health and Human Services program through which Federal Medicaid funds are made available to school districts in the State to help cover the costs of providing necessary school-based health services to students. By participating in this program, the School District is allowed to seek Federal Medicaid funds to help cover the costs of the health services the School District provides to your child. In order to seek the Federal funds, the School District must disclose information from your child's education records to Michigan Department of Health and Human Services. This may include personally identifiable information (ex. Name, Date of Birth) as well as records or information about the services that may be provided to your child.

The School District requests your consent to disclose information from your child's education records to Michigan Department of Health and Human Services as necessary for the School District to seek Medicaid funds to help cover the costs of the school-based health services the School District provided to your child. Whether or not you give your consent or if you withdraw your consent, the School District will continue to provide necessary health services to your child at no cost to you, the parent/guardian.

NOTIFICATION OF PARENT/GUARDIAN RIGHTS AND PROTECTIONS

To ensure that your child has access to a free appropriate public education, as required by Federal law, the School District must

- obtain your written consent prior to disclosing your child's health information to Michigan Department of Health and Human Services,
- may not require you to sign up for or enroll in any public benefits or insurance programs,
- may not require you to pay any out-of-pocket expenses such as a deductible or co-payment for the costs of the health services the School District provides to your child, and
- may not use your child's Medicaid or other public benefits if that use would.
    - decrease available lifetime coverage or any other insured benefit,
    - result in you or your family paying for services that would otherwise be covered by Medicaid or other public insurance program and that are required for your child outside of the time that your child is in school,
    - increase your insurance premiums or lead to the discontinuation of any public benefits or insurance, or
    - risk the loss of your eligibility for home and community-based waivers, based on aggregate health-related costs.

Giving your consent will cost you, the parent guardian, nothing, but will allow the School District to seek Federal financial support needed to better provide services to students. Whether or not you give your consent or if you withdraw your consent, the School District will continue to provide services to your child at no cost to you, the parent/guardian.

Please use the attached form to select your consent option.

PARENT/GUARDIAN CONSENT TO DISCLOSE STUDENT INFORMATION
TO
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

STUDENT'S NAME_____
(First) (Middle Initial) (Last)

STUDENT'S DATE OF BIRTH ___ ___/___ ___ / ___ ___

Please review the statements below and select your option by checking the appropriate box.

☐ Yes. As the parent/guardian of the student named above, I give my consent to the School District to disclose information from my child's education records to Michigan Department of Health and Human Services as necessary to allow the School District to seek Medicaid funds to help cover the costs of the school-based health services School District provided to my child.

I understand that my consent will remain in effect until I withdraw it, and that I may withdraw my consent at any time by notifying the School District. If I withdraw my consent, the School District will continue to provide necessary school-based health services to my child at no cost to me, the parent/guardian.

☐ No. As the parent/guardian of the student named above, I *do not* give my consent to the School District to disclose information from my child's education records to Michigan Department of Health and Human Services.

I understand that if I do not give my consent, the School District will continue to provide necessary school-based health services to my child at no cost to me, the parent/guardian.

Name: _____
(Name of parent/guardian)

Signature: _____ Date: _____
(Signature of parent /guardian) (Month-day-year)

Telephone: 906-863-5665

MENOMINEE COUNTY ISD
Intermediate School District

Fax: 906-863-7776

1201- 41st Avenue
Menominee MI 49858
Http://mc-isd.org

Dear Parent(s)/Guardian(s) of: _____

Therapy services in the schools are based on educational relevance and need as determined by the Individualized Education Planning Team (IEPT). A doctor's order is needed for school based services and, if your child becomes eligible for Medicaid, to bill Medicaid for these services.

Please sign this form and we will secure a physician authorization. If you prefer to take this form to your physician, please have him/her fax a prescription to our office. This prescription is required to be renewed annually.

If you have any questions or concerns please contact the Special Education Director at 906-863-5665 x1012.

