



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



2

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 ☐ OtherIn 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.



• UNION SCHOOL DISTRICT •

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.



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

Housing Status – 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: _____

PLEASE NOTE: 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.

Declaration

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 Del Mar / San Diego, California.
(Date)

Print Name

Signature of Parent or Guardian

Verification of Residency *(attach two proofs):*

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



union school district

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CONFIDENTIAL HEALTH & DEVELOPMENTAL HISTORY FORM

STUDENT INFORMATION					
Last Name:		First Name:		Middle Name:	
Birth Date:		Birth Place:		Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
School:	<input type="checkbox"/> Ashley Falls <input type="checkbox"/> Ocean Air	<input type="checkbox"/> Carmel Del Mar <input type="checkbox"/> Sage Canyon	<input type="checkbox"/> Del Mar Heights <input type="checkbox"/> Sycamore Ridge	<input type="checkbox"/> Del Mar Hills <input type="checkbox"/> Torrey Hills	
Grade:	<input type="checkbox"/> Pre-K <input type="checkbox"/> 3 rd	<input type="checkbox"/> K <input type="checkbox"/> 4 th	<input type="checkbox"/> 1 st <input type="checkbox"/> 5 th	<input type="checkbox"/> 2 nd <input type="checkbox"/> 6 th	Teacher: <input type="text"/>
PARENT/GUARDIAN INFORMATION					
Name of Parent/Guardian Completing This Form:				Date:	
Parent/Guardian Signature:					
Contact Number(s):			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
PHYSICIAN					
Physician Name:				Phone:	
Last Physical Exam:					
Results of Exam:					
FAMILY HISTORY					
Housing Status:	Student lives with <input type="checkbox"/> Mother(s) <input type="checkbox"/> Father(s) <input type="checkbox"/> Both Parents <input type="checkbox"/> Other:				
PARENT/GUARDIAN 1 INFORMATION					
Name:				<input type="checkbox"/> Biological <input type="checkbox"/> Step-Parent <input type="checkbox"/> 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:				<input type="checkbox"/> Biological <input type="checkbox"/> Step-Parent <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?									
<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>		Diseases or conditions such as:					
Poor school achievement, grades repeated, etc	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Reading problems	<input type="checkbox"/>	<input type="checkbox"/>		Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>			
Speech/Hearing disorder	<input type="checkbox"/>	<input type="checkbox"/>		Allergies	<input type="checkbox"/>	<input type="checkbox"/>			
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>		Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>		Bone or growth problems	<input type="checkbox"/>	<input type="checkbox"/>			
Mental/Nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>		Other:	<input type="checkbox"/>	<input type="checkbox"/>			
7. Has there been any unusual family events such as:	YES	NO	DATE	EXPLANATION					
Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>							
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>							
Death(s)	<input type="checkbox"/>	<input type="checkbox"/>							
Divorce(s)	<input type="checkbox"/>	<input type="checkbox"/>							
Frequent Moves	<input type="checkbox"/>	<input type="checkbox"/>							
Other	<input type="checkbox"/>	<input type="checkbox"/>							

8. PREGNANCY			
Did mother have any serious health problems prior to this pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did mother have any health problems during pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did mother have prenatal care?		<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> 37-42 wks <input type="checkbox"/> 36 wks or less (How many weeks? _____) <input type="checkbox"/> Greater than 42 wks (How many weeks? _____)			
9. BIRTH			
How long was the labor?			
Describe any complications during labor:			
Type of Delivery:		<input type="checkbox"/> Normal <input type="checkbox"/> Breech <input type="checkbox"/> Forceps <input type="checkbox"/> C-Section	
Did mother receive medication during labor?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did mother receive any anesthesia?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the child born in a hospital?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. NEWBORN			
What was the birth weight?			
At delivery, did your child have any trouble starting to breathe?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Need oxygen?		<input type="checkbox"/> Yes <input type="checkbox"/> No	For how long?
Incubator?		<input type="checkbox"/> Yes <input type="checkbox"/> No	For how long?
Did your baby have any obvious birth defects?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any complications?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any unusual problems?			
Jaundice?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe Treatment:
Did your child leave the hospital with you?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, how long did your child remain in the hospital?			
Diagnosis while in the hospital:		<input type="checkbox"/> Healthy	<input type="checkbox"/> Other:

