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Section XI - Special Education

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ADMINISTRATIVE PHILOSOPHY

The guidelines presented in the Handbook reflect the administrative philosophy of the Department of Special Education. This philosophy encompasses the following propositions:

All personnel in the District are perceived as professionals, using their special talents to contribute to optimum student success.

All personnel in the District have the right to:

- Receive clear definitions of district and department goals related to special education, and participate in goal revision.
- Receive clear definition of roles and expectations for themselves and colleagues, as they relate to special education.
- Participate in the definition of special education objectives for which they are responsible and accountable.
- Receive adequate assistance in meeting special education goals.

Primary emphasis shall be placed upon the achievement of instructional objectives. All personnel within the Special Education Department must manage resources in accordance with student-related objectives.

There shall be continuous monitoring, evaluation, and improvement of program effectiveness and viability.

Department of Special Education Personnel:

The Staff of the Special Education Department are support personnel, and as such shall be available to consult with site administrators and teachers regarding program implementation and innovation, provide inservice programs, assist with special student concerns, and provide help in any other matters which require special assistance.

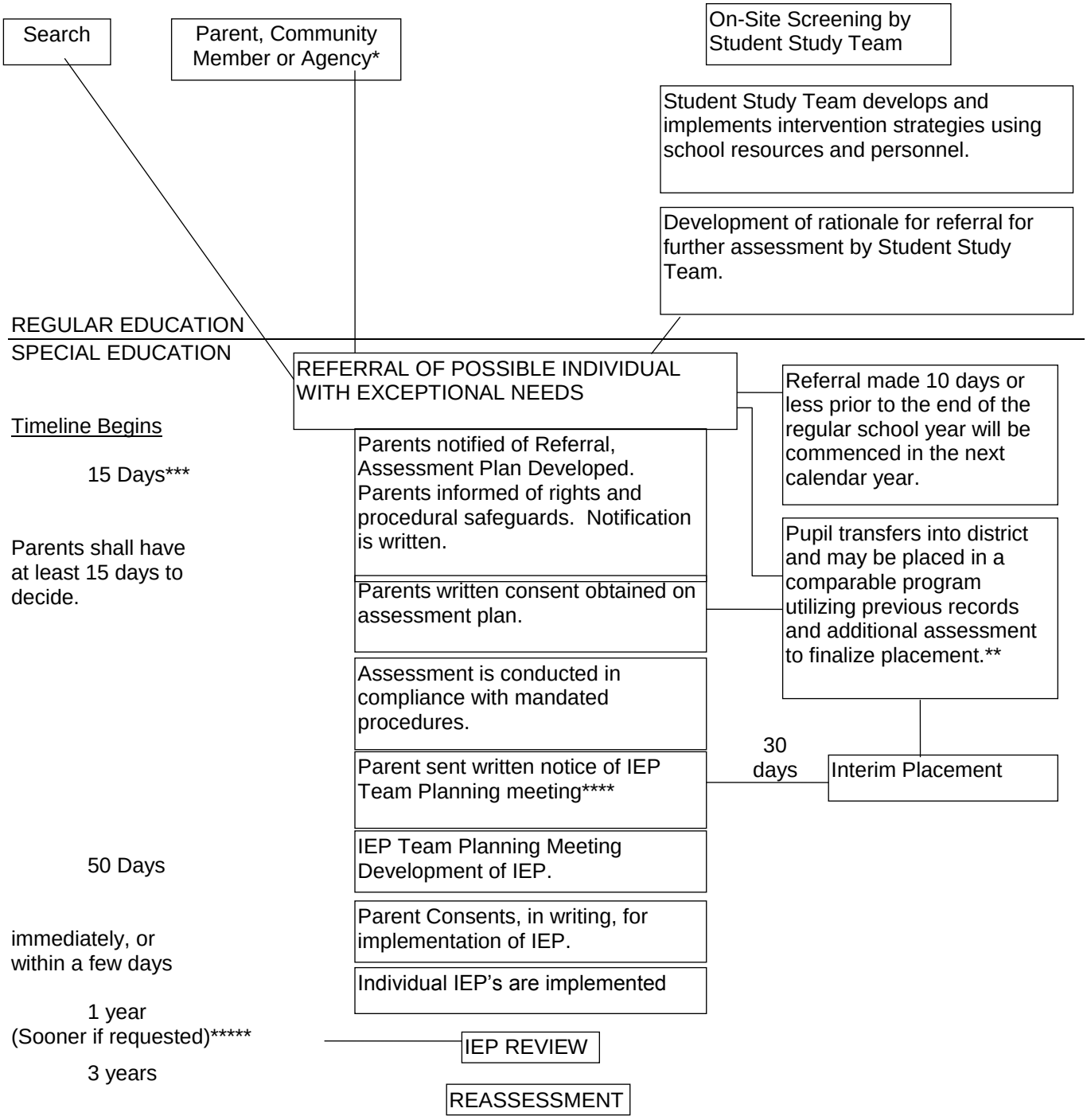
School Site Administration:

School site administrators have direct responsibility for supervision and evaluation of special day classes and resource specialist programs on school sites. While supervision of Designated Instruction and Services, itinerant personnel and school psychologists lies with the Department of Special Education, site administrators have supervisory responsibility over these staff members while they are on site.

Site administrators are responsible for the implementation of the Individualized Education Program (IEP) for each student. Site administrators are also responsible for assuring compliance with Federal and State special education regulations and District policies and procedures pertaining to students enrolled on the school site. Close and continuing collaboration between site personnel and Special Education Department personnel in the operation of special education programs is encouraged.

PROCEDURAL TIMELINES

(Identification, Referral, Assessment, Instructional Planning, Implementation and Review)



* May request assistance from school or district staff in making a written referral

** For Transfer Pupils, see Interim Placement Procedures

*** "Days" are defined as calendar days

**** Notice should be sent early enough to ensure that parents will have an opportunity to attend

***** Thirty (30) days if parent requests
Six Months for SED out-of-home/residential placements

INSTRUCTIONAL PROGRAMS AND SERVICES

The educational program shall be designed to meet each student's special and general needs. A student's curriculum objectives shall be identified during the Individual Educational Program (IEP) process. Each IEP shall be consistent with the curriculum and course of study pursued in the regular education program.

Special Education Services/Programs:

1. DESIGNATED INSTRUCTION AND SERVICE (DIS)

   Such instruction and services may be provided by the regular class teacher, the special class teacher, specialists competent to provide such instruction and services, or the appropriately credentialed Designated Instruction and Service (DIS) specialists. Some examples are: APE, speech/language therapy, vision services.

2. RESOURCE SPECIALIST PROGRAM (RSP)

   The Resource Specialist provides instructional services to students in order to implement the IEP. He/she also provides consultation to parents and regular staff members in areas such as assessment, curriculum, and classroom management, as well as monitoring pupil progress and assisting in coordinating special education services with regular school programs.

3. SPECIAL DAY CLASSES (SDC)

   Students with more intensive educational needs may require special day classes. Placement in special day classes shall occur only when the nature of the handicap is such that education in regular classes with the use of supplementary aides and services cannot be achieved satisfactorily.

4. STATE SPECIAL SCHOOLS

   The state provides residential schools and assessment for deaf, blind, and neurologically handicapped students, as appropriate.

5. NON-PUBLIC, NON-SECTARIAN SCHOOLS AND SERVICES

   All appropriate public school programs in the District or nearby Districts shall be explored and considered before considering the non-public school program alternatives. Non-public school placement shall be provided only when no appropriate public placement is available.

6. EARLY CHILDHOOD PROGRAM

   The Pasadena Unified School District operates a comprehensive, early Childhood Education program for children ages 18 months – 6 years who live in Pasadena, Altadena, or Sierra Madre. A wide range of service delivery options is available for all children who are identified as having special needs and are eligible for special education services. These services may be delivered in a regular preschool class, in speech and language therapy, adapted physical education or a special day class. Parents are important members of the assessment and educational team and are fully involved in decisions regarding their child's education.

   The early childhood special education department is committed to early identification of handicapping conditions and to early intervention in order to prevent or reduce learning problems in the future. Successful early intervention is critical for the child and cost-effective for schools and society.

REFERRAL OF STUDENTS TO SPECIAL EDUCATION

Referrals may be made:

1. Through a written referral by a parent, community member, or agency; or
2. By the school site Student Study Team, using the Student Study Team Form.

Referrals shall include documentation of regular education interventions which have been attempted to remediate concerns about student progress prior to referral.

If the parent has not participated in the Student Study Team, a Parent Notification of Referral (shall be sent by the site administrator immediately upon referral, and prior to development of the assessment plan. This is a mandated form, required by law, and cannot be omitted.

All forms provided to parents will be in the language of the home. Forms are available in Spanish, and will be translated into other languages upon request to the Department of Special Education.

ASSESSMENT

An assessment plan shall be developed within 15 days of referral, using the District Proposed Assessment Plan form. The plan shall be developed by the assessors, and may include the School Psychologist, Resource Specialist or Special Day Class teacher, Language, Speech and Hearing Specialist, Adaptive Physical Education Specialist, School Nurse, and others, as appropriate. The parent shall be included in the development of the assessment plan, whenever possible. The parent may be given a maximum of 15 days to consider the plan. Assessment shall not begin until the parent signs the plan, giving permission to assess.

- If the parent does not participate in the assessment plan meeting, a member of the assessment team will be appointed to obtain the parent signature.

- A copy of Parent Rights and Procedural Safeguards must be provided to the parent when the assessment plan is presented.

The assessment shall be conducted by a multidisciplinary team in all areas of suspected disability.

Those persons assessing a student shall maintain a complete and specific record of diagnostic procedures employed, the instruments utilized, the conclusions reached, and the proposed education or treatment alternatives indicated by the assessment results. School Psychologists shall use the approved District Psycho-Educational Assessment Report format.

Assessment Report

The personnel who assess the student will prepare a written report or reports, as appropriate, of the results of each assessment. The report shall include, but not be limited to, all of the following:

1. Whether the student may need special education and related services and the basis for making the determination.

2. Relevant behaviors noted during observation, and the relationship of those behaviors to the student's academic and social functioning, including any information from public or private agencies agreed upon in the assessment plan.

