PLEASE FAX TO: (408) 295-6104
OR MAIL TO: EARLY START PROGRAM
ATTN CINDY WRIGHT
780 THORNTON WAY
SAN JOSE CA 95128

Early Start Program: Student Intake Data

Packet Date / / ***DOB:*** / / ***Sex:***

Name: First ***Last*** ***Home Language:***

Parent Name(s): ***Child's Ethnicity:***

Address: ***Street*** ***Residential Type:***

City ***Zip:***

District of Residence:

Phones: ***Home:*** ***Work:*** ***Work (dad)***

Nature of the Disability
Diagnosis
Reason for Referral

IM Preference: ***Time:*** ***Day(s):*** ***Location:***

Referred by: ***Agency:***

Phone: ***Fax:***

Address:

Notes:

I give permission to share important medical information regarding my child to the Early Start Program.

Date:____/____/_____ ***Parent/Guardian Signature_____***

Please include medical information with your referral to expedite the referral process