SAN FRANCISCO UNIFIED SCHOOL DISTRICT
SPECIAL EDUCATION
DEPARTMENT

SFUSD - Early Childhood Special Education
3045 Santiago Street
San Francisco, CA 94116
Phone: (415) 759-2222 | Fax: (415) 242-2528

Dear Parent/Guardian:

Thank you for contacting the San Francisco Unified School District (SFUSD), Early Childhood Special Education (ECSE) Preschool Intake Unit (PIU). This letter has been sent in response to your request for an ECSE assessment of your child.

In order to better conduct our assessment, SFUSD requires you provide the following items:

- ❑ Completed Parent/Caregiver Questionnaire (attached).
- ❑ Completed Teacher Input Form (attached) if your child attends preschool or a childcare facility.
- ❑ Written verification of hearing and vision screenings results if your child's hearing and/or vision have been tested within the last 12 months.
- ❑ Copies of any previously completed assessments of your child.
- ❑ Two (2) original proofs of residency (example: PG&E bill, phone bill, or cable bill).
- ❑ Verification of child's birth date (copy of one of the following: Birth Certificate, Hospital Record, Baptismal Certificate, or Passport).

Upon receiving these items the PIU must reply within fifteen (15) calendar days with a written Assessment Plan (AP) for your child, or Prior Written Notice (PWN) letter explaining why an assessment will not be conducted. Please note that this timeline does not apply during summer recess, or school holidays exceeding five (5) days (e.g. winter break).

The questionnaire included in this packet and requested documents will help the SFUSD assessors get to know your child, accurately address your concerns, and determine any assessment needs.

Please complete in full and mail all documents to:

SFUSD: Special Education
ATTN: Prekindergarten Intake Unit
3045 Santiago Street
San Francisco, CA 94116

Or Fax to: (415) 242-2528
Attn: SPED- PreK Intake Unit

For your convenience, a list of frequently asked questions (FAQ) addressing the assessment process is included in this packet. If you have any additional questions about these forms or need assistance filling them out please contact our office at (415) 759-2222.

Sincerely,

San Francisco Unified School District

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ASSESSMENT TIMELINES

1. Within fifteen (15) calendar days of receipt of a referral, assessment staff will review the referral request and determine the appropriate response to the request. They will either develop an Assessment Plan stating areas to be assessed, or they will send a letter (Prior Written Notice) explaining why an assessment will not be conducted.

2. If an Assessment Plan is developed, it will be sent to the parent/guardian for signature. No child can be assessed without parental permission and a signed plan.

3. Within sixty (60) calendar days of receipt of the signed Assessment Plan, excluding summer and school holidays of more than five (5) days, an assessment will be conducted and an Individualized Education Program meeting (lEP) held.

FREQUENTLY ASKED QUESTIONS (FAQ)

Who will conduct assessments?

The nature and area of concern outlined in your request will determine the type of assessor(s) assigned. This could be an ECSE Psychologist, Speech-Language Pathologist, related service provider (e.g. Occupational Therapist, Physical Therapist, etc.), or any combination of these assessors.

What happens after the assessment?

The parent/guardian will be notified to participate in an IEP meeting. The IEP meeting will be scheduled to ensure the parent/guardian can attend.

What is an IEP meeting?

An IEP meeting is where Information gathered from the assessment is explained, discussed, and used to make decisions about your child's education. Information about your child will be used to:

- *Determine if your child is eligible for special education and related services and/or decide if your child meets the definition of a "child with a disability," under the Individuals with Disabilities Education Improvement Act (IDEIA).*

- *If your child is eligible for Special Education Services, goals will be developed to assist your child in receiving an educational benefit.*

For more information please visit our website: **www.sfusd.edu**
(http://www.sfusd.edu/en/programs-and-services/special-education/pre-school-special-education-services.html)

(Keep this page for your records)

Revised 3/1/2016

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Parent/Caregiver Questionnaire

Date: _____ **Questionnaire Completed by:** _____

Did another person assist you when completing this form? ○Yes / ○No

If yes, please list Name and relationship to child: _____

Child's Full Legal Name: _____ / _____ / _____
First Middle Last

Child's Nickname: _____ Gender (Check): ○Male ○Female

Child's Date of Birth: Month _____ /Day _____ / Year _____

Child's Ethnicity (List all that apply): _____

Reason for referral: _____

Caregiver #1: ○*Parent* / ○*Grandparent* / ○*Guardian* / ○*Adoptive Parent* / ○*Other*_____