3. The educationally relevant health and development, and medical findings, if any.

4. Discrepancies between achievement and ability requiring special education for learning disabled students.

5. Determination of the effects of environmental, cultural, or economic disadvantage, where appropriate.

6. Need for specialized services, materials, and equipment for students with low-incidence disabilities, consistent with guidelines established pursuant to EC 56136 (low incidence disability guidelines).

If a psychological assessment is essential to IEP planning, such assessment will be provided. If mental retardation or a specific learning disability is suspected, or if appropriateness of current program is questioned, consultation with, and/or assessment by, the psychologist is recommended.

Parents have the following rights pertaining to assessment:

1. The right to obtain a copy of assessment findings, including test and subtest scores, **prior to the IEP Team Meeting**.

2. The right to be informed of the purpose of the IEP conference, assessment results, recommendations, and rationale for the recommendations.

3. The right to obtain an independent educational assessment if the parent disagrees with the public education agency assessment. Private assessment is at public expense unless the public education agency initiates a due process hearing, and a determination is made in the hearing that the public education agency assessment was appropriate.

4. The right to have the private educational assessment considered by the public agency.

PASADENA UNIFIED SCHOOL DISTRICT
Special Education Department

ASSESSMENT PLAN

DATE_____

NAME OF STUDENT:_____ DOB:_____ SCHOOL:_____
NAME OF PARENT:_____ HOME PHONE:_____ WORK PHONE:_____
ADDRESS:_____
SOCIAL SECURITY NUMBER:_____ GRADE:_____ TEACHER:_____
PRIMARY LANGUAGE OF HOME:_____ LEP:_____ LANGUAGE OF STUDENT:_____
REASON FOR REFERRAL:_____

In order to meet your child's individual education needs, the following assessment may be required. Assessment will be conducted by appropriately qualified staff, and in your child's native language or other means of communication, unless other provisions are necessary and explained below. The Assessment may also include observations, interviews, existing independent assessments, as well as a review of school records. If alternative means are used to assess, a description will be written below.

Check areas to be assessed:

_____ACADEMIC LEVEL: To measure current reading, spelling, written language and arithmetic; or readiness skills such as counting, colors, and shapes._____
Assessor title

_____SOCIAL/EMOTIONAL/ADAPTIVE BEHAVIOR: To determine the student's self-help skills, social proficiency, attitude, and feelings about school work and self._____
Assessor title

_____INTELLECTUAL FUNCTIONING/ABILITY LEVELS: To measure understanding, reasoning and problem-solving skills involving verbal and non-verbal abilities._____
Assessor title

_____MOTOR/PERCEPTUAL DEVELOPMENT: To measure how a student coordinates body movement and how he/she perceives the world through sensory input._____
Assesssor title

_____COMMUNICATION: To measure the student's ability to understand and use language, speech and non-oral communication appropriately._____
Assessor title

_____VOCATIONAL: To determine the student's vocational interests and aptitude._____
Assessor title

_____HEALTH: To assess the student's health status. A developmental history will be done when appropriate._____
Assessor title

_____OTHER: (O & M, Braille, etc.)_____
Assessor title

CASE COORDINATOR: (name)_____ Phone:_____

PARENTAL CONSENT FOR ASSESSMENT

I consent to the assessment. I understand the results will be discussed with me and, upon request, I will be provided with a copy of the assessment report. I understand the results will be confidential. I understand no change in educational placement/program will result from the assessment without my consent. An Individualized Education Program (IEP) team meeting will be scheduled. I have a copy of the Parents' Rights.

SIGNATURE OF PARENT/GUARDIAN:_____ DATE:_____

_____*I do not consent to the proposed Assessment Plan.*

SIGNATURE:_____ DATE:_____

DISTRIBUTION: White, Psychological file; Yellow, Teacher; Pink, Parent

Distrito Escolar Unificado de Pasadena
Departamento de Educación Especial

PLAN DE EVALUACION

Fecha:_____

Nombre del Estudiante:_____FDN:_____Escuela:_____
Nombre del Padre:_____Teléfono del Hogar_____Teléfono del trabajo_____
Domicilio:_____
Número del Seguro Social:_____Grado:_____Maestro/a:_____
Idioma que se usa en el Hogar:_____LEP:_____Idioma del estudiante:_____
Razón de Referimiento:_____

Con el fin de alcanzar las necesidades individuales de su hijo/a la siguiente evaluación será requerida. La evaluación será conducida por personal apropiadamente calificado, y en el idioma de su niño/a o en otra forma de comunicación, a menos que otras provisiones sean necesarias y explicadas más abajo. La evaluación también podrá incluir observaciones, entrevistas, evaluaciónes independientes actuales, al igual que reviso de archivos escolares. Si otras formas son usadas para evaluar, una descripción será escrita más abajo.

Marque las areas que serán evaluados:

_____ NIVEL ACADÉMICO: Para medir su lectura actual, deletreo, lenguaje escrito y aritmética, o habilidades de estar preparado para leer como contando, colores y formas._____
_____Título del Evaluador_____

_____ COMPORTAMIENTO SOCIAL/EMOCIONAL/ADAPTIVO: Para determinar las habilidades de ayuda propia del estudiante, capacidad social, actitud, y sentimientos sobre el trabajo escolar y si mismo. _____
_____Título del Evaluador_____

_____ FUNCIONAMIENTO INTELECTUAL/NIVELES DE HABILIDAD: Para medir entendimiento, razonaminto y habilidades de resolver problemas incluyendo habilidales orales y no verbales. _____
_____Título del Evaluador_____

_____ DESARRALLO MOTRIZ/PERCEPTUAL: Para medir como nu estudiante coordina movimientos del cuerpo y como el/ella percibe el mundo a tranés del ingreso sensorio. _____
_____Título del Evaluador_____

_____ COMUNICACIÓN: Para medir apropiadamente las habilidades del estudiante de comprender y usar apropiadamente lenguaje, habla y comunicación no oral. _____
_____Título del Evaluador_____

_____ VOCACIONAL: Para determinar los intereses vocacionales y aptitudes._____
_____Título del Evaluador_____

_____ SALUD: Para evaluar el estado de la salud del estudiante. Una historia del desarrollo será echa cuando sea adecuado. _____
_____Título del Evaluador_____

_____ OTRO: (O & M, Braille, etc.)_____
_____Título del Evaluador_____

Coordinadora del caso (nombre)_____Teléfono_____

Consentimiento del Padre Para la Evaluación

Consiento a la evaluación. Comprendo que se hablará conmigo sobre los resultados, y si lo solicito, seré proveido con una copia del reporte de evaluación. Comprendo que no habrá cambio en la colocación del programa educacional como resultado de la evaluación, sin mi consentimiento. Una reunión del grupo del Programa de Educación Individualizada (IEP) será programada. Tengo una copia de los derechos de los padres.

Firma del Padre/Tutor_____Fecha_____

_____No doy consentimiento al propuesto Plan de Evaluación.

Firma_____Fecha_____

DISTRIBUTION: White, Psychological file; Yellow, teacher; Pink, parent

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

SPECIAL EDUCATION ASSESSMENT PROCESS

The school nurse is a member of the "specialized staff" providing special education assessment services to children in the identification or reevaluation of their handicapping condition. The following outline provides a guide for the completion of this assessment.

A. Student Study Team (SST)
   1. This team develops and implements intervention strategies using school resources and personnel.
   2. The school nurse may be involved in the SST meeting.
   3. The SST determines if there is a need for further special education assessment.

B. Special Education Assessment
   1. Complete a "Health and Development History" with the parent or guardian (attached form).
   2. Obtain medical information: send "Authorization to Disclose or Receive Medical Information" form to appropriate agencies.
   3. Interview Student in Health Office
      a. Complete a vision and hearing screening
      b. Height and weight measurements
      c. Conduct a neurological soft sign screening, if appropriate
      d. Review student health record
   4. Interview classroom teacher, speech therapist, or other school personnel to gather background information.
   5. Complete "Nurse's Assessment Report" - 2 pages (See sample forms)
   6. Attend IEP meeting and share assessment report with team.
   7. Document health assessment and IEP results on student health record.

C. Three-Year Reevaluation
   1. Complete vision and hearing screening
   2. Height and weight measurements
   3. Update Student Health History with parent
   4. Complete Special Education Department Assessment Results-3 Form. (See Sample Forms)

D. Annual Evaluation - If Requested By Staff
   Same as Three Year Reevaluation

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

STUDENT STUDY TEAM
NURSING REFERRAL

Student Name _____

Grade _____

Teacher _____

Date of SST _____

NURSING ASSESSMENT

Date: _____

Height: _____ Percentile: _____ Weight: _____ Percentile: _____

Vision: _____ Right _____ Left

Referral needed: _____

Hearing: _____ Right _____ Left

Referral needed: _____

Medication/Specialized Procedures _____

_____

Comments: _____

_____

_____

Nurse Name: _____
(Please Print)

Signature: _____ Date: _____

OUTLINE - NURSE ASSESSMENT REPORT

I. Current Health Status
   A. General Health
   B. Medications
   C. Hearing and Vision Status
   D. Primary Physician/Clinic
   E. Immunizations/TB Mantoux Status
   F. Other Agencies/Physicians involved with client/family

II. Significant Health and Family History
   A. Family Constellation
   B. Mother's Obstetrical History
      1. Pregnancy
         a. Prenatal care
         b. Problems
      2. Labor and delivery
      3. Early neonatal period
   C. Familial Health History
   D. Medical History
      1. Diagnoses
      2. Illnesses and accidents
      3. Hospitalizations and surgeries
      4. Special tests and diagnostic workups

III. General Appearance and Behavior
   A. Physical Appearance
   B. Behavior
      1. Personality
      2. Activity level
      3. Attention span
      4. Note where child was observed (i.e. home, classroom, playground)
   C. Developmental Milestones
      1. Age achieved
      2. Current functioning re: self-help skills

IV. Developmental Profile
   A. Test Used
   B. Scores/Level of Functioning
   C. Comments
      1. Name of historian
      2. General remarks

V. Summary
   A. Assessment of Child
   B. Ongoing Health Needs

SPECIAL EDUCATION • NURSE ASSESSMENT LOG

	Student	DOB	Grade	Teacher/ School	Comments	Date Assign/Due	Report Date	IEP Date	Disposition
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

Date_____
School_____
Grade_____

HEALTH AND DEVELOPMENTAL HISTORY FOR SPECIAL EDUCATION ASSESSMENT

Child's Name_____ Birthdate_____ Sex_____

Primary Language_____ Place of Birth_____

Address_____ Home Telephone_____

Usual Source(s) of Medical Care_____
(name) (address)

