SOUTH BEND COMMUNITY SCHOOL CORPORATION
Special Education Services
215 South St. Joseph St., South Bend, IN 46601
Tel: (574) 283-8130; Fax: (574) 283-8105

Date Received by Psych _____

REFERRAL FOR MULTIDISCIPLINARY TEAM EVALUATION *(50 day timeline)*

Parent/Guardian Survey

The referral for multidisciplinary team evaluation may be initiated by a parent/guardian or by school/public agency personnel. If a parent makes a request, the school has 10 instructional days to provide the parent with notice stating that they propose or refuse to conduct the evaluation. At that time, parental consent for the evaluation may be sought.

Date:_____ **Student Name:**_____ **School:** _____

Name of person providing information: _____

Relationship to student: ☐ Parent ☐ Foster Parent ☐ Legal Guardian ☐ Relative

Primary language spoken at home _____ List other languages spoken _____

Reason for Evaluation ☐ Academic Problems ☐ Behavior/Emotional Problems ☐ Don't know

---

FAMILY INFORMATION

Who is the primary guardian (*adult who takes full legal responsibility*) for this child?

Name: _____ Relation to child: _____

Age: _____ Education: _____ Address: _____

Phone: _____ email: _____ Does the child live with this person? ☐ No ☐ Yes

Marital Status of Guardian(s) ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

If the Child also lives/spends time at another residence other than the primary guardian, please indicate

Name: _____ Relation to child: _____

If there are any other adults who live with the child, please indicate below

NAME	RELATION TO PRIMARY GUARDIAN
_____	_____
_____	_____

Children who live with the child

NAME	RELATION TO CHILD	AGE
_____	☐ Sibling ☐ half-sibling ☐ other *(specify)* _____	_____
_____	☐ Sibling ☐ half-sibling ☐ other *(specify)* _____	_____
_____	☐ Sibling ☐ half-sibling ☐ other *(specify)* _____	_____
_____	☐ Sibling ☐ half-sibling ☐ other *(specify)* _____	_____

If parents are separated or divorced, how old was the child when the separation occurred? __

Does the child see the non-custodial parent? ☐ No ☐ Yes
If so, how often? _____

If the child has been adopted at what age? _____

Does the child know of the adoption? ☐ No ☐ Yes.

Has the child been in foster care? ☐ No ☐ Yes. If yes, provide details *(when, why, how long and with whom)*. _____

_____

If any brothers or sisters are living outside the home, list their names and ages_____

_____

Is there a history of learning and/or behavioral problems in the family? ☐ No ☐ Yes - specify _____

_____

TELL US ABOUT YOUR CHILD

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

What are some positive things about your child? _____

As a parent/guardian, what are your biggest concerns regarding your child's schooling and behavior?_____

_____

When did you first become concerned? _____

What has helped? _____

What makes the problem(s) worse? _____

Quality of Sleep: ☐ no problems ☐ trouble falling asleep ☐ trouble staying asleep ☐ difficult to wake up

Explain above: _____

Typical bedtime _____ Typical wake time _____ Does child take naps? ☐ No ☐ Yes

Describe the area where your child sleeps *(room or type of area, alone or with others)* _____

_____

In a typical day, how much time does your child spend in front of a screen *(TV, movies, video games, tablets, cellphones, computers)* ☐ less than 1 hr ☐ 1-2 hrs ☐ 3-5 hrs ☐ 6 or more hrs

When does your child use screens during the day *(check all that apply)* ☐ before school ☐ after school ☐ right before bed ☐ weekends only ☐ middle of night.

Have there been any recent changes to the student's behavior/academics ☐ No ☐ Yes (*describe*)_____

_____

Are there any conditions at home that could be influencing your child's behavior and/or achievement in school *(e.g., marital problems, exposure to violence, illness of family members, absent family members, financial stress etc)*?

_____

_____

TELL US ABOUT YOUR CHILD'S DEVELOPMENT & MEDICAL HISTORY

Biological Mother	Biological Father
☐ Medical Problems ☐ Drug Abuse ☐ Alcohol Abuse ☐ Unknown	☐ Medical Problems ☐ Drug Abuse ☐ Alcohol Abuse ☐ Unknown
If checked, specify _____	If checked, specify _____

During the pregnancy

Did the mother take medication? ☐ No ☐ Yes - What kind? _____

Did the mother smoke? ☐ No ☐ Yes - How many cigarettes each day? _____

Did the mother drink alcoholic beverages? ☐ No ☐ Yes - How frequently? ☐ Daily ☐ Weekly ☐ Monthly

Did the mother use drugs? ☐ No ☐ Yes – What kind (specify) _____

How frequently? ☐ Daily ☐ Weekly ☐ Monthly.

