SFUSD

San Francisco Unified School District
Special Education Services
Preschool Intake Unit
(415) 379-7693
750 25th Avenue
San Francisco, CA 94121

Dear Parent/Guardian:

Thank you for contacting us at the Preschool Intake Unit. You have asked the San Francisco Unified School District (SFUSD) to conduct an assessment of your child.

In order to respond to your phone request, the District needs the following items:

1. Written request or letter that tells us your concerns about your child with your signature (you can use the request form in this packet)
2. Two proofs of residency (examples are a PG&E bill or phone bill)
3. Copy of your child birth certificate.

After the District receives your written request and two proofs of residency, the Preschool Intake Clerk will reply within 15 calendar days. Please note that the 15 days do not apply during the summer and during school holidays exceeding 5 days.

The other forms in this packet ask for information that will help the SFUSD assessment professionals get to know your child, address your concerns and determine assessment needs. Please complete and return these forms including the Developmental and Family/Home Study. If you have any questions about these forms or need help filling them out, please call us at 379-7693.

You will also find in this packet some frequently asked questions that explain the assessment process and a list of the forms.

Please return all forms to

Minoo Shah
Special Education Services
Preschool Intake Unit
750 25th Avenue
San Francisco, CA 94121

Sincerely,

Minoo J. Shah

Minoo Shah
Supervisor, Preschool Special Education Services

SFUSD SAN FRANCISCO PUBLIC SCHOOLS

Special Education Services
Preschool Intake Unit
750 25th Avenue , San Francisco, CA 94121
Telephone: (415) 379-7693
Fax: (415) 750-8690

Parent/Caregiver Questionaire

Date:_____ Completed by:_____

*Did another person assist you when completing this form? Name/relationship to child:*_____

Child's Full Name:_____ Goes by:_____

Child's Date of Birth:_____ Child's Gender: □ male □ female

Child's Ethnicity: (list as many as appropriate)_____

Reason for referral:_____

Caregiver #1
□ Parent □ Guardian □ Grandparent □ Foster Parent

Name:_____

Address:_____

Apt. #_____Zip_____
Is this the child's primary residence? □ yes □ no

Best # to call:_____
□ home □ cell □ work

Additional # to call:_____
□ home □ cell □ work

Caregiver #2
□ Parent □ Guardian □ Grandparent □ Foster Parent

Name:_____

Address:_____

Apt. #_____ZIP_____
Is this the child's primary residence? □ yes □ no

Best # to call:_____
□home □cell □work

Additional # to call:_____
□ home □ cell □ work

Who has Educational Rights for the child?: _____

Home Language Survey
What language do the adults use most frequently at home? _____
What language do you use most frequently to speak to your child?_____
What language did your child first learn when s/he began to talk? _____
What language does your child use most frequently at home?_____

Preschool/Childcare Information (if applicable):

School Name:_____ Start Date:_____

Address:_____ Teacher:_____

Telephone Number:_____ Days/time:_____

Previous schools/childcare:_____

(Please use the back of the form if you need more space to write)

Birth/Delivery Information:

Length of Pregnancy:_____ Birth Weight:_____

Any complications during pregnancy: □ yes (please explain below) □ no

_____

Any complications during delivery: □ yes (please explain below) □ no ___

_____

Any complications after birth: □ yes (please explain below) □ no _

_____

Developmental Milestones: (Indicate child's age or "not yet")

Gross Motor: Sit upright:_____ Crawl:_____ Walk independently:_____

Fine Motor: Pinch small objects:_____ Self-feed:_____ Hold bottle:_____

Communication: First words:_____ Combining 2+ words:_____

Toilet training: Day:_____ Night:_____

Medical/Health Information:

Is there a history of illness, accidents and/or hospitalizations? □ yes (explain) □ no

_____

Does your child have a diagnosed disorder, delay or special condition? □ yes (explain) □ no

_____

When was your child's last physical examination?_____

Who is your child's primary physician?_____

Telephone #_____ Address:_____

Did your child pass the Newborn Hearing Screening? □ yes □ no

Chronic ear infections: □ yes □ no Have PE tubes been placed? □ yes □ no When?:_____

Date and location of most recent hearing screening/test:_____
Results:_____

Date/location of last vision screening/test:_____
Results:_____

(Please use the back of the form if you need more space to write)

Is there a history of:

Special diet/ food restrictions: □ yes (explain) □ no _____

Feeding Issues: □ yes (explain) □ no _____

Thumb sucking, pacifier use, bottle use? □ yes □ no At what age did s/he stop: _____

Allergies: □ yes (explain) □ no

_____

Asthma: □ yes (explain) □ no

_____

Head injury: □ yes (explain) □ no _____

Genetic testing: □ yes (explain) □ no _____

Is your child currently taking any medications? □yes (please list) □ no

_____

Additional Health Information/Concerns:_____

_____

Description of your child:

As a baby, my child was: (check all that apply)

□ very active □ very quiet □ hard to comfort
□ easy to comfort □ had colic □ hard to feed/nurse
□ shy □ friendly □ easy going
□ trouble sleeping □ cried more than most babies

As a toddler/preschooler, my child was/is: (check all that apply)

□ very active □ very quiet
□ cries a lot □ friendly
□ easy going □ shy
□ interested in other children □ trouble sleeping
□ looks at pictures in books □ not interested in toys
□ not interested in other children/people □ learned to talk easily
□ learning to talk was/is difficult

My child shows unusual difficulty with: (check all that apply)

□ unclear speech □ learning to talk
□ following directions □ walking
□ expressing ideas/wants/needs □ head banging
□ skipping/hopping □ dressing self
□ riding a bike/trike □ extreme fears
□ hand flapping □ self-feeding
□ separating from parents □ throwing/catching a ball
□ interacting with peers □ easily upset by noises
□ excessive temper tantrums □ being in their own world
□ grasping a pencil/crayon/marker □ interested in particular toys
□ easily upset by change in routine □ repetitive behaviors
□ unusual body movements

(Please use the back of the form if you need more space to write)

My child's strengths:_____

_____

My child's interests/favorite toys/activities:_____

_____

How long does your child stay with/pay attention to favorite activities?_____

_____

Describe your child's daily routines (mealtime, sleeping, playing, etc):_____

_____

Things that concern me about my child: _____

_____

Is there a family history of learning difficulties, developmental delays, mental health concerns?
□ yes (explain) □ no

_____

If your child attends a preschool/daycare, does the provider/teacher have any concerns? □ yes (explain) □ no

_____

_____

Does/did your child receive any therapy/intervention services (OT, PT, SLP, ABA, Behavioral, etc)

*Type:_____ Provider:_____ Dates of service:_____

*Type: _____ Provider:_____ Dates of service:_____

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*Type:_____ Provider:_____ Dates of service:_____

<u>*Please provide copies of evaluations and progress reports for your child's current therapy services</u>

Is there anything else you would like us to know about your child?_____

_____

_____

(Please use the back of the form if you need more space to write)

Thank-you for helping us better understand your child!