Date of Last Physical Examination_____ Agencies Working with Family_____

Health Problems_____

Historian_____ Interviewer_____ Translator_____

****

	Full Name	Age	Education	Occupation	In Home	Health Problems
Mother						
Father						
Step-Parent						
Guardian						

Other Children (in order of age):

Name	Age	Relationship	School	Grade	School Difficulties	Health Problems

****

PREGNANCY

When did prenatal care begin?_____ Mother's Age_____

Birth Order (circle 1) 1 2 3 4 5 Father's Age_____

Length of Pregnancy_____ Bleeding_____

Rh Factor_____ Medications_____

Smoking_____ Speed_____ Alcohol_____

Marijuana_____ Cocaine_____ Other_____

Birth: Hospital_____ Home_____ Birth Weight_____ Length of Labor_____ Anesthesia_____

Delivery: Vaginal_____ Cesarean_____ Reason_____

Color_____ Cry: Strong _____ Weak_____ Birth Defects_____

Complications: Difficulty Breathing _____ Resuscitation_____

Incubator_____ Reason_____

Length of Hospital Stay: Mother_____ Infant_____

While hospitalized, did you hold and/or feed infant?_____

Feeding: Breast_____ How long_____ Problems_____

Bottle_____ How long_____ Problems_____

****

HEALTH PROBLEMS IN INFANCY AND/OR CHILDHOOD

☐ Head Injury	☐ Hyperactivity	☐ Asthma	☐ Fevers (105° or more)	Other Health Concerns :
☐ Headaches (frequent)	☐ Eye/Vision Problems	☐ Allergies	☐ Meningitis	_____
☐ Fainting	☐ Glasses	☐ Heart Murmur	☐ Urinary/Kidney Problems	_____
☐ Dizziness	☐ Ear/Hearing Problems	☐ Diabetes	☐ Skin Problems	_____
☐ Seizures (Convulsions)	☐ Frequent Ear Infections	☐ Weight Concerns	☐ Menstrual Problems	_____

****

MEDICATION

Is your child currently taking any medication? ☐ Yes ☐ No

If yes, list medication, dosage, when taken:_____

What medications(s) is your child allergic to?_____

Has your child taken prescribed medication for longer than two months? ☐ Yes ☐ No If yes, describe_____

****

SPEECH

Child's speech was understandable to most people by age 3 years? ☐ Yes ☐ No If not, at what age?_____

Is child currently receiving speech therapy? ☐ Yes ☐ No If yes, list provider:_____

****

DEVELOPMENTAL

At about what age did your child do the following things?

Sit alone_____ Use words understandably_____ Complete bath with little help_____

Crawl_____ Speak in 3 word sentences_____ Toilet trained : bladder____ bowel____

Walk Alone_____ Button shirt or blouse_____ Tie shoes_____

Ride Bicycle_____

How does this child's growth and development compare to brother(s) and sister(s) or other children in the neighborhood?

☐ Slower ☐ Same ☐ Faster Describe_____

****

PATTERNS OF BEHAVIOR Please circle any items below that apply to your child

Bites Nails	Discipline Problem	Bites self/others	Bed wetting
Sucks Thumb	Quick to anger	Tires easily	Temper tantrums
Impulsive	Purposely hurts self	Sleep problems	Holds Breath
Lies excessively	Clumsy	Sleepwalking	Fights excessively with other children
Distractible	Eats dirt/paint/other	Rocking	Blames others for difficulties
Bangs head repeatedly	Extremely shy	Easily frustrated	Destructive
Hyperactive	Special fears	Withdraws from others	Steals
Pulls hair	Afraid of dark	Unusual body movements	Cries easily
Tics	Nightmares	Excessive masturbation	Inappropriate sexual behavior
Sensitive to criticism			

What does child do to gain your attention?_____

Describe behavior of major concern:_____

CURRENT INFORMATION

Social/family information: Number of adults living in home? _____

Number of children living in home? _____

How many times have you moved in the last two years? _____

How many schools has your child attended? _____

Did your child attend preschool? _____

Does your family have medical insurance? _____ Medi-Cal?_____

Please circle any family problems which might affect this child:

Separation Divorce Illness Death Drugs Alcohol Family violence Incarceration Child abuse

Foster placement Mental illness Homelessness Financial problems Job loss Other _____

How much television does your child watch daily? _____ (approximate hours)
How many hours of computer /video games does your child play daily? _____ (approximate hours)
What time does your child go to bed? _____ What time does your child get up in the morning? _____

Friends:
- Makes friends easily: ☐ Yes ☐ No
- Keeps friends: ☐ Yes ☐ No
- Likes to be boss/leader: ☐ Yes ☐ No
- Is a follower: ☐ Yes ☐ No
- Friends tend to be: older ____ younger_____ same age_____ adults_____
- Timid: ☐ Yes ☐ No
- Loner: ☐ Yes ☐ No
- Overly quiet: ☐ Yes ☐ No

School: Answer the next section with regard to school and your child:

- ☐ Yes ☐ No Likes school
- ☐ Yes ☐ No Poor attendance if yes, why? _____
- ☐ Yes ☐ No Difficulty getting child to school if yes, why? _____
- ☐ Yes ☐ No Difficulty learning
- ☐ Yes ☐ No He/she could do better if tried harder
- ☐ Yes ☐ No Needs help with homework
- ☐ Yes ☐ No Has received tutoring
- ☐ Yes ☐ No Retention has been recommended
- ☐ Yes ☐ No Has been retained
- ☐ Yes ☐ No Has been told that child needed Special Education
- ☐ Yes ☐ No Enrolled in special program
- ☐ Yes ☐ No Has been tested by a psychologist

****

FAMILY INTERACTION

List your child's strengths: _____

How does your child handle conflict?: _____

How is your child disciplined?: _____

By Whom?: _____ Is it effective?: _____

How many directions can your child follow at one time?: _____

What does your child do in his/her free time?: _____

_____

What pleases you most about your child?: _____

_____

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

Fecha_____
Escuela_____
Grado_____

HISTORIA DE SALUD Y DE DESARROLLO PARA EVALUACIÓN DE EDUCACIÓN ESPECIAL

Nombre del Niño_____ Fecha de Nacimiento_____ Sexo____

Idioma Materno_____ Lugar de Nacimiento_____

Domicilio_____ Teléfono del Hogar_____

Medios Usuales de Cuidado Médico_____
(nombre) (domicilio)

Fecha del Último Exámen Físico_____ Agencias Trabajando con la Familia_____

Problemas de Salud_____

Historiador_____ Persona Entrevistando_____ Traductor_____

****

	Nombre Completo	Edad	Educación	Ocupación	En el hogar?	Problemas de Salud
Madre						
Padre						
Padrastro						
Tutor						

Otros niños (en órden de edad):

Nombre	Edad	Parentesco	Escuela	Grado	Dificultades Escolares	Problemas de Salud

****

EMBARAZO

¿Cuándo comenzó el cuidado prenatal?_____ Edad de la Madre_____

Orden de Nacimiento (circunde 1) 1 2 3 4 5 Edad del Padre_____

Duración del Embarazo_____ Sangrando_____

Tipo de Sangre_____ Medicamentos_____

Fuma_____ Estimulantes_____ Alcohol_____

Mariguana_____ Cocaina_____ Otro_____

Nacimiento: Hospital_____ Home_____ Birth Weight_____ Length of Labor_____ Anesthesia____

Parto: Vaginal_____ Cesarean_____ Reason_____

Color_____ Cry: Strong ___ Weak____ Birth Defects_____

Complicaciones: Dificultad para Respirar _____ Resuscitación_____

Encubadora_____ Motivo_____

Tiempo en el Hospital: Madre_____ Infante_____

Mientras en el Hospital, ¿cargó al niño y/o le dió de comer?_____

Alimentación: Pecho_____ ¿Por Cuanto Tiempo?_____ Problemas_____

Biberón_____ ¿Por Cuanto Tiempo?_____ Problemas_____

****

PROBLEMAS DE LA INFANCIA Y/O NIÑEZ

☐ Lastimadura en la cabeza	☐ Hiperactividad	☐ Asma	☐ Fiebres (105° o más alta)	Otros Problemas de Salud :
☐ Dolores de cabeza (frec.)	☐ Problema de la Visión/Ojos	☐ Alergias	☐ Meningitis	_____
☐ Desmayos	☐ Lentes	☐ Murmullo en el corazón	☐ Problemas con los Riñones/Orina	_____
☐ Mareos	☐ Problemas del Oído	☐ Diabetes	☐ Problemas de la Piel	_____
☐ Convulsiones	☐ Infecciones de Oído frecuentes	☐ Preocupaciones con el Peso	☐ Problemas con la Menstruación	_____

****

MEDICAMENTO

¿Está su niño tomando actualmente alguna medicina? ☐ Sí ☐ No

Anote cual medicina, dósis, y cuando la toma:_____

¿Cuál(es) medicina(s) le dan alergia a su hijo?_____

¿Ha tomado su hijo medicinas por más de dos meses? ☐ Sí ☐ No Descríbalas_____

****

HABLA

¿Entendía la mayoría de la gente lo que decia el niño a la edad de 3 años? ☐ Sí ☐ No ¿Si no, a que edad?_____

¿Está recibiendo su niño actualmente terapia del habla? ☐ Sí ☐ No ¿Quien la Provee?:_____

****

DESARROLLO

¿A qué edad más o menos hizo su niño lo siguiente?

Se sento solo_____ Habló con comprensión_____ Se baño con poca ayuda_____

Gateó_____ Habló en frases de 3 palabras_____ Entrenado para ir al excusado : Orinar___ Evacuar___

Caminó solo_____ Se abrochó la camisa o blusa_____ Se abrochó los zapatos_____

Anduvo en bicicleta_____

¿Cómo se compara el crecimiento y desarollo de este niño con sus hermanos, o con otros niños del vecindario?