Name: _____ *Is this the child's primary residence? ○Yes / ○No*

Address: _____ Apt.#_____ Zip: _____

Best Phone to call: _____ *Check: ○Home / ○Cell / ○Work*

Email Address/Other Phone: _____ *Check: ○ Home / ○ Cell / ○ Work*

How do you preferred to be contacted?: ○ *Phone* / ○ *Email* / ○ *No preference*

Caregiver #2: ○*Parent* / ○*Grandparent* / ○*Guardian* / ○*Adoptive Parent* / ○*Other*_____

Name: _____ *Is this the child's primary residence? ○Yes / ○No*

Address: _____ Apt.#_____ Zip: _____

Best Phone to call: _____ *Check: ○Home / ○Cell / ○Work*

Email Address/Other Phone: _____ *Check: ○ Home / ○ Cell / ○ Work*

How do you preferred to be contacted?: ○ *Phone* / ○ *Email* / ○ *No preference*

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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 more frequently at home? _____

What is your preferred language for written communication between home and SFUSD? _____

What is your preferred language for verbal communication between home and SFUSD? _____

Members of Household

Name	Relationship to Child	Age	Occupation

Prekindergarten/Preschool/Childcare Information:

Does your child attend a school, childcare facility, or any other regularly scheduled group activity with other children (e.g. play group, gym class, etc.)? ○ *Yes, please specify below* ○ *No*

School/Program Name: _____ Start Date: _____

Address: _____ Teacher: _____

Telephone Number: _____ Days/Time: _____

Previous Schools/Childcare (*See end of form for additional space*) _____

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*

_____

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Developmental Milestones:
(Indicate the age at which your child achieved the following milestones, or indicate "Not Yet")

Gross Motor: Sit Upright:_____ Crawl:_____ Walk Independently:_____

Fine Motor: Pinch Small Objects:_____ Self-feed:_____ Hold Bottle:_____

Communication: First Words:_____ Combining two or more (2+) words:_____

Toilet Training: Day:_____ Night:_____

Medical/Health Information:

Is there a history of illness, accidents, and/or hospitalizations? ○ *Yes, please explain* ○ *No*

_____

Does your child have a diagnosed disorder, delay or special condition? ○ *Yes, please 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*

Has your child experienced ear infections? ○ *Yes- How many?* _____ ○ *No*

How were the ear infections treated? _____

Have PE Tube been placed? ○ *Yes- When?*_____ ○ *No*

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

*Results*_____

Date and location of most recent vision screening/test:_____

*Results*_____

Please provide written verification of hearing and vision screenings results if your child's hearing and/or vision have been tested within the last 12 months.

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Additional Information:

Does your child have a special diet or any food restrictions? ○ *Yes, please explain below* ○ *No*

Did your child use a pacifier or bottle? Did your child suck his/her thumb?
○ *Yes, please explain below* (*Age stopped:* _____ *)* ○ *No*

Does your child have any allergies? ○ *Yes, please explain below* ○ *No*

Does your child have asthma? ○ *Yes, please explain below* ○ *No*

Has your child experienced any head injuries? ○ *Yes, please explain below* ○ *No*

Has you child undergone any genetic testing? ○ *Yes, please explain below* ○ *No*

Does your child use any specialized equipment (e.g. walker, wheelchair, adaptive seating, voice output device, etc.)? ○ *Yes, please explain below* ○ *No*

Is there a family history of or have any family members had learning difficulties, developmental delays or mental health concerns? ○ *Yes, please explain below* ○ *No*

Other information: *(describe)*_____

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Description of your child:

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

- ○ Very Active
- ○ Easy to comfort
- ○ Shy
- ○ Trouble sleeping
- ○ Very quiet
- ○ Had colic
- ○ Friendly
- ○ Cried more than most babies
- ○ Hard to comfort
- ○ Hard to feed/nurse
- ○ Easy going

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

- ○ Very active
- ○ Cries a lot
- ○ Easy going
- ○ Interested in other children
- ○ Looks at pictures in books
- ○ Not interested in other children/people
- ○ Learning to talk was/is difficult
- ○ Very quiet
- ○ Friendly
- ○ Shy
- ○ Trouble sleeping
- ○ Not interested in toys
- ○ Learned to talk easily

My child shows <u>unusual difficulty</u> with (Check all that apply):

