Date Received in Office:

Del Mar
• UNION SCHOOL DISTRICT •

11232 El Camino Real, San Diego, CA 92130 – Ph: (858) 755-9301- Fax: (858) 523-6114

PRESCHOOL SCREENING REQUEST

Student Name:				**DOB:**	
Name of Parent(s):				**Email:**	
Home Phone:				**Cell/Work Phone:**	
Address:					
City:		**State:**		**Zip:**	
Home School:	<Select from List>				
Home Language:				**Student Language:**	
Preschool Attending: (if applicable)					
Other Therapies:					

Did your child use single words by 16 months of age?	**Yes** ☐	**No** ☐
Does your child speak in short phrases?	**Yes** ☐	**No** ☐
Does your child speak in clearly understandable speech?	**Yes** ☐	**No** ☐
Does your child ask for things or use gestures to communicate what he/she wants?	**Yes** ☐	**No** ☐
Does your child use names of family members?	**Yes** ☐	**No** ☐
Does your child follow simple directions (come here, give me a hug)?	**Yes** ☐	**No** ☐
Does your child answer questions?	**Yes** ☐	**No** ☐
Does your child engage in pretend play?	**Yes** ☐	**No** ☐
Does your child regularly look at other children in his/her immediate environment?	**Yes** ☐	**No** ☐
Does your child listen to stories read by you?	**Yes** ☐	**No** ☐

Concerns:

Parent Signature:		**Date:**	

By signing this form, I give the Del Mar Union School District consent to observe and screen my child to determine if further assessment is warranted to determine eligibility for special education services. If further assessment is warranted, an additional assessment plan will be provided and consent will be received before assessments are started.

Student Emergency Information

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School Use Only: Date:_____

School of Residence_____Placement_____

Teacher_____ ID #_____

Student's Name (Last, First, Middle, Suffix) ***Note**: The legal name of this student as shown on the original birth certificate/passport will be entered in the student record.*

Student's Nickname | Birth Date *(mm/dd/yy)* | Gender: ❒ Male ❒ Female ❒ Non-Binary | Current Grade

Residence of Student - Street Address, City, Zip Code | Primary Phone ❒ *Check if cellular*

Mailing Address of Student *(if different from above)*

Student lives with: ❒ Mother ❒ Father ❒ Both Parents ❒ Court Appointed Guardian ❒ Foster Parent(s) ❒ Other

Family Information

❒ Mother ❒ Father ❒ Stepmother ❒ Stepfather ❒ Guardian

Full Legal Name (Last, First, Middle)

Home Address (if different from above)

Employer/Occupation ❒ Active Military ❒ Retired Military ❒ Reserve/National Guard

Work/Daytime Phone Cell Phone

Email Address

Highest level of education: ❒ Graduate School ❒ College Grad. ❒ Some College ❒ High school grad. ❒ Not a high school grad.

❒ Mother ❒ Father ❒ Stepmother ❒ Stepfather ❒ Guardian

Full Legal Name (Last, First, Middle)

Home Address (if different from above)

Employer/Occupation ❒ Active Military ❒ Retired Military ❒ Reserve/National Guard

Work/Daytime Phone Cell Phone

Email Address

Highest level of education: ❒ Graduate School ❒ College Grad. ❒ Some College ❒ High school grad. ❒ Not a high school grad.

By providing an email address, you agree to receive important District information via email.

Siblings (List all siblings/children living at home)

Name (Gender: ❒ Male ❒ Female) Birth Date School

Name (Gender: ❒ Male ❒ Female) Birth Date School

Name (Gender: ❒ Male ❒ Female) Birth Date School

Name (Gender: ❒ Male ❒ Female) Birth Date School

Emergency Information

***In an emergency, person to contact first*: Name**_____Phone_____

❒ Mother ❒ Father ❒ Court Appointed Guardian ❒ Nanny/Child Care ❒ Other

In the event of illness or disaster, you may release my student to one of the following people, if a parent or guardian or person listed above is not available (relatives, friends or neighbors with a car). ↓Please do not list parent or guardian here.