Thank you.

****

To: Dr. _____

RE: _____ Date of Birth: _____
Student Name

A prescription is needed for the following services:

_____ Speech/Language - Evaluation and/or treatment per educational goals

_____ Occupational Therapy - Evaluation and/or treatment per educational goals

_____ Physical Therapy - Evaluation and/or treatment per educational goals

_____ Orientation and Mobility - Evaluation and/or treatment per educational goals

_____ Personal Care Services (Please check all that apply)

☐Ambulation	☐Dressing	☐Personal Hygiene	☐Toileting
☐Mobility/Positioning	☐Grooming	☐Skin Care	☐Muscle Strengthening
☐Bathing	☐Respiratory Assistance	☐Eating/Feeding	☐Medical Equipment Maintenance
☐Transferring	☐Meal Preparation	☐Maintaining Continence	☐Health Related Functions through Hands On Assistance, Supervision and Cueing
☐Redirection and Intervention for Behavior	☐Intervention for Seizure Disorder	☐Assistance with Staff Administered Medications	

Please fax a prescription to the Menominee County ISD (Fax: 906-863-7776) as soon as possible

Parent Signature: _____

Authorization to Release *Early On*® Record

Child Information

Child's Name:	Date of Birth:
Parent's/Guardian's Name:	

Purpose

The purpose of this form is to obtain parental consent to release information from the *Early On* record to other agency(ies) or person(s).

Agency(ies)/Person(s) to Whom Information May Be Released

Agency/Person:

_____

Information to be released:
☐ Full *Early On* record
☐ Specific information within *Early On* record: _____

Agency/Person:

_____

Information to be released:
☐ Full *Early On* record
☐ Specific information within *Early On* record: _____

Authorization

My signature below means I understand that:

- ✓ My authorization to allow the sharing of information about my child is voluntary and expires:
  - ☐ upon exit from *Early On* or my child's third birthday.
  - ☐ one year after signature date.
- ✓ *Early On* has no control over the agency(ies)/person(s) I have listed to receive my protected information. Therefore, my protected information disclosed under this authorization may no longer be protected by the requirements of the Family Educational Rights and Privacy Act (FERPA), and will no longer be the responsibility of *Early On*.
- ✓ Refusal to sign this authorization will not affect my ability to obtain *Early On* services.
- ✓ I may revoke or cancel consent at any time, without penalty, by notifying *Early On* in writing. Information that has already been shared based on this authorization cannot be taken back.

I have read and understand this authorization form (or it has been read to me in a language I understand) and:

☐ I authorize *Early On* to engage in verbal, written, and/or electronic communication with the identified agency(ies) or person(s) in order to release the information listed.
OR
☐ I do not wish to have any information released at this time.

Signature of Parent/Guardian:	Relationship to Child:	Date:

Early On® Request for Protected Information (Health)

Child Information	
Child's Name:	Date of Birth:
Parent's/Guardian's Name:	

Purpose

The purpose of this request is to collect information necessary to determine your child's eligibility for *Early On*, and to plan and provide services as determined through the multidisciplinary team process.

Medical Provider(s) Authorized to Share Information with *Early On*

The medical provider(s) listed below have permission to share the specific information listed about my child.

Medical Provider:	Specific information to be shared with *Early On:*
Medical Provider:	Specific information to be shared with *Early On:*

Authorization

My signature below means I understand that:

- ✓ My authorization to allow the sharing of information about my child is voluntary and expires upon exit from *Early On* or my child's third birthday.
- ✓ Information regarding behavioral and mental health services or communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Deficiency Syndrome or AIDS related complex) may be shared if I initial here ____ or if I list this type of information above.
- ✓ Information received under this authorization becomes part of my child's educational record, is protected by the Family Educational Rights and Privacy Act (FERPA), and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA).
- ✓ Information may be re-disclosed by *Early On* as part of the educational record protected by FERPA.
- ✓ I may refuse to sign this authorization.
  - o Refusal to sign may affect the ability of *Early On* to obtain information necessary to demonstrate that my child meets *Early On* eligibility criteria.
  - o If my child is found eligible for *Early On*, refusal to sign this authorization will not affect my ability to obtain *Early On* services. However, the information obtained can help provide services that are individualized for my child.
- ✓ I may revoke or cancel consent at any time, without penalty, by notifying *Early On* in writing. Information that has already been shared based on this authorization cannot be taken back.