- ○ Expressing ideas/wants/needs
- ○ Skipping/hopping
- ○ Riding a bike/trike
- ○ Separating from parents
- ○ Interacting with peers
- ○ Excessive temper tantrums
- ○ Grasping a pencil/crayon/marker
- ○ Hand flapping
- ○ Learning to talk
- ○ Unclear speech
- ○ Following directions
- ○ Walking
- ○ Head banging
- ○ Dressing self
- ○ Extreme fears
- ○ Self-feeding
- ○ Throwing/catching a ball
- ○ Easily upset by noises
- ○ Being in their own world
- ○ Interested in particular toys
- ○ Repetitive behaviors
- ○ Easily upset by change in routine
- ○ Unusual body movements

Other observations or details: *(describe)*_____

_____

_____

_____

_____

My child's strengths_____

_____

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

_____

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Description of your child (continued):

How long does your child stay with/pay attention to an activity? _____

_____

Things that concern me about my child_____

_____

Has your child ever been evaluated before?

Evaluation Type	**Name of Evaluator/Agency**	**Evaluation/Report Date**

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

Type of Therapy/Intervention	**Provider**	**Dates of Service**

Please provide copies of evaluations and progress reports for your child's current therapy services and any previous evaluations

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

_____

_____

_____

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Additional Space: (Please indicate page number and which section of form is referenced)

Thank you for helping us better understand your child.

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I hereby authorize the exchange of information regarding:

Child's Name:_____ **DOB:**_____

I, _____ (print your name) give permission to providers checked off below to share pertinent information regarding my child with the San Francisco Unified School District.

(Indicate ☑ or fill-in any and all appropriate agencies)

☐ Golden Gate Regional Center
1355 Market Street, #220
San Francisco, CA 94103

☐ SF Dept. of Human Services
PO Box 7988
San Francisco, CA 94103

☐ SF Easter Seal Society
95 Hawthorne
San Francisco, CA 94105

☐ SF Hearing & Speech Ctr.
1234 Divisadero Street
San Francisco, CA 94115

☐ Support for Families
2601 Mission Street, Ste. 606
San Francisco, CA 94110

☐ Childcare/School
Principal/Teacher
Name:_____
Address:_____
City/Zip:_____
Telephone:_____

☐ Physicians
Name:_____
Address:_____
City/Zip:_____
Telephone:_____

☐ California Children Services
30 Van Ness Ave. Ste. 210
San Francisco, CA 94102

☐ Chinatown Child Dev. Ctr.
720 Sacramento Street
San Francisco, CA 94108

☐ Infant Parent Program
SFGH Bldg. 9
2550 23rd Street, RM 130
San Francisco, CA 94110

☐ Family Development Ctr.
2730 Bryant Street
San Francisco, CA 94110

☐ UCSF Hospital
400 Parnassus Ave. RM A67
San Francisco, CA 94143

☐ Children's Council of SF
445 Church Street
San Francisco, CA 94114

☐ Other
Name:_____
Address:_____
City/Zip:_____
Telephone:_____

☐ CA Pacific Medical Center
3700 California Street
San Francisco, CA 94118
415-750-6200

☐ Kaiser Permanente
350 St. Joseph Street
San Francisco, CA
Fax: 415-883-3071

☐ SF General Hospital
1001 Potrero Ave.
San Francisco, CA 94110

☐ St. Luke's Hospital
3555 Cesar Chavez
San Francisco, CA 94110

☐ Multidisciplinary
Assessment Center (MDAC)
SF General Hospital
1001 Potrero Ave.
San Francisco, CA 94110

☐ Other
Name:_____
Address:_____
City/Zip:_____
Telephone:_____

This authorization may be revoked at any time upon presentation of written request to the address above.

Signature:_____ Date:_____

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Teacher/Care Provider Input Form

TO BE COMPLETED BY TEACHER/CHILDCARE PROVIDER

Name of Child:_____ Date of Birth:_____

School/Center Name:_____

Program Type:_____
(e.g. Child Care Center, Montessori, Play-Based Preschool, Pre-Kindergarten, etc.)

Language(s) used during instruction: _____

Name of person completing this form: _____ Date: _____

Number of children in class: _____ Adult-to-child ration in class: _____/_____
(Adults) (Children)

How long have you worked with this child? _____

Please provide information on the child's strengths and challenges (if any) with regard to the following developmental domains.

Pre-Academics/Academics: _____

_____

_____

_____

Classroom Behavior/Participation: _____

_____

_____

_____

Communication: _____

_____

_____

_____

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Teacher/Care Provider Input Form (Continued)

Daily Living Skills: _____

Fine & Gross Motor: _____

Social/Emotional: _____

Additional Comments: _____

Thank you for helping us better understand your student.