Name (Gender: ❒ Male ❒ Female) Address Daytime Phone/Cell Phone Relationship

Name (Gender: ❒ Male ❒ Female) Address Daytime Phone/Cell Phone Relationship

Name (Gender: ❒ Male ❒ Female) Address Daytime Phone/Cell Phone Relationship

Doctor's Name Phone

Dentist's Name Phone

Health Insurance? ❒ Yes ❒ No Name of Insurance Company/Policy #_____

In the event paramedics need to be called for your child, please list any medical information you would like paramedics to be made aware of:

Health conditions: _____

Allergies: _____

Medications: _____

Parent Completing this Form:_____Relationship: ❒ Mother ❒ Father ❒ Other_____ Date: _____

Thank you for returning this card promptly. Please notify your school office of any changes that occur mid-year.

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RACE/ETHNICITY IDENTIFICATION

Student's Name_____ Birth Date_____ Today's Date_____

As of 2009, school districts and states are now required to follow new federal standards in collecting race and ethnicity data on each student (72 Fed. Reg. 59267).

Part A: Is this student Hispanic or Latino? *Hispanic or Latino:* A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

(Select only one)

❒ No, not Hispanic or Latino
❒ Yes, Hispanic or Latino

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider the student's race to be.

Part B: What is this student's race? *(Select one or more)*

Asian
❒ Chinese
❒ Japanese
❒ Korean
❒ Vietnamese
❒ Asian Indian
❒ Laotian
❒ Cambodian
❒ Filipino
❒ Hmong
❒ Other Asian

❒ American Indian or Alaska Native
❒ Black or African American
❒ White or Caucasian

Native Hawaiian or Other Pacific Islander
❒ Hawaiian
❒ Guamanian
❒ Samoan
❒ Tahitian
❒ Other Pacific Islander

_____
Birth City, State / Birth Country

First enrolled _____ in CA School *(mm/dd/yy)*

First enrolled_____ in US school *(mm/dd/yy)*

HOME LANGUAGE SURVEY

The California Education Code requires schools to determine the language(s) spoken at home. If a language other than English is listed for the first three questions below, please fill out the multilingual questionnaire on pages 12-13 of this packet. Thank you for your help and cooperation.

1. Which language did your child learn when he or she first began to talk? _____
2. What language does your child most frequently use at home? _____
3. What language do you most frequently use to speak to your child? _____
4. Name the language most often spoken by the adults at home. _____

If Chinese, please specify Cantonese or Mandarin.

In grades K-6, if a language other than English is listed for the first three questions above, your child will be assessed with the English Language Proficiency Assessment for California (ELPAC) to determine his or her English proficiency. No testing will take place in preschool.

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Proof of Residency in Order to Enroll Student

I am the parent or legal guardian of

_____
Student's Name

and I wish to enroll such child in the Del Mar Union School District. I understand that California law provides, with few exceptions, that each child must attend a public school in the district where the parent or legal guardian resides. I state that my child and I reside at the following street address, which I believe is in the boundaries of the Del Mar Union School District:

_____
Residence of Student - Street Address, City, Zip Code

<u>Housing Status</u> – Where is your child/family currently living? (*Federally mandated by NCLB*)

Please check appropriate box:

❒ Permanent Housing *(In single family residence, apartment, condo, mobile home)*
❒ Temporarily Doubled-up *(sharing housing with other families or individuals due to economic hardship or loss)*
❒ Temporarily Unsheltered in a car/campsite
❒ In a temporary shelter/transitional housing program
❒ In a hotel/motel
❒ Foster Family or Kinship Placement
❒ Other - Please specify:_____

<u>PLEASE NOTE:</u> If any district employee reasonably believes the parent/guardian of a student has provided false or unreliable evidence of residency, the District shall make reasonable efforts to determine if the student meets residency requirements. Reasonable efforts include, but are not limited to home visits and investigation by a private detective. Falsification of any information or documents, either written or verbal will result in revocation of enrollment.