I have read and understand this authorization form (or it has been read to me in a language I understand) and:

☐ I authorize the above listed medical provider or designee to engage in verbal, written, and/or electronic communication in order to share specified records and information.
OR
☐ I do not wish to have any information shared at this time.

Signature of Parent/Guardian:	Relationship to Child:	Date:

Early On® Request for Information (Non-Health)

Child Information	
Child's Name:	Date of Birth:
Parent's/Guardian's Name:	

Purpose

The purpose of this request is to collect information necessary to determine your child's eligibility for *Early On*, and to plan and provide services as determined through the multidisciplinary team process.

Agency(ies)/Person(s) Authorized to Share Information with *Early On*

The agency(ies)/person(s) listed below have permission to share the specific information listed about my child.

Agency/Person:	Specific information to be shared with *Early On:*
Agency/Person:	Specific information to be shared with *Early On:*

Authorization

My signature below means I understand that:

- ✓ My authorization to allow the sharing of information about my child is voluntary and expires upon exit from *Early On* or my child's third birthday.
- ✓ Information received under this authorization becomes part of the child's educational record, and is protected by Family Educational Rights and Privacy (FERPA).
- ✓ Information may be re-disclosed by *Early On* as part of the educational record protected by FERPA.
- ✓ Refusal to sign this authorization will not affect my ability to obtain *Early On* services.
- ✓ I may revoke or cancel consent at any time, without penalty, by notifying *Early On* in writing. Information that has already been shared based on this authorization cannot be taken back.

I have read and understand this authorization form (or it has been read to me in a language I understand) and:

☐ I authorize the above listed agency(s)/person(s) to engage in verbal, written, and/or electronic communication in order to share specified records and information.

OR

☐ I do not wish to have any information shared at this time.

Signature of Parent/Guardian:	Relationship to Child:	Date:

Early On® Michigan Prior Written Notice: Birth to Three Years

Name of Child _____Date of Birth _____

Name of Parent/Guardian _____Date of Notice _____

Early On is required to provide you with written notice prior to proposing or refusing to initiate or change the identification, evaluation, placement, or provision of appropriate early intervention services with your child or family and to help you be part of the decision-making process. The intent is to provide notice of the action(s) and reason(s) being proposed or not selected for your child and a reminder of your procedural safeguards.

Early On Decision

Screening:

☐ Developmental screening proposed
☐ No evaluation is proposed (as a result of screening)

Reason:

Note: Parents may request an evaluation at any time during the screening process regardless of the screening results.

Developmental Evaluation(s):

☐ Developmental Evaluation for *Early On* eligibility
☐ Developmental Evaluation for Michigan Mandatory Special Education eligibility
☐ No evaluation is proposed

Reason:

Eligibility:

☐ Your child is eligible for *Early On* Michigan services.
☐ Your child is not eligible for *Early On* Michigan services.

☐ Your child is eligible for Michigan Mandatory Special Education services.
☐ Your child is not eligible for Michigan Mandatory Special Education services.

Reason:

Provision of *Early On* Services:

An Individualized Family Service Plan (IFSP) has been developed or updated. We are proposing to provide the service(s) and placement(s) listed in the service section of your IFSP dated _____.

Any service(s) and/or placement(s) proposed, but not accepted by the parent(s), thus not identified on this IFSP:

_____

Any service(s) and/or placement(s) discussed at the IFSP meeting, but not selected by the IFSP team:

_____

Reason:

Early Exit from *Early On*:

☐ *Early On* service provision will end before age three.

