

STAR NET Region IV Database / Library Borrower Form

Mail: STAR NET Region IV, 1000 South Illinois Street, Belleville, Illinois, 62220

Fax: 618-236-4868 Email: dcooper@sccroe50.org

Phone: 618-825-3968 www.starnet.org

Name _____ Email _____

(H) Address _____ City _____ State _____ Zip _____

(H) County _____ (H) Phone _____ (Cell) _____

Name of Agency/ School _____ (W) Phone _____

(W) Address _____ City _____ State _____ Zip _____

District Name/ Number _____ (W) County _____

IEIN _____ Gateways Membership ID# _____

Illinois Educator Identification Number (IEIN): If you have an educator license from Illinois, you **MUST** provide your IEIN in order to receive Illinois Professional Development Hours. If you do not know your IEIN, you can find it in ELIS on ISBE's website.

Please initial if you would like to use the STAR NET Library

I accept full responsibility for the items in my possession. In the event of loss or damage, I agree to reimburse the STAR NET Resource Center the full cost of replacing the borrowed item. I understand that materials are lent for preview purposes only. Any reproduction of copyrighted materials by others or me, while items are in my possession, is in violation of federal copyright laws.

Initial _____ Date _____

Program:

- Blended ECSE/Preschool for All
- Child Care
- Community Preschool
- Early Childhood Special Education (ECSE)
- Early Intervention (EI)
- Head Start
- Primary (K-3)
- Preschool for All (PFA)
- State Prevention Initiative (0-3)
- Preschool Expansion
- Other (please list) _____

Position:

- Administrator
- Developmental Specialist (EI)
- Family Educator
- OT PT SLP
- Parent/Family Member
- Psychologist
- Service Coordinator (EI)
- Social Worker
- Teacher
- Paraprofessional
- Other (please list) _____

Age of children you work with: birth-2 yrs. 3, 4, or 5 yrs. Other (please list) _____

1. What is your relationship with the child who has been identified as having a disability?

- Parent Grandparent Foster parent Guardian Other relative

2. Child's Age _____ Date of Birth _____ Male Female

3. Child's Primary Disability

- ADD/ADHD
- Autism Spectrum Disorder
- Cerebral Palsy
- Deafness/Hearing Impairment
- Developmental Delay
- Down syndrome
- Emotional Disability
- Intellectual Disability
- Multiple Disabilities
- Orthopedic Impairment
- Other Health Impairment
- Speech/Language Impairment
- Traumatic Brain Injury
- Visual Impairment
- Other (please list) _____

4. My child has an: **IFSP** (Individualized Family Service Plan) **IEP** (Individualized Education Program)

5. May we contact you if another parent is interested in talking with someone who has a child with a similar disability? Yes No

Educators/Professionals

Parents/Caregivers