☐ Más lento ☐ Igual ☐ Mas rápido Describa_____

****

MOLDES DE CONDUCTA Encierre en un círcuo todos los artículos de abajo que aplican a su niño

Se muerde las uñas	Probleams de disciplina	Se muerde a sí mismo/a otros	Se orina en la cama
Se mama el dedo	Se enoja rápidamente	Se cansa fácilmente	Hace rabietas
Impulsivo	Se lastima a proposito	Problemas para dormir	Detiene la resiración
Miente excesivamente	Torpe	Camina dormido	Pelea excesivamente con otros niños
Se distrae facilmente	Come tierra/pintura/otro	Se mece	Culpa a otros por sus dificultades
Se golpea la cabeza repetidamente	Extremadamente tímido	Se frustra fácilmente	Destructivo
Hiperactivo	Temores especiales	Se aleja de los demás	Roba
Jala el pelo	Temor a la oscuridad	Movimientos desusuales del cuerpo	Llora fácilmente
Tics	Pesadillas	Masturbación excesiva	Conducta
Sensible a la crítica			

¿Qué hace el niño para llamar su atención?_____

Describa la conducta de mayor preocupación:_____

INFORMACIÓN AL CORRIENTE

Información familiar/social: ¿Cuántos adultos viven en casa? _____

¿Cuántos niños viven en casa? _____

¿Cuántas veces se han mudado en los últimos dos años? _____

¿A cuántas escuelas ha asistido su niño? _____

¿Asistió su niño a la preescuela? _____

¿Tiene su familia seguro médico? _____ Medi-Cal?_____

Please circle any family problems which might affect this child:

Separación	Divorcio	Enfermedad	Muerte	Drogas	Alcohol	Violencia familiar	Encarcelamiento	Abuso del niño
Colocación como niño de crianza	Enfermedad mental	Sin hogar	Problemas financieros	Pérdida del trabajo	Otro _____			

¿Cuánta televisión mira su niño diariamente? _____ (horas approximadas)
¿Cuántas horas de computadora/juegos de video juega su niño diariamente? _____ (horas approximadas)
¿A qué hora se acuesta su niño? _____ ¿A qué hora se levanta su niño? _____

Amigos:
Hace amistades facilmente: ☐ Sí ☐ No
Conserva sus amigos: ☐ Sí ☐ No
Le gusta ser jefe/líder: ☐ Sí ☐ No
Es un seguidor: ☐ Sí ☐ No
Los amigos son: mayores _____ menores_____ de la misma edad_____ adultos_____
Timido: ☐ Sí ☐ No
Solitario: ☐ Sí ☐ No
Muy callado: ☐ Sí ☐ No

Escuela: Conteste la siguiente sección con relación a la escuela y a su niño:

☐ Sí ☐ No Le gusta la escuela
☐ Sí ☐ No Mala asistencia ¿Por qué? _____
☐ Sí ☐ No Dificultad para ir a la escuela ¿Por qué?_____
☐ Sí ☐ No Dificultad para aprender
☐ Sí ☐ No Puede hacer mejor si se esfuerza
☐ Sí ☐ No Necesita ayuda con la tarea
☐ Sí ☐ No Ha recibido ayuda de tutores
☐ Sí ☐ No Se ha recomendado que sea reprobado
☐ Sí ☐ No Ha sido reprobado
☐ Sí ☐ No Se ha dicho que el niño necesita Educación Especial
☐ Sí ☐ No Matriculado en un programa especial
☐ Sí ☐ No Ha sido examinado por un sicólogo

****

TRATO EN TRE LA FAMILIA

Anote las fortalezas de su niño: _____

¿Cómo arregla los conflictos su niño?: _____

¿Cómo disciplinan al niño?: _____

¿Quien lo disciplina?: _____ ¿Es efectivo?: _____

¿Cuántas instrucciones puede seguir su niño al mismo tiempo?: _____

¿Qué hace su niño en su tiempo libre?: _____

_____

¿Qué es lo que más le gusta de su niño?: _____

_____

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS
NEUROLOGICAL EXAMINATION

Certain abnormal clinical findings suggesting mild neurological impairment and occur in up to 30% of children with learning disabilities and/or attention deficit disorders. These findings are called neurological soft signs and may be identified during the neurological examination. These are the neurological soft signs described by Herzig and should be performed in an organized manner. About 5% of normal children display one or two soft signs.

SPEECH

Clarity and intelligibility of speech as well as word sound production are assessed based on examiner's ability to comprehend. This is a very subjective assessment.

BALANCE AND EQUILIBRIUM

Tests of balance and equilibrium assess cerebellar and vestibular function. A soft sign in balance is considered present, if the child's ability to accomplish two out of the following three tasks is impaired. These tasks include 1.) standing balance, 2.) hopping, 3.) tandem walking.

STANDING BALANCE: The child is required to stand still for 30 seconds with eyes closed, feet together, arms extended and fingers spread apart. Marked impairment is reflected by three or more back and forth movements of the body exceeding one inch in each direction during the observation period.

HOPPING: The child is asked to hop ten times consecutively on each foot. Failure to hop at least five times consecutively on both feet, is taken as marked impairment.

TANDEM WALKING: The child is asked to take ten steps, placing the heel directly in front of the toe of the other foot (as in walking on a tightrope) with their arms at their sides. The child should also take ten steps backward in a similar fashion. A failure to approximate heel and toe for at least five consecutive steps reflects marked impairment.

COORDINATED MOVEMENT

Coordinated movement assesses cerebellar and cerebral-integrative function. Coordination difficulty is determined by the inability to perform two of the five tasks below.

FINGER TO NOSE: The child is required to extend each arm laterally and touch his index finger to the tip of his nose five times with each hand with his eyes open. The sequence is repeated with the eyes closed. Failure to touch the tip of the nose at least three times with both hands with eyes closed indicates impairment.

ALTERNATING PRONATION-SUPINATION: The child stands with one arm relaxed at his side and the other elbow flexed at 90°, with the hand pointing forward. He is requested to pronate and supinate the extended hand quickly five times and to repeat the task using the other hand. Impairment is indicated by the movement of both elbows a distance of four more inches during execution of the alternating hand movements.

FOOT TAPS: The child is seated in a straight chair and asked to tap the toe of each foot ten times in succession, keeping his heel on the floor. He is then asked to tap both feet together an additional ten times. Failure to sustain at least five simultaneous toe taps indicates impairment.

SKIPS

GAIT: Gait is the result of the integrative actions of body, head, upper and lower extremities and includes operations of the cerebrum, cerebellum, vestibular system and spinal cord. Gait is observed as the child walks back and forth for a distance of 20 feet. The presence of at least two of the following is designated a "soft sign": a base wider than ten inches, failure to alternate flexion and extension of the knees smoothly, and absence of a heel-toe gait or immobility of the arms.

ORIENTATION

Orientation in this section refers to right-left discrimination. The following guideline can be used for right-left discrimination in children:

< 5 y.o.	not applicable
5 y.o.	identifies his or her own right and left hands.
6 y.o.	can place right hand on right ear, left hand on left ear.
7 y.o.	can place right hand on left ear, left hand on right ear.
8 y.o.	identifies right and left in examiner facing him or her.

MUSCLE FUNCTIONS/STRENGTHS

SEQUENTIAL FINGER-THUMB OPPOSITION: This task requires the child to imitate the examiner in the opposition of thumb to fingers in the sequence: index, fourth, middle, pinky, pinky, middle, fourth, index. The child is requested to repeat each movement before the next is illustrated. The performance of both hands is assessed. Imitative movements are designated a "soft" sign if at least two errors occur with each hand.

MUSCLE TONE: Muscle tone in the upper limbs is tested by (a.) flapping the hand while holding the lower forearm still; (b.) plantar and dorsiflexion of the wrist; (c.) flexing and extending the elbow; and (d.) dorsiflexing the wrist and bending the fingers back. Tone in the lower limbs is tested by (a.) holding the thigh above the knee with the leg hanging down and swinging the lower leg, and (b.) testing the range of motion of the ankle. In order to ensure that the extremity is limp while these movements are carried out, the child is engaged in conversation about something else to divert their attention from the examiners manipulation. Tone is recorded separately for all four extremities. For tone to be designated a soft sign, finding of marked hypotonea or hypertonia in all four extremities is required.

CHOREIFORM MOVEMENTS: Choreiform movements are assessed on the bases of the procedure developed by Prechtl and Stemmer (1962). The child is asked to assume the position previously described for the assessment of standing balance, while the examiner watches for small jerky twitches occurring in the fingers, wrist, joints, arms and shoulders. Choreiform movements are designated a soft sign if ten or more twitches are observed within a 30 second period.

PASADENA UNIFIED SCHOOL DISTRICT
NEUROLOGICAL EXAMINATION SHEET
5 YEARS AND OLDER

NAME _____ DATE _____

SPEECH	YES	NO
CLEAR		
WORD SOUND PRODUCTION GOOD		

BALANCE AND EQUILIBRIUM		
GOOD STANDING BALANCE		
HOPS ON ONE FOOT		
RIGHT		
LEFT		
HEEL/TOE TANDEM WALK (2 METERS)		
FORWARD		
BACKWARD		

CEREBELLAR FUNCTION/COORDINATED MOVEMENT		
PERFORMS FINGER TO NOSE TEST		
PERFORMS RAPID ALTERNATING HAND MOVEMENT		
PERFORMS FOOT TAPS SIMULTANEOUSLY		
APPROPRIATE GAIT		
SKIPS		

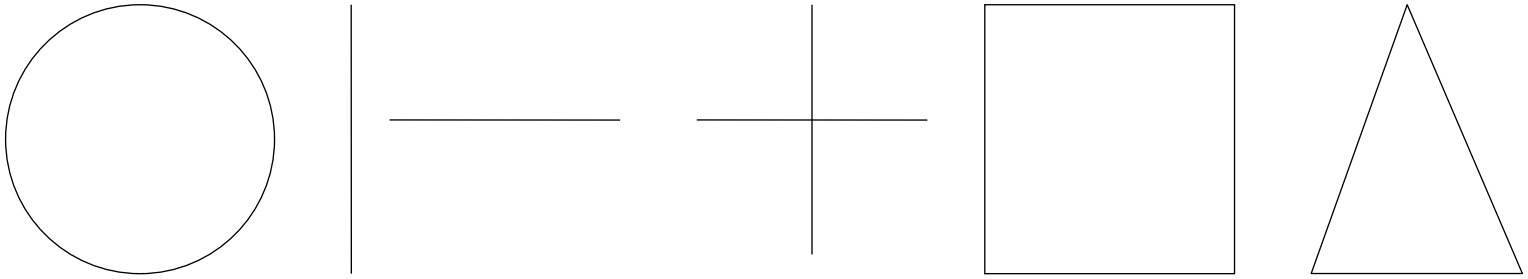
ORIENTATION		
AGE APPROPRIATE RIGHT-LEFT AWARENESS		