Reason: _____

Family Rights / Procedural Safeguards

A copy of the *Early On* Procedural Safeguards Protecting Families' Rights brochure can be found on the 1800*EarlyOn* website. You may request a copy of this document and/or ask for assistance in understanding your Family Rights by contacting your Service Coordinator or person listed below.

This notice was provided ☐ in person ☐ by mail ☐ by email.

_____

Name & Title Phone

You have the right to request mediation or an impartial due process hearing, or you may file a complaint should you disagree with the above proposed or refused action(s). Complaint forms can also be found on the 1800*EarlyOn* website.

If Parental Native Language or Other Mode of Communication is Not a Written Language

This Prior Written Notice information has been translated orally or by other means to the parent in the parent's native language or other mode of communication and the parent has indicated understanding of this notice. Method used to communicate this information:

_____

Service Coordinator Initials: _____ Service Coordinator Initials: _____

Early On® Parental Consent

Assessment/Evaluation Type

- ☐ Initial Evaluation
- ☐ Initial Assessment
- ☐ Evaluation for Ongoing Eligibility
- ☐ Ongoing Assessment

Child and Parent/Guardian Information

Child's Legal Name:_____ Birth Date:_____

Parent/Guardian Name:_____

Information

Early On Michigan helps to make sure eligible children get the services they need to be healthy, grow and develop appropriate skills. To find out if your child qualifies for services from *Early On,* **or to assess your child's development,** your child will be evaluated in the following areas:

- Communication:
  - ► how your child understands and lets you know what he/she wants.
- Social-Emotional:
  - ► how your child gets along with family members and other people.
- Cognitive:
  - ► how your child thinks and solves problems.
- Adaptive:
  - ► how your child performs tasks such as dressing, feeding, and toileting.
- Physical:
  - ► *Motor* – how your child moves.
  - ► *Health Status* – review of your child's health history and status, including vision and hearing screening.

You know your child best and can provide important information about your child. Additionally, your child's doctor and others who know your child may be asked to provide information about strengths, needs, health and development. *Early On* only gathers information about your child with your permission.

The information gathered is kept in a confidential *Early On* record. More information about how *Early On* works and your family's rights is in the *Early On* Michigan 'Your Family has Rights' brochure found at: Your Family Has Rights Brochure.

Consent

Please indicate Yes or No for the following statements that apply:

☐ I would like to learn if my child and family are eligible to participate or continue in *Early On* Michigan.

Yes No I consent to the evaluation/assessment of my child's abilities.

Yes No I consent to the review of medical, educational or other records to assist in the evaluation/assessment of my child.

Yes No I understand this consent form

☐ I do not give consent for an evaluation/assessment of my child. I understand that my child will not be evaluated for *Early On* eligibility. I understand that without consent and evaluation, an Individualized Family Service Plan (IFSP) will not be developed and we will not receive services available through *Early On* Michigan.

Signature of Parent/Guardian: _____ Date: _____

Early On Representative: _____ Date: _____

Child's Name:_____ Date of Birth:___-___-___
Date of Sceening:___-___-___Screener Name:_____Agency:_____

Hearing Development Screening Checklist

Birth to 3 Months:

Yes	No	
___	___	Does your child startle, awaken or cry at loud sounds?
___	___	Does your child turn to you when you speak?
___	___	Does your child smile when spoken to?
___	___	Does your child seem to recognize your voice and quiet down if crying?

4 to 6 Months:

___	___	Does your child respond to "No", or changes in your tone of voice?
___	___	Does your child look around for the source of new sounds, e.g., the door bell, vacuum, dog barking?
___	___	Does your child notice toys that make sounds?