Was your child premature? ☐ No ☐ Yes - how early? (*e.g. 4 weeks*) _____

Was a Cesarean section performed? ☐ No ☐ Yes - for what reason? _____

Were there any birth defects or complications? ☐ No ☐ Yes - please describe _____

At birth, was your child's weight ☐ less than 6lbs ☐ between 6lbs and 9lbs ☐ more than 9lbs

All children develop at different rates. We would like to learn about your child's early development. Please check any of the boxes below if you viewed your child's development, in that area, as delayed or a cause for concern.

☐ Rolling over ☐ Sitting alone ☐ Crawling ☐ Standing alone ☐ Walked alone

☐ Spoke first word ☐ Put several words together ☐ Toilet training ☐ Sleeping through the night

☐ Colicy/Fussy ☐ Feeding/Eating ☐ Other development/growth issues

Please explain any checked boxes above. _____

Has your child ever had any speech problems? ☐ No ☐ Yes - please describe _____

Has your child previously received speech/language therapy?

☐ No ☐ Yes (*by KPS*) ☐ Yes (*by ECSE/Headstart*) ☐ Yes (*Outside agency/doctor*) ☐ Yes (*other*) _____

_____

Please list any past injuries, serious illnesses, or surgeries your child has had. please note the approximate date (*or child's age at the time*) _____

_____

Has your child ever been hospitalized? ☐ No ☐ Yes If yes, indicate reason, length of stay and approximate age of the child _____

Has your child ever experienced seizures? ☐ No ☐ Yes If yes, please describe _____

_____

Has your child received outside professional services? (*use a **P** for past, **C** for current*)

__ Counseling __ Skills Trainer __ Case Manager __ Probation Officer __ Tutoring __ Mentoring

__ DCS Case Manager __ Occupational / Physical Therapy __ Other (Specify) _____

Provide any other helpful information about these services (*names, dates, reasons*): _____

_____

PRESENT MEDICAL INFORMATION

Child's Clinic: _____ Doctor: _____ Location: _____

Does your child presently have any medical problems (*illnesses, injuries, diagnoses, etc*.)? ☐ No ☐ Yes - specify below

MEDICAL CONDITION	DIAGNOSED WHEN?	MEDICAL CONDITION	DIAGNOSED WHEN?
☐ ADHD / ADD	_____	☐ Anxiety / OCD / Tics	_____
☐ ODD / Conduct Disorder	_____	☐ CAPD	_____
☐ Cerebral Palsy	_____	☐ Depression / Bipolar Disorder	_____
☐ Autism Spectrum Disorder	_____	☐ Down's Syndrome	_____
(Similar terms used in the past: Aspergers and PDD-NOS)			
☐ Other: _____	_____	☐ Other: _____	_____

Does your child take any prescription medication on a regular basis? ☐ No ☐ Yes. If yes, complete the following.

MEDICATION NAME	PURPOSE	DOSAGE	TAKEN AT SCHOOL?
_____	_____	_____	☐ Yes
_____	_____	_____	☐ Yes
_____	_____	_____	☐ Yes
_____	_____	_____	☐ Yes

If No, Has anyone suggested to you that your child may benefit from medication? ☐ No ☐ Yes - indicate why_____

_____

Medications taken in the past, but not presently _____

_____

Vision

Does your child have any vision problems? ☐ No ☐ Yes

Date of last exam _____

Physician _____

Results _____

Are glasses prescribed? ☐ No ☐ Yes

Does your child currently have a pair of glasses?

☐ Yes, has glasses but does NOT wear them

☐ Yes, has glasses and wears them

☐ No, prescribed glasses but does not currently have them

Hearing

Does your child have any hearing problems? ☐ No ☐ Yes

Date of last exam _____

Physician _____

Results _____

Has the child ever had tubes in his/her ears? ☐ No ☐ Yes If yes, when? _____

Does your child use (check all that apply)