MUSCLE FUNCTION/STRENGTH		
APPROPRIATE MUSCLE TONE FOR AGE		
CHOREIFORM (TWITCHING) MOVEMENTS		
FINGER-THUMB OPPOSITION		
GRIPS		
EYELIDS (CN III)		
SCM (CN XI)		
TRAPEZIUS (CN XI)		

CRANIAL NERVES	YES	NO
BALLOON CHEEKS(CNVII)		
RAISES EYEBROWS (CNVII)		
CLOSES EYES TIGHTLY (CNVII)		
PUT TONGUE BEHIND UPPER TEETH (CNXII)		
MOVES PROTRUDING TONGUE SIDE TO SIDE (CNXII)		
BITES ON TONGUE BLADE (CNV)		
GAG REFLEX (CN IX, X)		

DEEP TENDON REFLEXES		
BICEPS		
TRICEPS		
BRACHIORADIALS		
PATELLAR		
ACHILLES		

FIGURE RECOGNITION AND PRODUCTION		
PRINTS NAME		
FIRST NAME (5 YEAR OLD)		
BOTH (6 YEAR OLD)		
DRAWS A PERSON		
11-12 PARTS		
13 + PARTS		
COPIES/RECOGNIZES		
5 FIGURES (5 YEAR OLD)		
6 FIGURES (6 YEAR OLD)		
GRASPS PENCIL CORRECTLY		



COPY

NAME

L.H.

R.H.

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS
351 S. HUDSON AVE
PASADENA, CA 91109

AUTHORIZATION TO DISCLOSE OR RECEIVE MEDICAL INFORMATION

I hereby authorize: _____
Agency/Provider/Hospital/School

_____
Address

_____
City State Zip Code

To disclose information concerning: _____
Name

_____ _____
Birthdate Clinic or Other Identifying Number

This information is to be released to:

_____
Name

_____
Agency/Hospital/School/Provider

_____
Street

_____
City State Zip Code

For the following purpose (s): _____

_____

Specific Information requested is:

☐ DIAGNOSIS ☐ PERTINENT MEDICAL SUMMARY

☐ BEHAVIORAL REPORTS ☐ OTHER: Specify _____

_____

This authorization shall become effective immediately and shall be valid until: _____
Date

I request a copy of this authorization: Yes___ No___ Initial _____

I understand that this information is to be released only to the above named party and may not be further disclosed, except where specifically required or permitted by law, without additional authorization.

_____ _____
Signature of Parent/Guardian/ Student (18 years of age or older) Relationship to Student

_____ _____
Street Address Telephone Number

_____ _____
City State Zip Code Date

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD
351 S. HUDSON AVE
PASADENA, CA 91109

AUTORIZACION PARA DAR O RECIBIR INFORMACION MEDICA

Por medio de la presente autorizo a: _____
Agencia/Médico/Hospital/Escuela

_____
Domicilio

_____
Ciudad Estado Zona Postal

A dar información en cuanto a: _____
Nombre

_____ _____
Fecha de Nacimiento Clínica u Otro Número de Identificación

Esta información se debe dar a:

_____
Nombre

_____
Agencia/Hospital/Escuela/Médico

_____
Calle

_____
Ciudad Estado Zona Postal

Para el siguiente propósito (s): _____

_____

La Información Específica requerida es:

☐ DIAGNOSIS ☐ SUMARIO MEDICO PERTINENTE

☐ REPORTES DE CONDUCTA ☐ OTRO: Especifique _____

Esta autorización será efectiva inmediatemente y será válida hasta: _____
Fecha

Quiero copia de esta autorización: Sí____ No___ Inicial_____

Yo entiendo que esta información se dará únicamente a la persona o agencia arriba mencionada y no se dará a nadie más, excepto cuando sea específicamente requerido o permitido por la ley, sin autorización adicional.

_____ _____
Firma del Padre/Tutor/
Estudiante (de 18 años de edad o mayor)

Parentesco con el/la Estudiante

_____ _____
Domicilio Número de Teléfono

_____ _____
Ciudad Estado Zona Postal Fecha

MASTER LIST
"AUTHORIZATION TO RECEIVE MEDICAL INFORMATION" FORM SENT AND RECEIVED

Student	DOB	Grade	Teacher/School	Provider/Agency	Comments	Date Sent	Received

PASADENA UNIFIED SCHOOL DISTRICT

NURSE'S ASSESSMENT REPORT
BOTH PAGES TO BE COMPLETED BY A CERTIFICATED SCHOOL NURSE

CHECK APPLICABLE BOXES

- ☐ Initial Report
- ☐ Annual Review
- ☐ Triennial Review
- ☐ Health & Dev Hist on File
- ☐ Med Exam Report on File

School Grade Date

Nurse

Name of Student Birthdate Sex

Language(s) of Home Position in Order of Birth 1 2 3 4 5 Other

Father Mother

Legal Guardian Other

Height Percentile Weight Percentile Other

Vision Results Type of Test Date

Hearing Results Type of Test Date

SIGNIFICANT HEALTH/FAMILY HISTORY

CURRENT HEALTH STATUS (include all medications, dosage, and frequency)

STUDENT'S NAME _____
BIRTHDATE _____

HEALTH CARE PROVIDER AND/OR COMMUNITY AGENCIES (name & specialty)

OBSERVATIONS (general appearance, behavior, motor, etc.)

SERVICES CURRENTLY PROVIDED

ACTION(S) TAKEN BY NURSE - DATED

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

NURSE ASSESSMENT
TRIENNIAL EVALUATION

Student _____ DOB _____ Age _____

School _____ Grade _____ Teacher _____

Height: _____ Percentile: _____

Weight: _____ Percentile: _____

Date of last PE: _____ Primary health care provider: _____

Vision screening: _____ Date: _____ Referred: _____

Puretone hearing screen: _____ Date: _____ Referred: _____

Health Update:

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

School Nurse: _____ Date: _____

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

SPECIALIZED PHYSICAL CARE SERVICE DURING SCHOOL HOURS

Designated school personnel may assist students who require specialized physical health care services during the school day. This service is provided to enable the student to remain in school and to improve the potential for education and learning.

STUDENT NAME: _____ DATE OF BIRTH: _____

SCHOOL OF ATTENDANCE: _____ GRADE: _____ DATE: _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN

1. Name of standardized procedure: _____

2. Condition requiring procedure: _____

3. Precautions, possible untoward reactions and interventions:

4. Time schedule/indication for the procedure: _____

5. Continue procedure until: _____ (Date)

Physician: _____ _____
Name (Please Print) (Date)

_____ _____
Signature Telephone

Address: _____

THIS SECTION TO BE COMPLETED BY PARENT

I authorize school personnel to administer the above health care to my child as ordered by our physician.

Parent/Guardian: _____ Date: _____

Address: _____

Home Phone: _____ Work Phone: _____

ALL NECESSARY EQUIPMENT MUST BE SUPPLIED BY THE PARENT. APPROPRIATE INSTRUCTION AND/OR TRAINING MUST BE PROVIDED TO DISTRICT PERSONNEL.

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

MEDICATION AND SPECIAL PROCEDURE TRAINING DOCUMENTATION

School _____ Year _____

Student: _____ Grade/Teacher _____

Medication	Date of Initial Training	**Medication**	Date of Initial Training

Procedure		**Procedure**	

Follow-up evaluations

Procedure/Medication	Date	Procedure/Medication	Date

The following district personnel acknowledge receiving instruction from the school nurse in providing the above service to this student:

	Date	Signature		Date	Signature
1.			4.		
2.			5.		
3.			6.		

The above district personnel have been trained to provide the above services as indicated per MD order and/or district guidelines for this student.

_____
School Nurse

Specialized Physical Health Care Service

Daily Log of Treatment Administered

Name ________________________________ Birth date __________ School ____________

Procedure ___________________________________ From ___________ to ______________

Physician ___________________________________ Phone ____________________________

Date ___/___/___			Date ___/___/___			Date ___/___/___		
Time	Comment	Init.	Time	Comment	Init.	Time	Comment	Init.
Date ___/___/___			Date ___/___/___			Date ___/___/___		
Time	Comment	Init.	Time	Comment	Init.	Time	Comment	Init.
Date ___/___/___			Date ___/___/___			Date ___/___/___		
Time	Comment	Init.	Time	Comment	Init.	Time	Comment	Init.
Date ___/___/___			Date ___/___/___			Date ___/___/___		
Time	Comment	Init.	Time	Comment	Init.	Time	Comment	Init.
Date ___/___/___			Date ___/___/___			Date ___/___/___		
Time	Comment	Init.	Time	Comment	Init.	Time	Comment	Init.

Signatures	Title	Date

Directions:

Use one sheet per procedure and attach the standardized procedure to each sheet.
Person administering specialized physical health care shall initial in space daily and include identifying signature at bottom of page only one time.
If student is absent or if for any reason procedure is not done, indicate in “comment” column.
This form shall e included in student’s cumulative health record.
Additional comments should be entered on the back of the sheet.
Person supervising the procedure is to sign on days he or she is present in “signature” spaces at bottom.

Date	Comments
/ /	
/ /	
/ /	

SPECIALIZED PHYSICAL HEALTH CARE SERVICE
DAILY LOG OF TREATMENT ADMINISTERED

SUMMER SCHOOL

STUDENT/PHONE _____ DOB _____ GRADE ____ SCHOOL _____

PROCEDURE _____ START DATE _____ END DATE _____

SPECIAL INSTRUCTIONS_____

_____

_____

PHYSICIAN PHONE _____ DIAGNOSIS _____

JUN	1	2	3	4	5	6	7	8	9	10
	11	12	13	14	15	16	17	18	19	20
	21	22	23	24	25	26	27	28	29	30
JUL	1	2	3	4	5	6	7	8	9	10
	11	12	13	14	15	16	17	18	19	20
	21	22	23	24	25	26	27	28	29	30
	31									
AUG	1	2	3	4	5	6	7	8	9	10
	11	12	13	14	15	16	17	18	19	20
	21	22	23	24	25	26	27	28	29	30
	31									

NURSE _____ INITIALS _____

HEALTH CLERK _____ INITIALS _____

OTHER _____ INITIALS _____

DATE	COMMENTS	INITIALS

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

SEIZURE CHART

Name _____ Home Phone _____ Parent _____
Physician _____ Phone _____ Grade/Teacher _____

Day	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
1												
2												
3												
4												
5												
6												
7												
8												
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28												
29												
30												
31												

Date	Time	Length	Description of Seizure

HOME TEACHING

Home teaching is for students out of school for 4 weeks or longer.