<u>Declaration</u>

I declare that I have read the above statements and information provided by me, that such statements and information are true and complete to the best of my knowledge, and that this declaration was executed on _____ at <u>Del Mar / San Diego</u>, California.
(Date)

Print Name _____ **Signature of Parent or Guardian** _____

Verification of Residency (*attach two proofs*):

❒ Current SDG&E Utility Bill/Contract
❒ Current Water Bill or Cable Bill/Contract
❒ Current Telephone Bill/Contract (not cellular)
❒ Lease Agreement (must be signed by tenant & landlord, list all residents) or Rent Receipts
❒ Grant Deed or Property Tax Bill or Receipt (must accompany at least one current utility bill)
❒ Declaration of residency (Residency Affidavit, Verification Form or Shared Residence Affidavit)
❒ Voter Registration
❒ Government Correspondence
❒ Paycheck Stub
❒ Escrow Documents

Revised 2/12/15

Del Mar
• UNION SCHOOL DISTRICT •
11232 El Camino Real, San Diego, CA 92130 – Ph: (858) 755-9301- Fax: (858) 755-4361

CONFIDENTIAL
HEALTH & DEVELOPMENTAL HISTORY FORM

STUDENT INFORMATION					
Last Name:		First Name:		Middle Name:	
Birth Date:		Birth Place:		Sex: ☐ Male ☐ Female	
School:	☐ Ashley Falls ☐ Carmel Del Mar ☐ Del Mar Heights ☐ Del Mar Hills ☐ Ocean Air ☐ Sage Canyon ☐ Sycamore Ridge ☐ Torrey Hills				
Grade:	☐ Pre-K ☐ K ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th	Teacher:			

PARENT/GUARDIAN INFORMATION					
Name of Parent/Guardian Completing This Form:				Date:	
Parent/Guardian Signature:					
Contact Number(s):		☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐ Work	

PHYSICIAN			
Physician Name:		Phone:	
Last Physical Exam:			
Results of Exam:			

FAMILY HISTORY					
Housing Status:	Student lives with ☐ Mother(s) ☐ Father(s) ☐ Both Parents ☐ Other:				

PARENT/GUARDIAN 1 INFORMATION			
Name:		☐ Biological ☐ Step-Parent ☐ Adoptive Parent*	
Occupation:		Highest Grade Completed:	
If adopted* or step-parent, do you have any information on biological parents?:			
Learning or other difficulties in school:			
Appraisal of own health:			

PARENT/GUARDIAN 2 INFORMATION			
Name:		☐ Biological ☐ Step-Parent ☐ Adoptive Parent*	
Occupation:		Highest Grade Completed:	
If adopted* or step-parent, do you have any information on biological parents?:			
Learning or other difficulties in school:			
Appraisal of own health:			

3. ADOPTION INFORMATION (IF APPLICABLE)			
Age Child Adopted:		Adopted From:	
Were there any medical diagnoses known at adoption? ☐ Yes ☐ No *(Please include all known pregnancy/birth history under the Pregnancy and Birth sections 8, 9 & 10.)*			

4. SIBLINGS (IN ORDER OF AGE)			
Sibling 1 Name:		**Age:**	
Health:			
School Difficulties:			
Sibling 2 Name:		**Age:**	
Health:			
School Difficulties:			
Sibling 3 Name:		**Age:**	
Health:			
School Difficulties:			
Sibling 4 Name:		**Age:**	
Health:			
School Difficulties:			

