



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 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 screening results (must be completed within the last 12 months).
- Copies of any previously completed assessments of your child.
- One (1) original proofs of residency (example: PG&E bill, water bill, or cable bill).
- Verification of child's birth date (ex. Birth Certificate, Hospital Record) If the document does not contain the Parent/Guardian name, additional guardianship verification is required.
- Parent/Guardian picture ID

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 Services
PreK Assessment Unit
1520 Oakdale Ave. Ground Floor
San Francisco, CA 94124

Or Email to: ECreferrals@sfusd.edu Or Fax to: (415) 920-5075 Attn: SPED- PreK Assessment 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) 401-2525 x1101.

Sincerely,
San Francisco Unified School District

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 (IEP) 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>)



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



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

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



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.



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 your 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)* _____



Description of your child:

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

- | | | |
|--|---|--|
| <input type="radio"/> Very Active | <input type="radio"/> Very quiet | <input type="radio"/> Hard to comfort |
| <input type="radio"/> Easy to comfort | <input type="radio"/> Had colic | <input type="radio"/> Hard to feed/nurse |
| <input type="radio"/> Shy | <input type="radio"/> Friendly | <input type="radio"/> Easy going |
| <input type="radio"/> Trouble sleeping | <input type="radio"/> Cried more than most babies | |

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

- | | |
|---|--|
| <input type="radio"/> Very active | <input type="radio"/> Very quiet |
| <input type="radio"/> Cries a lot | <input type="radio"/> Friendly |
| <input type="radio"/> Easy going | <input type="radio"/> Shy |
| <input type="radio"/> Interested in other children | <input type="radio"/> Trouble sleeping |
| <input type="radio"/> Looks at pictures in books | <input type="radio"/> Not interested in toys |
| <input type="radio"/> Not interested in other children/people | <input type="radio"/> Learned to talk easily |
| <input type="radio"/> Learning to talk was/is difficult | |

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

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

Other observations or details: *(describe)* _____

My child's strengths _____

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



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? _____



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

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

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

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

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

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

SF Easter Seal Society
95 Hawthorne
San Francisco, CA 94105

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: _____

Date: _____



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: _____



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.