Melanie L. Watson, Ph.D.
Fl. Licensed Psychologist PY 8772

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APPLICATION FOR SERVICE

Child's Name:	Date of Birth:
Age: Gender:	
Name of School:	Grade:
Reason for Referral:	
Previous Evaluations (where and what date?):	
Is Your Child Currently Receiving Exceptional Student Education? Yes No *(if yes, please indicate what program).*	
Does Your Child Wear Glasses? Yes No *(Please indicate if corrective lenses are for distance vision or close vision)* Does Your Child Wear Hearing Aids? Yes No *(Please indicate type of hearing loss)*	
Form Completed By: *(please print)*	
Relationship to Child:	
Phone:	