☐ hearing aid

☐ cochlear implant

☐ FM amplification

ANSWER THE FOLLOWING IF YOUR CHILD IS IN KINDERGARTEN OR FIRST (1st) GRADE. IF NOT SKIP THIS PAGE

	Yes	No
Does your child draw shapes, such as circle, square, diamond?	☐ Y	☐ N
Does your child use scissors with one hand to cut paper?	☐ Y	☐ N
Does your child copy a picture of two lines that intersect? (i.e. X)	☐ Y	☐ N
Is your child able to say his/her first name, last name, age, and sex?	☐ Y	☐ N
Does your child use the restroom independently?	☐ Y	☐ N
Does your child put on his/her shoes correctly?	☐ Y	☐ N
Does your child appropriately manage large buttons, zippers, and shoelaces?	☐ Y	☐ N
Does your child know who to call in an emergency?	☐ Y	☐ N
Can your child name a friend he/she spends time with?	☐ Y	☐ N
Does your child show awareness of how others feel ("she is mad")?	☐ Y	☐ N
Does your child play group games with other children without adult supervision?	☐ Y	☐ N
Does your child consider the interests of friends when planning activities with them?	☐ Y	☐ N
Can your child correctly finish a list of chores, given a list to follow?	☐ Y	☐ N
What opportunities does your child have to play with children his/her age?	☐ Y	☐ N
Does your child understand the concept of "one more" (e.g. can take "one more" bite of food when asked)?	☐ Y	☐ N
Can your child count with one-to-one correspondence up to 10?	☐ Y	☐ N
When asked, does your child correctly place something BETWEEN, UNDER and OVER other objects?	☐ Y	☐ N
If your child were told a brief story (10 seconds), could he/she answer basic questions about it?	☐ Y	☐ N

	Yes	No
Can your child point to a penny, nickel, and dime when asked to?	☐ Y	☐ N
Can your child name the seven days of the week?	☐ Y	☐ N
Can your child tell you which day comes before or after another (e.g. what day comes after Tuesday)?	☐ Y	☐ N
Does your child speak in sentences?	☐ Y	☐ N
Does your child correctly follow two-step directions (e.g. get your shoes and put them on)	☐ Y	☐ N
Does your child name (not repeat) at least 20 things seen in pictures?	☐ Y	☐ N
Does your child use at least 50 words?	☐ Y	☐ N
Can your child sing a simple song?	☐ Y	☐ N
Can your child tell a story by looking at the pictures in a book	☐ Y	☐ N
Can your child name at least two words that rhyme with another word (e.g. Mat and sat rhyme with cat)	☐ Y	☐ N

Check ALL of the experiences your child has had:

☐ Participating in organized sports

☐ Going to the grocery

☐ Visiting a museum

☐ Going to the beach

☐ Attending camp

☐ Going on vacation out of town

☐ Riding on a train

☐ Visiting a zoo

☐ Attending story time at the library

☐ Checking out books from the library

☐ Other: _____

_____

Does your child have any difficulties with:

Large motor skills (*i.e. walking, riding a bike, etc.)?*
☐ No ☐ Yes - describe: _____

_____

Small motor skills (*i.e. using hands, cutting/writing, etc.*)?
☐ No ☐ Yes - describe: _____

_____

Some students display unusual behaviors that interfere with daily activities. Please rate your child on the following behaviors;

Grinds teeth	☐ Does not Occur ☐ Occasional ☐ Frequently
Poor eye contact	☐ Does not Occur ☐ Occasional ☐ Frequently
Very sensitive to pain	☐ Does not Occur ☐ Occasional ☐ Frequently
Intensely aware of smells	☐ Does not Occur ☐ Occasional ☐ Frequently
Highly sensitive to certain sounds	☐ Does not Occur ☐ Occasional ☐ Frequently
Chews/Mouths clothes/inedible objects	☐ Does not Occur ☐ Occasional ☐ Frequently
Extremely limited food preferences	☐ Does not Occur ☐ Occasional ☐ Frequently
Hurts self (biting, head banging, cutting etc.)	☐ Does not Occur ☐ Occasional ☐ Frequently

Please provide additional information regarding above concerns:_____

_____

Does your child exhibit any other unusual or atypical behaviors for his/her age? ☐ No ☐ Yes - please describe: ____

_____

SCHOOL HISTORY

Did your child attend preschool ☐ No ☐ Yes - indicate (place and year) _____

Please list in order the previous schools the child has attended

School	Location	Grade(s)	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child been retained? ☐ No ☐ Yes in _____ grade.

Has your child ever been formally evaluated? ☐ No ☐ Yes by SBCSC (in ___ grade) ☐ Yes outside of this school corporation (*e.g. Bronson, KRESA, etc; indicate who and when testing occurred*)

_____ If yes, please provide copy of results.

Has your child ever had a 504 Plan? ☐ No ☐ Yes - When and Why? _____

Has your child been seen by the school social worker? ☐ No ☐ Yes - When and Why?_____

_____

Describe anything else that the assessment team should know about your child.

_____

What are the best days/times for you to meet:

Days _____ Times _____ Phone # _____ Email _____