7 Months to1 Year:

___	___	Does your child recognize words for items like "cup", "shoe", "juice"?
___	___	Does your child respond to requests like "Come here" or "Want more"?
___	___	Does your child enjoy games like peek-a-boo or pat-a-cake?
___	___	Does your child turn or look up when you call his or her name?

1 to 2 Years:

___	___	Can your child point to pictures in a book when they are named?
___	___	Does your child point to a few body parts when asked?
___	___	Can your child follow simple commands and understand simple questions such as : "Roll the ball." "Kiss the baby." "Where's your shoe?"

2 to 3 Years:

___	___	Does your child continue to notice sounds (telephone ringing, television sounds or knocking at the door)?
___	___	Can your child follow two requests like: "Get the ball." or "Put it on the table,"

All Ages:

___	___	Do you have any concerns about your child's hearing?

Conditions associated with possible hearing loss: *(Parent or physician may check any that apply)*

___ repeated episodes of otitis media (ear infection)
___ prematurity
___ cranio-facial anomalies
___ excessive noise exposure
___ any serious illness (including high fever)
___ family history of hearing loss
___ failed hearing screening
___ experienced head trauma
___ exposure to ototoxic drugs

Outcome: Referral to: ___Audiology evaluation Date: __-__-__
___ENT assessment Date: __-__-__
___***Early On***® Date: __-__-__

Child's Name:_____ Date of Birth:___-___-___
Date of Sceening:___-___-___Screener Name:_____Agency:_____

Vision Screening Checklist

Birth to 1 month:

Yes	No	
___	___	Pupil reaction to light.
___	___	Blinks when light is too bright.
___	___	Fixates on face (eye contact).
___	___	Eyes turn the opposite direction that head turns or tilts; this reflex (doll's eyes reflex) is inhibited after a few weeks as an infant's fixation increases.

1 to 3 Months:

___	___	Stares at light source.
___	___	Eye movements poorly coordinated (may not always appear to be straight or work together)
___	___	Fascinated by lights and bright colors.
___	___	Shifts eyes toward sound source.
___	___	Follows or tracks a slowly moving object horizontally. Tracks from center to side to side to center (can't cross midline).
___	___	Emerging convergence on objects as close as 5 inches.
___	___	Visually inspects nearby surroundings (may move head and eyes as well as body)
___	___	Watches own hand movements.
___	___	Prefers to look at some pictures, people, toys longer than others, alerts to favorite object.

3 to 5 Months:

___	___	Looks at objects in hands momentarily.
___	___	Looks at hands and plays with hands at midline.
___	___	Shifts gaze from hand to object and from object to hand.
___	___	Fixates on object at 3 feet distance.
___	___	Reaches for caregiver's face.
___	___	Reaches for dangling toy.
___	___	Follows a moving object over 180 degree arc.
___	___	When sitting or laying down, turns head to either side to look at something she or he hears.
___	___	Watches object dropped.
___	___	Visually directed reach and grasp.

5 to 7 Months:

___	___	Fixation fully developed.
___	___	Eyes appear to be in balance with each other. Any deviation (in, out, up or down) seen at 6 months should be followed medically.
___	___	While sitting, tracks a toy moving across the table.
___	___	Looks into mirror and may smile or pat image.

Child's Name:_____ Date of Birth:___-___-___
Date of Sceening:___-___-___Screener Name:_____Agency:_____

7 to 12 Month:

Yes	**No**	
___	___	Turns to look for objects out of reach.
___	___	Looks after toys which fall to the floor when sitting in a chair.
___	___	Removes cover to obtain toy which was hidden.
___	___	Looks at small objects, e.g., Cheerio, raisin, or cereal.
___	___	Tilts head to look up;
___	___	Looks at picture in book.
___	___	Eye-hand coordination developing.
___	___	Fix, follow, shift, scan, converge & diverge well developed and integrated into functional skills: reaching, manipulation, self-care, play, getting around, exploring and observing.