11. MILESTONES	AGE	SLOW	AVERAGE	FAST			
Roll Over		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sit Alone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Crawl		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Walk Alone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Spoke First Word		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Combining Two or More Words		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Toilet Trained		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
12. LANGUAGE							
With regard to language development, which of these apply to your child? <div> <input type="checkbox"/> Speech easy to understand <input type="checkbox"/> Limited Vocabulary </div> <div> <input type="checkbox"/> Unclear or Immature Speech <input type="checkbox"/> Responds Slowly </div> <div> <input type="checkbox"/> Difficulty in Relating Ideas <input type="checkbox"/> Short Attention Span </div> <div> <input type="checkbox"/> Answers Don't Make Sense <input type="checkbox"/> Needs Directions Repeated </div>							
If child has trouble speaking, what is his/her way of communicating?							
Has your child ever been enrolled in a speech/language program?		<input type="checkbox"/> Yes <input type="checkbox"/> No Age: Place:					
Is your child currently in a speech/language program?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you have any concerns about your child's speech or language?		<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:					
13. EMOTIONAL ADJUSTMENT, BEHAVIOR, DISCIPLINE							
Which of the following characteristics describe your child? <div> <input type="checkbox"/> Tires Easily <input type="checkbox"/> Quiet <input type="checkbox"/> Slow to Learn </div> <div> <input type="checkbox"/> Withdrawn <input type="checkbox"/> Generally Happy <input type="checkbox"/> Sucks Thumb </div> <div> <input type="checkbox"/> Very Shy <input type="checkbox"/> Bangs Head <input type="checkbox"/> Gives Up Easily </div> <div> <input type="checkbox"/> Will Not Obey <input type="checkbox"/> Aggressive <input type="checkbox"/> Destructive </div> <div> <input type="checkbox"/> Jealous <input type="checkbox"/> Stubborn <input type="checkbox"/> Repetitive Motions </div> <div> <input type="checkbox"/> Falls a Lot <input type="checkbox"/> Holds Breath <input type="checkbox"/> Angry </div> <div> <input type="checkbox"/> Talkative <input type="checkbox"/> Difficulty in Sleeping <input type="checkbox"/> Hand Flapping </div> <div> <input type="checkbox"/> Nightmares <input type="checkbox"/> Doesn't Like to be Touched <input type="checkbox"/> Tics/Twitches </div> <div> <input type="checkbox"/> Tantrums <input type="checkbox"/> Easily Managed <input type="checkbox"/> Sensitive to Sound </div> <div> <input type="checkbox"/> Very Active <input type="checkbox"/> Daydreams </div>							
Is there any behavior not listed that concerns you?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?			<input type="checkbox"/> Yes <input type="checkbox"/> 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?			<input type="checkbox"/> Yes <input type="checkbox"/> 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?			<input type="checkbox"/> Yes <input type="checkbox"/> No			Reason:	
Is your child:			<input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed <input type="checkbox"/> Both			Since age:	
Did your child repeat a grade?			<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/>		Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	
Encopresis	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Enuresis	<input type="checkbox"/>	<input type="checkbox"/>		GI Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>		Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>		High Fevers	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Problems	<input type="checkbox"/>	<input type="checkbox"/>		Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>		Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>		Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder/Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>		Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>					
Please explain any illnesses checked above:							
Has your child had any hospitalizations?			<input type="checkbox"/> Yes <input type="checkbox"/> No				
If so, what for? (Please include child's age at hospitalization.)							
Physical Limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, please describe:							

Has your child had any of the following:	YES	NO	AGE/DATE	IF YES, PLEASE EXPLAIN:	
Serious Burns	<input type="checkbox"/>	<input type="checkbox"/>			
Poisoning	<input type="checkbox"/>	<input type="checkbox"/>			
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>			
Cuts Needing Stitches	<input type="checkbox"/>	<input type="checkbox"/>			
Concussions	<input type="checkbox"/>	<input type="checkbox"/>			
Near Drowning	<input type="checkbox"/>	<input type="checkbox"/>			
Severe Allergic Reaction	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Is your child on any medication at the present time?				<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Used for:	
Eye Doctor Name:				Phone:	
Last Exam:					
Results of Exam:					
Vision Concerns:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
(If Yes, Please Explain.)					

HEARING					
Does the student have a history of ear infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
History of PE Tubes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Placed:		Date Removed:	
Did your child pass his/her newborn hearing screening?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
What was the date of your child's last hearing screening?		Did your child pass?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inconclusive		
Who performed the hearing screening?					
Does the student have hearing loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear <input type="checkbox"/> 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 PRACTITIONER	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				



• 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				

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: Yes ____ No ____	Sequential Learner: Yes ____ No ____	Dominant Language: Yes ____ No ____	List Dominant Language: _____
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• 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:** _____