5. Has the child lived with you continuously since birth?

☐ Yes ☐ No* **If not, with whom did the child live?**

6. Is there any biological family history of the following?:	YES	NO	RELATIONSHIP TO CHILD		YES	NO	RELATIONSHIP TO CHILD
Late in learning to speak	☐	☐		*Diseases or conditions such as:*			
Poor school achievement, grades repeated, etc	☐	☐		Diabetes	☐	☐	
Reading problems	☐	☐		Low Blood Sugar	☐	☐	
Speech/Hearing disorder	☐	☐		Allergies	☐	☐	
Intellectual disability	☐	☐		Heart Problems	☐	☐	
Seizure disorder	☐	☐		Bone or growth problems	☐	☐	
Mental/Nervous disorders	☐	☐		Other:	☐	☐	

7. Has there been any unusual family events such as:	YES	NO	DATE	EXPLANATION
Serious Illness	☐	☐		
Hospitalizations	☐	☐		
Death(s)	☐	☐		
Divorce(s)	☐	☐		
Frequent Moves	☐	☐		
Other	☐	☐		

8. PREGNANCY	
Did mother have any serious health problems prior to this pregnancy?	☐ Yes ☐ No
Did mother have any health problems during pregnancy?	☐ Yes ☐ No
Did mother have prenatal care?	☐ Yes ☐ No
If yes, what month?	
Did mother have any infections, illnesses, accidents, or injuries during the pregnancy?	
How much alcohol consumed daily by mother?	
How many cigarettes smoked daily by mother?	
Was the baby born at: ☐ 37-42 wks ☐ 36 wks or less (How many weeks? _____) ☐ Greater than 42 wks (How many weeks? _____)	

9. BIRTH	
How long was the labor?	
Describe any complications during labor:	
Type of Delivery:	☐ Normal ☐ Breech ☐ Forceps ☐ C-Section
Did mother receive medication during labor?	☐ Yes ☐ No
Did mother receive any anesthesia?	☐ Yes ☐ No
Was the child born in a hospital?	☐ Yes ☐ No

10. NEWBORN			
What was the birth weight?			
At delivery, did your child have any trouble starting to breathe?	☐ Yes ☐ No		
Need oxygen?	☐ Yes ☐ No	For how long?	
Incubator?	☐ Yes ☐ No	For how long?	
Did your baby have any obvious birth defects?	☐ Yes ☐ No		
Any complications?	☐ Yes ☐ No		
Any unusual problems?			
Jaundice?	☐ Yes ☐ No	Describe Treatment:	
Did your child leave the hospital with you?	☐ Yes ☐ No		
If no, how long did your child remain in the hospital?			
Diagnosis while in the hospital:	☐ Healthy	☐ Other:	

11. MILESTONES	AGE	SLOW	AVERAGE	FAST
Roll Over		☐	☐	☐
Sit Alone		☐	☐	☐
Crawl		☐	☐	☐
Walk Alone		☐	☐	☐
Spoke First Word		☐	☐	☐
Combining Two or More Words		☐	☐	☐
Toilet Trained		☐	☐	☐

12. LANGUAGE

With regard to language development, which of these apply to your child?

- ☐ Speech easy to understand
- ☐ Unclear or Immature Speech
- ☐ Difficulty in Relating Ideas
- ☐ Answers Don't Make Sense
- ☐ Limited Vocabulary
- ☐ Responds Slowly
- ☐ Short Attention Span
- ☐ Needs Directions Repeated

If child has trouble speaking, what is his/her way of communicating?	
Has your child ever been enrolled in a speech/language program?	☐ Yes ☐ No Age: Place:
Is your child currently in a speech/language program?	☐ Yes ☐ No
Do you have any concerns about your child's speech or language?	☐ Yes ☐ No Describe:

13. EMOTIONAL ADJUSTMENT, BEHAVIOR, DISCIPLINE

Which of the following characteristics describe your child?