When a student has sustained an injury, is to have surgery or has a non-communicable disease, parents can request a home school teacher by completing the appropriate forms. Pregnancy does not qualify unless there is a medical complication documented by the medical care provider.

Students who are known to require home or hospital teaching should be brought to the attention of the school nurse as soon as possible. The time a student is expected to be out **must be a minimum of four weeks.**

A health care provider will need to complete verifying information. It is also acceptable for parents to bring from the doctor a written verification of the diagnosis and length of time the student is expected to be out. The school nurse can complete the district paperwork.

In certain circumstances, to expedite the student's admission to home teaching, the school nurse can certify the diagnosis and the student's expected time out from school with the physician by phone. The nurse can contact the Health Programs office to initiate services while waiting for written verification.

Paperwork should be sent or brought by school nurse or school district personnel to Health Programs office, at the Education Center, who will complete arrangements for home school.

Home Teaching consists of 5 hours per week of one-to-one teaching. A maximum of 3 classes is offered.

A student completes most assignments independently. An adult must be present in the home at all times.

INDEPENDENT STUDY

Independent study is arranged through the counselor. The assignments must be picked up at school. This involves the student studying at home and working independently on assignments.

PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

PROCEDURE FOR HOME TEACHING APPLICATION

- Give parent the Physician's Diagnosis and Recommendation form. Have the child's physician complete the form and return it to the school nurse.*

- Have the parent complete and sign the Parent Application and Agreement card. After the card is signed, give parent the Home Teaching Letter.

- When both of these forms have been received and reviewed by the school nurse, complete the Request for Home Teaching form.

- Forward all three forms to the Health Programs office at the Education Center.

- Upon approval by the Health Program Office, a home teacher will be assigned.

* Forms may be faxed to the school or to the Education Center Health Office at (626) 584-1540.

Pasadena Unified

School District

Special Education/Home Teaching Program

Dear Parent/ Guardian:

A request has been made to provide a home teacher for your son/daughter. It is important that you understand the following conditions.

- Home teaching is provided for those pupils who are temporarily physically impaired or handicapped to the extent that they are unable to attend school.
- This program provides a home instructor for up to five hours a week, Monday-Friday, to guide, supervise, and direct the student's home study, in the areas of Reading or English, Mathematics, and Social Studies. Home teaching is not provided during school holidays, Saturdays, or during Winter, Spring, or Summer Recess.
- An adult must be present in the home when the instructor is present.
- Grades for the time your son/daughter is on home teaching will be sent to the school of attendance upon termination of the program. It will be the responsibility of the school of attendance to determine whether promotion or graduation requirements have been met.
- Your son/daughter should remain at home during the hours of 8:00 a.m. to 1:30 p.m. to avoid being mistaken for a truant student.

Sincerely,

Ann Rector,
Director of Health Programs

Pasadena Unified

School District

Home Teaching Program

Estimado Padre/Tutor:

Se ha hecho una petición para proveer un maestro en el hogar para su hijo/a. Es importante que sepa las siguientes condiciones:

- Enseñanza en el hogar se provee para aquellos alumnos quienes tienen impedimento físico temporal o están incapacitados hasta cierto punto que no pueden asistir a la escuela.

- Este programa provee un instructor en casa hasta por cinco horas por semana, de lunes a viernes, para guiar, supervisar, y dirigir el estudio del hogar del alumno, en las áreas de Lectura o Inglés, Matemáticas, y Estudios Sociales. No se ofrece el maestro en el hogar durante los días festivos, sábados, o durante las vacaciones del invierno, primavera, o verano.

- Debe de haber siempre un adulto presente en el hogar cuando el instructor esté presente.

- Los grados por el tiempo que su hijo/a reciba la enseñanza en casa se enviarán a la escuela a la que asiste su hijo/a, cuando termine el programa. Será la responsabilidad de la escuela de asistencia para determinar si se han llenado los requerimentos para que pase al siguiente grado o para la graduación.

- Su hijo/a deberá permanecer en casa durante las horas de las 8:00 a.m. a la 1:30 p.m. para evitar que sea confundido con un alumno que anda de vago.

Cordialmente,

Ann Rector
Director of Health Programs

PASADENA UNIFIED SCHOOL DISTRICT
Special Education

REQUEST FOR HOME TEACHING

_____ _____
Teacher School

_____ _____
Counselor Date

Student's Name: _____ M F
Last First M.I. Sex

Student I.D. # _____ Special Education Student? Yes _____ No _____

Date of Birth: _____ Age: _____ Grade Level: _____

Name of Parent or Guardian: _____

Address: _____ Phone Work _____
Home _____

Reason for Request: _____

_____

_____

Anticipated length of Home Teaching: _____

Home teaching provides assistance in 3 subject areas or courses only: Math, English, and Social Studies

Nurse's Comments: _____

_____

_____

Nurse's Recommendation: _____

_____

Signature of School Nurse _____

Submitted by _____

Approved: _____
Ann Rector, Director of Health Programs

Note: When this form is completed, forward the original to the Health Programs Department

PASADENA UNIFIED SCHOOL DISTRICT
Special Education

REQUEST FOR HOME TEACHING
PHYSICIAN'S DIAGNOSIS AND RECOMMENDATION

Student's Name _____

Address _____

Parent's Name _____

Physician's Diagnosis _____

_____

_____

I recommend that this child: ☐ Attend a regular school.

☐ Be provided services of a home teacher for four weeks or longer.

Other _____

_____

Physician's update on student's condition required every six weeks.

Physician's Signature _____ M.D. Date _____

Address _____
Street City Zip

Phone _____

Please return form to: _____

_____

_____

PASADENA UNIFIED SCHOOL DISTRICT
PARENT APPLICATION AND AGREEMENT
HOME TEACHING PROGRAM

Pupil's
Name _____
Address _____
Birthdate _____
Parent/Guardian _____
Home Phone _____ Work Phone _____
School _____ Grade _____
Name
Of Physician _____
Address _____ Phone _____

Office Use Only
Teacher _____
Date Assigned _____
Date Dismissed _____
Regular _____
Special Ed _____

I have applied for a home teacher for my son/daughter. I understand that an adult must be present during the time the home teacher is in my home.

Signature _____
Parent/Guardian Date

PASADENA UNIFIED SCHOOL DISTRICT

Infant-Preschool Assessment

HEALTH AND DEVELOPMENTAL HISTORY

IDENTIFICATION Date _____

Child's Name _____
(Last) (First) (Nickname)

Sex _____ Date of Birth _____ State and Country where child was born _____

Address _____ Phone _____

Primary Language of the child _____ Primary Language in the home _____

Father's Name _____
(Last) (First) (Middle)

In the Home? _____

Date of Birth _____ Occupation _____ How long? _____

Employed by _____
(Business Address) (Telephone Number)

Mother's Name _____
(Last) (First) (Middle) (Maiden)

In the Home? _____

Date of Birth _____ Occupation _____ How long? _____

Employed by _____
(Business Address) (Telephone Number)

FOSTER PARENT/LEGAL GUARDIAN _____
(Last) (First) (Middle)

Date of Birth _____ Occupation _____ How long? _____

Employed by _____
(Business Address) (Telephone Number)

Please list names of family members and/or personnel employed to assist in the care of your foster children.

_____

_____

_____

_____

Date of placement in present home _____ Language(s) spoken in the home _____

HOME BACKGROUND

Please list other members of the household. (Please put a * on the siblings living out of the home)

Name	Relationship to Child	Birthdate

SCHOOL

List all public and private schools/programs/daycare your child has participated in since birth:

Names of School	City & State	Dates
		From_____ To_____
		From_____ To_____

Who referred you to the Pasadena Unified School District? _____

MEDICAL AND DEVELOPMENTAL HISTORY

Please answer the following questions as accurately as you can. If you do not understand a question, cannot remember, or wish to discuss the subject, put a star (*) by the quesiton and it will be discussed with you later.

GENERAL HEALTH

Place of Birth _____

Name of Hospital _____

Address of Hospital _____
(Street) (City, State & Zip)

Name of physician who delivered the child _____

Address of Physician _____
(Street) (City, State & Zip)

Please check type of health insurance your child has: Private _____ Medi-Cal _____ None _____

How would you describe your child's general health now? _____

Primary physician's name and address: _____

_____

Name and addresses of other physicians, specialists and/or clinics that have treated or have been consultants to your child: _____

_____

_____

Is your child currently being seen or have you made an appointment with any other professional individuals or agencies? _____

_____ Regional Center

_____ Department of Children and Family Services (DCFS)

_____ California Children's Services (CCS)

_____ Other, please specify _____

Does your child receive therapy services (speech, physical, occupational)? ( ) Yes ( ) No

Type of agency: _____

Type of therapy: _____ Frequency of sessions _____

PREGNANCY AND BIRTH HISTORY

Natal and Prenatal History: What number of pregnancy was this one? 1 2 3 4 5 6
(Please Circle)

Your age when child was born? _____

Any miscarriages or deaths before age one? ( ) Yes ( ) No
Comment:

Pregnancy: Did you receive prenatal care? _____ Beginning when? _____

Did you experience any of the following during this pregnancy?

Yes	No	
		Emotional distress
		Hemorrhage
		Infection
		Medications
		Prenatal Vitamins

Yes	No	
		Major Illness
		Premature delivery
		Toxemia
		Trauma
		Smoking
		Alcohol and/or drugs

Comments: _____

Labor and Delivery: Length of pregnancy _____ weeks _____ months.
Birthweight _____ Length _____
Apgar scores 1 min. _____ 5 min. _____

How was your baby delivered? Vaginal _____
Cesarean section _____ reason for cesarean? _____

Was labor spontaneous with no complications? ( ) Yes ( ) No

Complications: _____

Neonatal History:

Did the child go home from hospital with you? ( ) Yes ( ) No
Length of mother's hospital stay
Length of child's hospital stay __

How long did you: breastfeed _____ bottlefeed _____
Was this baby's sucking: strong _____ weak _____

Did your child experience any of the following during the first month of life:

Yes	No	
		Anoxia
		Transfusion
		Incubator
		Jaundice
		Poor feeding

Yes	No	
		Rehospitalization
		Resuscitation
		Seizures
		Surgery
		Other

If yes, please comment _____

_____

CHILD'S MEDICAL HISTORY

Date of your child's last physical examination: _____

Current weight _____ Current height _____

Is your child allergic to any specific food or medication? If yes, please list _____

_____

Has your child ever been given a diagnosis of asthma by a doctor? _____

Has your child ever experienced any of the following?

