



Date \_\_\_\_\_

ID# \_\_\_\_\_

Person Completing Form \_\_\_\_\_

Assessment Team: \_\_\_\_\_

Submitted by Parent  Submitted by Agency Agency Name: \_\_\_\_\_

Agency Case Manager: \_\_\_\_\_ Agency Contact Number: \_\_\_\_\_

**SDUSD Early Childhood Special Education Intake Questionnaire**

**STUDENT INFORMATION:**

Legal Last Name \_\_\_\_\_

Legal First Name \_\_\_\_\_

Middle \_\_\_\_\_

**FAMILY CONTACT INFORMATION**

	PARENT/GUARDIAN	PARENT/GUARDIAN
Full Name		
Relationship to Student		
Home Phone		
Cell Phone		
E-Mail		
Education Level (circle one)	<input type="checkbox"/> NHS <input type="checkbox"/> HS <input type="checkbox"/> SC <input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> DEC	<input type="checkbox"/> NHS <input type="checkbox"/> HS <input type="checkbox"/> SC <input type="checkbox"/> C <input type="checkbox"/> G <input type="checkbox"/> DEC

Education levels: NHS=not a high school graduate, HS=high school graduate, SC=some college/AA degree C=college G= graduate/post graduate, DEC=decline to state

**STUDENT INFORMATION:**

Household Address:

City, State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

City/State of Birth: \_\_\_\_\_

Country of Birth: \_\_\_\_\_

SOR: \_\_\_\_\_ Attends Preschool:  No  Yes If yes, Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  M  F  Siblings (gender/ages)

What language(s) does your child speak: Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

What language(s) are spoken at home: \_\_\_\_\_?

Is student Hispanic or Latino?  Yes  No If No, please indicate primary ethnicity

Ethnicity: (select one or more)

- American Indian or Alaska Native     Black African American     White     Chinese     Japanese
- Korean     Vietnamese     Asian Indian     Laotian     Cambodian
- Hmong     Other Asian     Filipino     Hawaiian     Guamanian
- Samoan     Tahitian     Other Pacific Islander

Student Name: \_\_\_\_\_

Student residential status: (check one)

- |  |  |
|--|--|
| <input type="checkbox"/> Parent/legal guardian                           | <input type="checkbox"/> Homelessness unsheltered*   |
| <input type="checkbox"/> Foster family home (FFH)                        | <input type="checkbox"/> Hospital-not state hospital |
| <input type="checkbox"/> Foster group home (FGH, FFA)                    | <input type="checkbox"/> Residential facility        |
| <input type="checkbox"/> Homelessness-doubling up (living with someone)* | <input type="checkbox"/> Incarcerated institution    |
| <input type="checkbox"/> Homelessness-(hotel/motel)*                     | <input type="checkbox"/> Confidential                |
| <input type="checkbox"/> Homelessness sheltered *                        | <input type="checkbox"/> Other                       |

\*Temporary residence due to financial hardship

Assessed by Regional Center, Rady Children's, First 5, Kaiser, Balboa Naval Hospital or other agencies?

No  Yes If yes, please state the outcome:

Services received:  No  Yes If yes, please state

Has your child been evaluated by a doctor?  No  Yes

Medical Diagnosis/Conditions:  No  Yes If yes, please state

Does your Child take Medications:  No  Yes If yes, please state

When was your child's hearing last evaluated:  No  Yes/Outcome

When was your child's vision last evaluated:  No  Yes/Outcome

Why are you referring your child for special education assessment/ what are your concerns?