- ☐ Tires Easily
- ☐ Withdrawn
- ☐ Very Shy
- ☐ Will Not Obey
- ☐ Jealous
- ☐ Falls a Lot
- ☐ Talkative
- ☐ Nightmares
- ☐ Tantrums
- ☐ Very Active
- ☐ Quiet
- ☐ Generally Happy
- ☐ Bangs Head
- ☐ Aggressive
- ☐ Stubborn
- ☐ Holds Breath
- ☐ Difficulty in Sleeping
- ☐ Doesn't Like to be Touched
- ☐ Easily Managed
- ☐ Daydreams
- ☐ Slow to Learn
- ☐ Sucks Thumb
- ☐ Gives Up Easily
- ☐ Destructive
- ☐ Repetitive Motions
- ☐ Angry
- ☐ Hand Flapping
- ☐ Tics/Twitches
- ☐ Sensitive to Sound

Is there any behavior not listed that concerns you?	☐ Yes ☐ No
If yes, what is it?	
What are your child's best qualities?	
How does your child get along in the family?	
How does your child get along with peers?	
What upsets your child?	
What kind of discipline is most effective?	

14. SCHOOL HISTORY					
Did your child attend preschool?	☐ Yes ☐ No		Age?:		
Name of Preschool:			How many hours/week?		
What is your child's social/play history in preschool?					
Were there any problems noted at that time?					
What schools has your child attended other than in the Del Mar Union School District?					
Does he/she like school?	☐ Yes ☐ No				
What is your child's best school subject?					
What is your child's weakest school subject?					
Has your child missed a lot of school?	☐ Yes ☐ No		Reason:		
Is your child:	☐ Right Handed ☐ Left Handed ☐ Both		Since age:		
Did your child repeat a grade?	☐ Yes ☐ No		If yes, what grade?:		
What special help has your child received in the past?					

15. MEDICAL HISTORY							
Which of the following illnesses has your child had?							
	YES	**NO**	**AGE/DATE**		**YES**	**NO**	**AGE/DATE**
Measles/Mumps/Rubella	☐	☐		Diabetes	☐	☐	
Sleeping Problems	☐	☐		Chicken Pox	☐	☐	
Encopresis	☐	☐		Asthma	☐	☐	
Enuresis	☐	☐		GI Problems	☐	☐	
Strep Throat	☐	☐		Frequent Colds	☐	☐	
Allergies	☐	☐		High Fevers	☐	☐	
Eating Problems	☐	☐		Heart Problems	☐	☐	
Meningitis	☐	☐		Tonsillitis	☐	☐	
Seizure Disorder	☐	☐		Pneumonia	☐	☐	
Bladder/Kidney Problems	☐	☐		Headaches	☐	☐	
Other:	☐	☐					
Please explain any illnesses checked above:							

Has your child had any hospitalizations?	☐ Yes ☐ No
If so, what for? (Please include child's age at hospitalization.)	
Physical Limitations? ☐ Yes ☐ No	
If yes, please describe:	

Has your child had any of the following:	YES	NO	AGE/DATE	IF YES, PLEASE EXPLAIN:
Serious Burns	☐	☐		
Poisoning	☐	☐		
Broken Bones	☐	☐		
Cuts Needing Stitches	☐	☐		
Concussions	☐	☐		
Near Drowning	☐	☐		
Severe Allergic Reaction	☐	☐		
Surgery	☐	☐		
Is your child on any medication at the present time?				☐ Yes ☐ No

Medication	Dosage	Times Taken	Used to Treat	When was medication initiated?

Previous Medications:

Medication	Dosage	Date/Age Initiated	Used to Treat	Date/Age Discontinued

VISION			
Does the student wear glasses?	☐ Yes ☐ No	Used for:	
Eye Doctor Name:		Phone:	
Last Exam:			
Results of Exam:			
Vision Concerns:	☐ Yes ☐ No		
(If Yes, Please Explain.)			