Yes	No	
		Hospitalization
		Surgery
		Major Illness
		Major Accidents or Trauma

Please comment further on any of the above, including the type of illness or surgery, etc., and the date.

_____

_____

Has your child had any seizures? _____ How old was your child when the seizures began? _____
How often does your child have a seizure? _____
Are the seizures associated with a high fever? _____
What was the date of the last EEG? _____

Please write in "yes" or "no" to the following:
_____ eye problems?

_____ wears glasses?
_____ follows moving objects with eyes?
_____ reaches for toy?
_____ ear or hearing problems?
_____ responds to sounds?
_____ ear infections? If so, how many? _____
_____ speech or language problems?

If the answer is "yes" to any of the above questions, please describe the problem(s) as specifically as you can:

_____
_____
_____

Previous vision evaluation? Date _____
Previous hearing evaluation? Date _____

What medical diagnoses have been given to your child? _____
_____
_____
_____

Is your child on any medication at the present time? _____

Name of Medication	Dosage	Time Administered
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEVELOPMENTAL HISTORY

Lifts head when lying on stomach? at _____ weeks / at _____ months
Rolls from stomach to back? at _____ weeks / at _____ months
Sat unsupported at _____ months.
Crawled at _____ weeks / at _____ months
Walked unsupported at _____ months
Searches with eyes for sound? ( ) Yes ( ) No
Coos? ( ) Yes ( ) No
Bables *such as "baba baba") ? ( ) Yes ( ) No
Used two or three words other than "mama" or "dada" at _____ months.
Spoke two or three word sentences at _____ months.
Toilet trained (bladder) at _____ months.
Toilet trained (bowel) at _____ months.
How many toileting accidents a week? _____
Tricycle riding at _____ years _____ months
Difficulty swallowing? ( ) Yes ( ) No
Difficulty chewing foods? ( ) Yes ( ) No
Chokes on liquids? ( ) Yes ( ) No
Chokes on solids? ( ) Yes ( ) No
Using bottle after 2 years? ( ) Yes ( ) No
Difficulty drinking from cup? ( ) Yes ( ) No
Feeding skill level (needs assistance? _____ Independent with utensils? _____).
Dressing skill level (needs assistance? _____ Independent with utensils? _____).

Did this child make a variety of sounds during the first year? Please comment _____

_____

How old was your child when you first began to have a concern that perhaps he/she was not developing the way you thought he/she should? _____

Emotional/Behavioral Symptoms.

Yes	No	
		Frequent Crying
		Discipline problems
		Destructive
		Stutter/Stammer
		Head banging, rocking
		Hyperactive

Yes	No	
		Excessive fearfulness
		Sleep disturbances
		Accident prone
		Hurts self/others
		Thumb/finger sucking
		Unusual preoccupations

If yes, please comment _____

_____

Would you describe your child as: happy ____ sad _____ quiet _____ sociable _____ affectionate _____?

As an infant, did your child like to be held? _____.

What calmed you infant when he/she was upset? _____.

Does your child tantrum? _____ How often? _____.

What does he/she do? _____

How is your child disciplined? _____

By whom? _____

Is this method effective? _____

Please add any other behavior that was a problem early on. _____

_____

FAMILY HISTORY

Please check any of the following illnesses or traits that have occurred in any of your family members (Parents, Grandparents, Aunts, Uncles, Cousins, Brothers, and Sisters).

Yes	No	Ilness/Trait
		Congenital Disease
		Genetic Abnormality
		Autism
		Epilepsy
		Emotional/Mental Illness
		Developmental Disability

Yes	No	Illness/Trait
		Learning Disability/Hyperactivity
		Neurologic Disease
		Obesity
		Speech problems/delays
		Other:

Please identify the family member if you checked “yes”. _____

_____

_____

Are there any family problems which currently might affect this child? ( ) Yes ( ) No
Example: divorce, death, drugs, alcohol, family violence, etc. If yes, please describe: _____

What are your major concerns regarding your child at the present time? _____

What pleases you most about your child? _____

Parent/Caregiver

Interviewer

Translator

PASADENA UNIFIED SCHOOL DISTRICT
SPECIAL EDUCATION
INFANT-PRESCHOOL PROGRAMS

HEARING SCREENING

The initial hearing evaluations and assessments of infants and preschoolers, from birth through five years of age, must, at a minimum, include the following:

1. Review of medical and/or case history.
2. Informal behavioral observation(s)
3. One or more hearing test procedures, appropriate for the age, development, and unique needs of the child. Such procedures may be grouped into the following categories:

    - Electrophysiological testing
    - Otoacoustic emission response
    - Behavioral assessment measures

Preferred practice is a combination of the three procedures as appropriate for the child. Optional procedures include *tympanometry* in conjunction with electrophysiological, acoustic emittance, or behavioral assessments; and *visual inspection* of the external ears.

Review of Case History

While reviewing the child's medical and/or case history, the reviewer(s) must note any factors that might place the child at high risk for a hearing impairment and warrant continuous monitoring and possible in-depth testing. Table 1 illustrates the high risk criteria for a hearing impairment as developed and approved by the Joint Committee on Infant Hearing. If any risk factor is present, the child must receive a comprehensive audiological evaluation/assessment by an audiologist. This review can be part of the required review of the records related to the child's current health status and medical history.

Personnel: The review of the case history should be done by a person who has knowledge of the various applicable medical conditions and terms. Doctors and nurses have such knowledge. Other team members, especially those from the allied health fields, may also have such knowledge or could be trained specifically to recognize the criteria.

PASADENA UNIFIED SCHOOL DISTRICT
SPECIAL EDUCATION
INFANT-PRESCHOOL PROGRAMS

HEARING SCREENING

_____ Initial assessment
_____ Annual review
_____ Triennial review _____ Regional Center
_____ Transition assessment (30-36 months) Date _____

Person completing form _____

Child's name_____Age_____yrs_____mos DOB_____
Parent's name_____ Phone _____
Diagnosis or presenting condition _____
Pediatrician _____ Phone _____
Hearing specialist _____ Phone _____
Date of last hearing exam _____ Follow-up date _____
Hearing diagnosis and current treatment (for example, medical management, aides) _____

PARENT INTERVIEW

1. Do you have any concerns about your child's hearing? Yes ____ No _____
2. Does your sleeping child move/awaken when there is a loud sound? Yes ____ No _____
3. Does child attempt to turn his head toward an interesting sound or when you call his name? Yes ____ No _____
4. Does he enjoy playing with noisemaker toys? Yes ____ No _____
5. Does child attempt to imitate sounds that you make? Yes ____ No _____
6. Is child beginning to repeat some of the words that you say? Yes ____ No _____
7. Does he coo to himself and make noises when he is alone? Yes ____ No _____
8. Can he identify familiar pictures when you name them? Yes ____ No _____
9. Does he name things when he wants them, like cookie, milk? Yes ____ No _____
10. Can he match a sound with an object like "moo" to a "cow"? Yes ____ No _____
11. Does child turn when his name is called from behind? Yes ____ No _____
12. Can the child follow a verbal command? Yes ____ No _____

SCREENING SCORE CARD

IMPORTANT: Repeat procedure on each ear

Name _____ Age _____ Date _____

Assessor _____

EAR	NOISEMAKER	DISTANCE	0-5 MONTHS	5 MOS. – 24 MOS.
Right Ear	Egg rattle	3 ft. (90 cm.)		Pass ____ Fail ____
Left Ear	Squeeze toy	3 ft. (90 cm.)		Pass ____ Fail ____
Right Ear	Bell	3 ft. (90 cm.)		Pass ____ Fail ____
Left Ear	Key rattle	3 ft. (90 cm.)		Pass ____ Fail ____
Right Ear	Horn	6 inches (15 cm.)	Pass ____ Fail ____	Pass ____ Fail ____
Left Ear	Horn	6 inches (15 cm.)	Pass ____ Fail ____	Pass ____ Fail ____

COMMENTS:

PASADENA UNIFIED SCHOOL DISTRICT
SPECIAL EDUCATION
Infant/Pre-School Program

Report of Hearing Screening

Your child did not pass a hearing screening given on _____.
Please consult with you health care provider for an examination and recommendation. We urge you to give this your prompt attention. If you need help locating a health care provider or require financial assistance, contact your school nurse.

School Nurse _____ Telephone _____

Identifying Information:

Child _____ Birth Date _____
Parent(s) _____ Phone No. _____
Address _____
_____

Referral to:

Primary Health Care Provider _____ Program _____
Address _____ FAX No. _____
_____

Referral Source:

Teacher/Specialist/Nurse _____ Program _____
Address _____ Phone No. _____
_____ FAX No. _____

Referral Reason(s)

Case History:

_____ No significant factors
_____ Indicators associated with sensorineural and/or conductive hearing loss are:

_____
_____
_____
_____

Informal Observation Assessment:

_____ No significant factors
_____ Indicators associated with sensorineural and/or conductive hearing loss are:

_____
_____
_____
_____

Hearing Screening Procedures: _____

_____ Passed
_____ Failed

Comments: _____
_____
_____
_____

PASADENA UNIFIED SCHOOL DISTRICT
SPECIAL EDUCATION
INFANT-PRESCHOOL PROGRAM

VISION SCREENING

INSTRUCTIONS FOR FIRST LOOK ASSESSMENT

Vision, like other aspects of a child's development, is dynamic. The visual system in the one-year-old infant may be still maturing. Typically, the visual behaviors examined in this tool are present by six months of age. Any atypical, suspect, or absent visual skills should be referred to the child's primary physician. Educational follow-up by a teacher of the visually impaired is recommended.

