SOUTH BEND COMMUNITY SCHOOL CORPORATION
Special Education Services
215 S. Dr. Martin Luther King Jr. Blvd., South Bend, IN 46601
574-393-6119; Fax 574-283-8105

Date *Written Notice* rec'd by certified personnel

EARLY CHILDHOOD REFERRAL FOR MULTIDISCIPLINARY TEAM (SNAP) EVALUATION

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

****The case conference committee meeting has been scheduled for:**

(Date)_____ (Time)_____(Location)_____

***This conference must be scheduled at the time of this referral. Be sure to inform all CC members immediately. A formal Notice of Case Conference must still be sent prior to the scheduled CC.*

FOR OFFICE USE ONLY

Date rec'd-certified personnel: _____

50 instructional days: _____

45 instructional days: _____

Rec'd in office: _____

*Parent requests meeting five (5) days prior: Yes ☐ No ☐

First Steps Referral? Yes ☐ No ☐
If yes, Service Coordinator?

_____

Transition on time? Yes ☐ No ☐

Assigned to: _____

Date of Meeting w/Psych: _____

Was SBCSC invited to transition? Yes ☐ No ☐

Did SBCSC attended transition? Yes ☐ No ☐

Child _____ Birth Date _____ Age _____ Sex ☐ M ☐ F

Ethnic Code: *(check all that apply):*
☐ Am. Indian ☐ African American ☐ Asian ☐ Hispanic ☐ White ☐ Multiracial ☐ Hawaiian/Pacific Islander

PARENT SURVEY

Name of person providing information: _____

Relationship to child: ☐ Parent ☐ Foster Parent ☐ Legal Guardian

Family Information

Who is the primary guardian(s) *adult(s) 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

Primary language spoken at home _____ Other languages spoken _____

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

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

Name	**Relation to primary guardian**
_____	_____
_____	_____

Other 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? _____

If the child has been adopted, at what age? _____

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

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

Has the child been in foster care? ☐ No ☐ Yes - provide as much details as possible (*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, behavioral , or mental illness issues in the family? ☐ No ☐ Yes - specify _____

_____

Reason for Evaluation: (please list any concerns you have i.e. language, motor skills, behavior, etc.)

_____

_____

Developmental History

Biological Mother

☐ Medical Problems ☐ Drug Abuse ☐ Alcohol Abuse

☐ Other (?)

If checked, specify _____

Biological Father

☐ Medical Problems ☐ Drug Abuse ☐ Alcohol Abuse

☐ Other (?)

If checked, specify _____

During the pregnancy

Did the mother take medication? ☐ No ☐ Yes If yes, what kind? _____ _____

Did the mother smoke? ☐ No ☐ Yes If 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 | How frequently? ☐ Daily ☐ Weekly ☐ Monthly.

What kind _____

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

Did your child spend time in Neonatal Intensive Care Unit (NICU) ☐ No ☐ Yes - how long _____

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

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

Birth weight _____

All children develop at different rates. We would like to learn about your child's early development. Please provide us with the approximate age that each developmental milestone occurred:

Behavior	Age	Behavior	Age
Rolling over		Use single words	
Sitting up alone		Put several words together	
Crawling		Toilet trained	
Walking		Stayed dry at night	

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

_____

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

Has your child ever experienced seizures? ☐ No ☐ Yes - describe _____

Present Medical Information

Child's Doctor: _____ Location: _____ Phone: _____

Other Doctors/Specialists the child has seen:

Doctor/Specialist:_____ Location: _____ Phone:_____

Doctor/Specialist:_____ Location: _____ Phone: _____

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

MEDICAL CONDITION	DIAGNOSED WHEN/BY WHOM?
☐ ADHD / ADD	_____
☐ Autism Spectrum Disorder	_____
☐ Other: _____	_____

Does your child take any prescription medication on a regular basis? ☐ No ☐ Yes

If yes, MEDICATION NAME	PURPOSE	DOSAGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If No, Has anyone suggested to you that your child may benefit from medication? ☐ No ☐ Yes – Why?

_____

Medications taken in the past, but not presently

_____

<u>Vision</u>

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

Date of last exam _____

Doctor _____

Results _____

Are glasses prescribed? ☐ No ☐ Yes

Does your child currently have a pair of glasses?

☐ Yes, has glasses but <u>does NOT</u> 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

Has the child ever had tubes in his/her ears? ☐ No ☐ Yes

If yes, when? _____

Date of last exam _____

Doctor _____

Results _____

Does your child use (check all that apply)

☐ hearing aid

☐ cochlear implant

Motor Skills

Does your child have any difficulties with:

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

_____

Fine motor skills (i.e. using hands, drawing/cutting/writing, etc.)? ☐ No ☐ Yes - Describe: _____

_____

Unusual Behaviors

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

Grinds teeth	☐ Does not Occur ☐ Occasionally ☐ Frequently
Poor eye contact	☐ Does not Occur ☐ Occasionally ☐ Frequently
Unusual reaction to pain	☐ Does not Occur ☐ Occasionally ☐ Frequently
Intensely aware of smells	☐ Does not Occur ☐ Occasionally ☐ Frequently
Highly sensitive to certain sounds	☐ Does not Occur ☐ Occasionally ☐ Frequently
Chews or Mouths clothes/inedible objects	☐ Does not Occur ☐ Occasionally ☐ Frequently
Extremely limited food preferences	☐ Does not Occur ☐ Occasionally ☐ Frequently
Other behavioral concerns (biting, head banging, other)	☐ Does not Occur ☐ Occasionally ☐ Frequently

Please provide additional information regarding above concerns:_____

_____

Does your child exhibit any other unusual or atypical behaviors for his/her age? ☐ No ☐ Yes

If yes, describe: _____

_____

Tell us about your child

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? _____

Typical bedtime _____ Typical wake time _____ Does child take naps? _____

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

Explain above: _____

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

_____

Does your child have access to toys, books? ☐ No ☐ Yes What are his/her favorites? _____

_____

Does your child have opportunities to play with children his/her own age? ☐ No ☐ Yes If yes, where/when? _____

_____

Have there been any recent changes to the child's behavior/learning ☐ No ☐ Yes ☐ N/A _____

_____

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

_____

School History

Does your child attend preschool/daycare/Head Start? ☐ No ☐ Yes – indicate where _____

_____

Has your child ever been evaluated?

☐ No ☐ Yes outside of this school corporation (e.g. Riley Children's Hospital, Oaklawn, etc…, indicate who and when testing occurred) _____ If yes, please provide copy of results.

Has your child received: First Steps? ☐ No ☐ Yes

Hospital therapy? ☐ No ☐ Yes (physical therapy, occupational therapy, speech therapy) _____

_____

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

_____

Please attach copy of birth certificate and record of immunization

Thank you so much for your time and consideration in completing the form.