HEARING					
Does the student have a history of ear infections?	☐ Yes ☐ No				
History of PE Tubes?	☐ Yes ☐ No	Date Placed:		Date Removed:	
Did your child pass his/her newborn hearing screening?	☐ Yes ☐ No				
What was the date of your child's last hearing screening?		Did your child pass?	☐ Yes ☐ No ☐ Inconclusive		
Who performed the hearing screening?					
Does the student have hearing loss?	☐ Yes ☐ No		☐ Left Ear ☐ Right Ear ☐ Both		
Describe Hearing Loss					
ENT Physician:			Phone:		
Last Exam:					
Results of Exam:					

Other examinations-therapy/treatment child has received. Please name specialists who have cared for your child.

TYPE	NAME OF PRACTICIONER	LAST VISIT	RESULTS/DIAGNOSIS
Dentist			
Psychiatrist			
Neurologist			
Therapist/Psychologist			
Tutor			
Other			
Other			

Is there anything else you think that the school should know about your child that has not been asked for in this report? Please explain.

Please list any past or current diagnoses and dates of diagnosis:

DATE	DIAGNOSIS

Del Mar
• UNION SCHOOL DISTRICT •

Multilingual Questionnaire Intake Form
(BILINGUAL/MULTILINGUAL STUDENTS ONLY)

Student's Name:	**Today's Date:**
Student's Date of Birth:	**School of Attendance:**

	Native Language	Language 2	Language 3
Father's			
Mother's			
Siblings'			
School Teacher's			

Please Describe Your Current Concern for Making This Referral:

Multilingualism is the use of more than one language by an individual speaker. In order to help address your concern it is important for our speech/language pathologist to know the following information prior to scheduling an assessment for your child in order to prepare for the assessment. It is important for your child's speech/language pathologist to know specific information about the exposure to each language.

Student's Language Exposure SINCE BIRTH:

Language Exposure	List Languages	Age at Exposure	Percent Time Used/Day	Spoken By
Native		Infancy		
Language 2		___years, ___months		
Language 3		___years, ___months		

Student's Language Exposure AT PRESENT:

Language Exposure	List Languages	Percent Time Used/Day	Spoken By?	Where?
Native				
Language 2				
Language 3				

rev. 10/7/2019

At Home:

Rank Student's Language Proficiency from Most to Least	For Understanding – List Language Here	Use of the Language – List Language Here
Most		
Less		
Least		

At School:

Rank Student's Language Proficiency from Most to Least	For Understanding – List Language Here	Use of the Language – List Language Here
Most		
Less		
Least		

Pronunciation: How does your child pronounce the sounds in all languages spoken:

Please check: ☐ equally well
☐ one language is better than the other (if so, which language?) _____

Communication Experience	
At what age did you child begin school?	**Years_____, Months _____**
How many days per week and hours per day does your child attend school?	**Days _____, Hours/Day _____**
Which language does your child use when playing with brothers and sisters?	
Which language does your child use when playing with friends?	

Language Development and Health History	
At what age did your child produce his/her first word?	**_____ months**
At what age did your child try two words together?	**_____ months**
When was your child's last hearing test?	**Date: _____**
Did your child pass the hearing test?	**_____ yes _____ no**
How many ear infections has your child had since birth?	**Number: _____**
Has your child had P.E. Tubes surgically placed?	**_____ yes _____ no dates: _____**

Please provide any other pertinent information that you think would be helpful:

_____

For Office Use:

Simultaneous Learner:	Sequential Learner:	Dominant Language:	List Dominant Language:
Yes _____ No _____	**Yes _____ No _____**	**Yes _____ No _____**	**_____**

• UNION SCHOOL DISTRICT •

Preschool Vision and Hearing
Del Mar Union School District

Student Name: _____ DOB: _____

Teacher/Case Manager: _____ Date: _____

Vision:	
Hearing:	
Other:	

Completed by: _____Date: _____
District Nurse

I give permission for my student to have their vision and hearing tested as well as a school health record review.

Parent Signature:_____Date:_____