This tool is a vehicle for describing the present levels of visual skills in infants and toddlers. Retesting is recommended on an annual basis. This tool is not a substitute for a medical examination. It does not test visual acuity.

GENERAL INSTRUCTIONS

Observe the child's behavioral state. The visual assessment of a sleepy or fussy child will not be accurate. A child with low muscle tone may need to engage in activities that increase arousal level before the visual assessment may begin. A child with high muscle tone should be positioned so that he or she is most relaxed. Some children fatigue or become overstimulated easily and should be assessed over small increments of time.

Position the child so that he or she is not working on maintaining head control. Some children are most comfortable being held by caregivers.

Determine which visual stimulus is most interesting to the child. Younger children often prefer black and white stripes, a bull's-eye pattern, or drawings of faces. Some children respond to an opaque toy attached to the end of a penlight, producing a colored light. Suggested materials for a visual stimulus include penlights or small toys (2-3 inches in size) that are brightly colored. Children who do not respond to objects may respond to light-reflective materials such as mylar pinwheels. A child with a suspected cortical visual impairment may respond better to a familiar object, a moving object, or an object that is red or yellow.

Provide the child with ample light to engage in visual tasks. Face the baby away from the light source. Observe his or her sensitivity to light.

RISK FACTORS

The purpose of this section is to identify any conditions or information which indicates the presence or potential for visual impairment as described in a parent's report or in medical reports. The list can be completed by the family in advance or as part of the interview. Identification of one or more risk factors may indicate the need for a referral to a pediatric ophthalmologist and an assessment by a teacher of the visually impaired.

Instructions: Place a check by all that apply:

_____ Cerebral Palsy
_____ CHARGE Syndrome
_____ Down Syndrome
_____ Fetal Alcohol Syndrome
_____ Hydrocephalus
_____ Hypoxia, anoxia, birth trauma
_____ Intrauterine drug exposure
_____ Intraventricular hemorrhage (IVH grade I-IV), stroke
_____ Low Apgar score

Maternal TORCH
_____ Toxoplasmosis
_____ Other (syphilis, for example)
_____ Rubella
_____ Cytomegalovirus
_____ Herpes
_____ Prematurity
_____ Meningitis
_____ Shaken baby syndrome
_____ Seizure disorder
_____ Other _____

CONDITIONS RELATED TO THE EYE AND VISUAL PATHWAY

_____ Albinism
_____ Amblyopia
_____ Anophthalmia
_____ Aniridia
_____ Astigmatism
_____ Cataracts
_____ Coloboma
_____ Congenital glaucoma
_____ Cortical visual impairment
_____ Delayed visual maturation
_____ Hyperopia
_____ Leber's amaurosis

_____ Microphthalmia
_____ Myopia
_____ Nystagmus
_____ Optic atrophy
_____ Optic nerve hypoplasia
_____ Photophobia
_____ Retinal detachment
_____ Retinoblastoma
_____ Retinopathy of prematurity (ROP or RLF)
_____ Strabismus
_____ Other _____

This list is not exclusive.

PASADENA UNIFIED SCHOOL DISTRICT
SPECIAL EDUCATION
INFANT-PRESCHOOL PROGRAMS

VISION SCREENING

_____ Initial assessment
_____ Annual review
_____ Triennial review _____ Regional Center
_____ Transition assessment (30-36 months) Date _____ Person completing form _____

Child's name_____Age_____yrs_____mos DOB_____
Parent's name_____ Phone _____
Diagnosis or presenting condition _____
Pediatrician _____ Phone _____
Eye care professional _____ Phone _____
Date of last eye exam _____ Follow-up date _____
Vision diagnosis and current treatment (for example, glasses, patching, eye drops) _____

PARENT INTERVIEW

1. Do you have any concerns about your child's vision?

2. Does anyone in your family have a vision problem?

3. Does your child look at your face?
   Follow your face with his/her eyes?
   Follow you across the room?

4. Have you noticed anything unusual in the appearance or movement of your child's eyes? Do your child's eyes appear straight or do they turn in or outward, up or down?

5. Does your child hold his or head in an unusual way when viewing objects?

6. Does your child enjoy visually interesting toys (colorful and different shapes, for example)?

7. Not all risk factors for visual impairment. (See list on page 25).

8. Is your child taking any medications?

9. Does your child seem to recognize you or other members of your immediate family?
   How does he or she show recognition?

10. Does your child seem to recognize familiar toys?
    At what distance?

11. Does your child react to light?
    If so, how?

12. Does he or she exhibit an eye preference?

13. How does your child move around in the home/yard?
    Does he or she bump into things?
    Does he or she trip over things?

VISUAL RESPONSES TO STIMULI AND VISUAL REFLEXES: INSTRUCTIONS

Check the appropriate box (***P**resent, **A**bsent, **S**uspect, or **N**ot **E**xamined*). Check **S** (**S**uspect) for any responses of which you are unsure.

Blinks to bright light – the baby should blink to a bright flashlight beam.

Pupils constrict to light – Use a penlight positioned 12-18 inches from the baby's eyes, aimed at the pupil of each eye. The pupils should constrict.

Defensive blink – Quickly open your fingers as your hand approaches the baby's eyes. The baby should blink to a hand movement in the central and peripheral visual fields. If the baby gives no response, use a larger object, but try to limit air movement, which may induce the blink, and note an atypical response.

Corneal reflection test – Use a penlight positioned 12-18 inches from the baby's eyes, aimed at the nose. The reflection of the penlight should be observed in the same position in each pupil, indicating alignment of the eyes.

VISUAL SKILLS: INSTRUCTIONS

The same object can be used in an uninterrupted flow to assess locating, watching, and following.

Check the appropriate box (***P**resent, **A**bsent, **S**uspect, or **N**ot **E**xamined*). Check **S** (**S**uspect) for any responses of which you are unsure.

Locates object – Introduce the stimulus into central and peripheral fields: upper, lower, left, and right. The child needs to look at the object but does not need to maintain gaze. Children with cortical visual impairment may have difficulty sustaining gaze.

Watches object – Upon localization, use the same object to observe whether the child can maintain looking at (fixating on) the object. The child may use a peripheral gaze and not appear to look directly at the object.

Follows object – Observe whether the child will follow (track) the object. Normal movements will follow a 180-degree arc, both horizontally and vertically across midline. Note where baby loses fixation.

Displays convergence – Observe convergence: bring the object directly to the nose. The eyes should cross. Note whether the child uses eye and/or head movements when tracking.

Watches distant movement – Note whether the child will follow the movements of another person across the room.

Shifts gaze – Present two penlights equidistant from the baby at a 6-inch distance from each other. Turn on one light and wait for fixation; then, turn off the first light and turn on the second light. Note whether the baby can move his or her eyes from the position of the first light to watch the second light.

Reaches for object – This skill can be tested after the child is six months old. Observe the baby's eye-hand coordination. Note any inaccuracies in depth perception, such as under or over reaching missing the object to the right or left.

Tries to secure small object – accept any attempt the child makes. Such as assessment tests the ability of the child to see a small object, gives an indication of visual acuity, and tests eye-hand skills.

VISUAL RESPONSES TO STIMULI AND VISUAL REFLEXES

CHECK: Present, Absent, Suspect, or Not Examined

	P	A	S	NE	Comments
Blinks to bright light.					
Pupils constrict to light.					
Displays defensive blink.					
Responds to corneal reflection/test.					

Notes and comments:

VISUAL SKILLS

CHECK: Typical, Atypical, Suspect, or Not Examined

	T	A	S	NE	Comments
Locates object.					
Watches object.					
Follows object with eyes.					
180 Horizontal					
Upward					
Downward					
Displays convergence.					
Watches distant movement.					
Shifts gaze.					
Reaches for objects.					
Tries to secure small object.					

Notes and comments:

ASSESSMENT

Observation of Behaviors: (Check all that apply).

Note any movements toward or away from visual stimuli. In children with motor impairments, observe any subtle movements which may indicate a visual response. These movements might be increased blinking, eye widening, changes in breathing, or movements of the fingers, mouth, and feet.

_____ Brings eyes closed to objects or objects close to eyes.
_____ Turns/tilts head when looking at objects.
_____ Rarely or never makes eye contact with caregiver.
_____ Displays little interest in visual stimuli.
_____ Hesitates to reach out for objects (after five months of age).
_____ Shows excessive sensitivity to sunlight.
_____ Bumps into objects frequently when walking or crawling or trips frequently.

Notes and comments:

ASSESSMENT

Observation of the Eyes: (Check all that apply).

Note any asymmetry or unusual features readily observed in the eye structures or movements. These anomalies may affect vision. Note the direction the eye turns (in, out, up, or down) which may indicate the presence of strabismus and require medical intervention. In the comments section, identify the eye in which unusual movements occur.

_____ Pupil sizes are unequal, or pupils react unequally to light.
_____ Pupil of the eye is not black.
_____ One or both eyelids droop.
_____ Eyes do not completely close when child is sleeping.
_____ Eyes appear to be crossed or turned.
_____ Movements of the eye are unsteady, shaky, jerky, or pendular (nystagmus).
_____ Eyes roll upward.
_____ Eyes seem cloudy.
_____ Eyes show abnormal tearing or redness.
_____ Size of eye appears to be abnormal (small or large).

Notes and comments:

PASADENA UNIFIED SCHOOL DISTRICT
SPECIAL EDUCATION
Infant/Pre-School Program

Report of Vision Screening

As a result of a recent vision screening on _____ we believe that your child should have a complete eye examination. We urge you to give this your prompt attention. Please take this form to your health care provider for an examination and recommendation. If you need help locating a health care provider or require financial assistance, contact your school nurse.

School Nurse _____ Telephone _____

Identifying Information:

Child _____ Birth Date _____
Parent(s) _____ Phone No. _____
Address _____
_____

Referral to:

Primary Health Care Provider _____ Program _____
Address _____ FAX No. _____
_____

Referral Source:

Teacher/Specialist/Nurse _____ Program _____
Address _____ Phone No. _____
_____ FAX No. _____

Referral Reason(s)

Case History:

_____ No significant factors
_____ Indicators associated with possible vision deficits are:

_____
_____
_____
_____

Informal Observation Assessment:

_____ No significant factors
_____ Indicators associated with possible vision deficits are:

_____
_____
_____
_____

Vision Screening Procedures: _____

_____ Passed
_____ Failed

Comments: _____
_____
_____
_____