1 to 2 Years:

___	___	Finds different object from a group of like objects.
___	___	Interest in pictures.
___	___	Marks and scribbles.
___	___	Points to object asked for on a picture.
___	___	Looks at picture book.
___	___	Points to familiar persons, animals, or toys on request.
___	___	Imitates isolated marks and circular motion with crayon.
___	___	Interested in TV momentarily.
___	___	Visually searches for missing object or person.

2 to 3 Years:

___	___	Imitates adult making vertical or horizontal lines with pencil/crayon.
___	___	Imitates circle with pencil or crayon
___	___	Matches colors (red, yellow, blue, black, white)
___	___	Discrimination and identification of familiar objects such as toys, foods or clothing
___	___	Matches pictures to objects and pictures to pictures
___	___	Points to body parts on doll or in picture when asked
___	___	Names or points to self in photograph
___	___	All optical skills smooth

Symptoms of possible eye problems

___	Squinting	___	Light gazing
___	Frequent blinking	___	Red, encrusted, swollen eyes
___	Sensitivity to light	___	Crossed eyes
___	Inflamed or watery eyes	___	Eye wanders (after 6 months of age)
___	Frequent rubbing of eyes	___	Stumbling or falling over objects
___	Over or under reaching of objects		

Physician information: _____
_____
_____

Outcome: Referral to: ___Ophthalmology evaluation Date: __-__-__ and
___***Early On*®** Date: __-__-__

Compiled by Connie Doss & Catherine Hula, Ingham ISD, Reformated by EOTTA 5-6-05
Bibliography: Li,A.,Hwang, T.,Hula, C. 1994 Educational and Functional Vision Evaluation for the Visually Impaired (EFVE)
Michigan Eye Health Resource Center, Eyes to See, Upshaw Instituted for the Blind

INITIAL REFERRAL FORM

☐ Carney-Nadeau ☐ Stephenson ☐ Menominee ☐ North Central ☐ Headstart

Date of Referral:	Student's Name:			
Date of Birth:	Sex:	Grade:	Race:	UIC#:
Mother/Guardian:		Father/Guardian:		
Mother Address:		Father Address:		
City, State, Zip:		City, State, Zip:		
Mother Phone:		Father Phone:		
Mother Email:		Father Email:		
Student's Primary Residence: □ Mother's Address □ Father's Address □ Shared Equally/Live Together				

PARENT PERMISSION FOR INITIAL EVALUATION

Your child has been referred for a special education evaluation to determine if they are eligible to receive special education programs and services. Areas of concerns:

□ Math □ Reading □ Writing □ Social/Emotional □ Speech/Language □ Cognitive Functioning □ Other _____

PROPOSED EVALUATION/SERVICE: If you consent to have your child evaluated, the following persons **may be involved.** (An explanation of these services is found on the reverse side of this form.)

□ Psychologist □ Teacher/Consultant □ Occupational Therapist □ School Social Worker □ Speech/Language Pathologist □ Other_____

PARENT/GUARDIAN CONSENT:

In consenting to the evaluation of _____

Student's Name *Native Language if other than English*

I understand the results of this evaluation will be presented at an individualized educational planning team meeting. These results will be used to determine whether my child is eligible for special education programs or services. I understand the contents of this notice and have received a copy of the procedural safeguards detailing student's and parent's rights.

PARENT/GUARDIAN INPUT:

Please provide any additional information you think would be helpful to the diagnostic team (continue on back if needed).

My signature below indicates my consent to this evaluation*

_____

Parent, Legal Guardian, or Self *Date*

_____

Administrator Receiving Consent *Date Received*

*If this form is not returned within 7 days, the school district has a right to request a hearing to determine if an evaluation may be given without your consent

Person Making Referral _____ Person Completing Form _____

Date received by MCISD _____

Send Completed Form to:

Menominee County ISD
1201 – 41st Avenue
Menominee, MI 49858
Fax: 906-863-7776
Phone: 906-863-5665