Amphitheater Public Schools
Student Services Department
Preschool Screening

BY USING THIS ELECTRONIC DOCUMENT, YOU AGREE TO USE OUR ELECTRONIC SIGNATURE FONT AND SIZE. PLEASE INITIAL HERE TO AGREE TO OUR TERMS OF USE:

This is to confirm the appointment scheduled for you and your child.

Child's Name:

Date of Meeting: TO BE DETERMINED

Time: TO BE DETERMINED

Type of Meeting: In Person

- **Please send the attached documents filled out along with your Child's Birth Certificate, Immunization Records, and Proof of Residency Document.**
- **Once this has been received, you will receive a call or email to confirm a screening appointment.**

Examples of acceptable Proof of Residency Documents are:

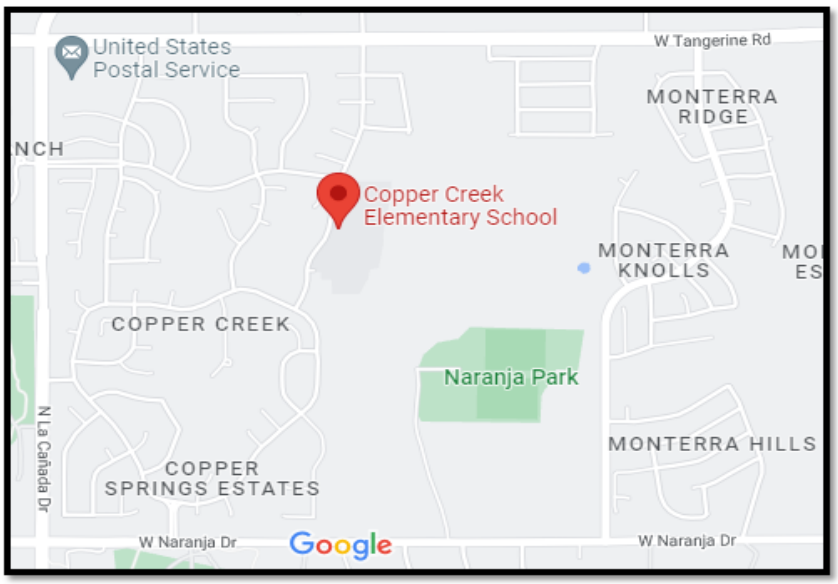
- Driver's License with current physical address
- Mortgage Papers
- Lease/Rental Agreement
- Utility Bill – Gas, Water or Electric
- Shared Residence: If Parent/Guardian is living with a relative or friend and unable to provide a document on list there is another way to prove residency – please contact the office for instructions.

In Person appointments will take place at the following address:

COPPER CREEK ELEMENTARY SCHOOL
11620 N COPPER SPRING TRAIL
ORO VALLEY, AZ 85737

The team looks forward to meeting with you.

If you have any questions or need to **cancel/reschedule** please call our coordinator assistant at (520) 696-6860.



Amphitheater Preschool Special Education

Free Preschool Screenings @ Child Find

Child Find Services are available to all residents living within the Amphitheater Public Schools attendance area.
Preschool Special Education Information & Screening Requests
(520) 696-6860

What is Child Find?
Screening to locate and identify preschool-aged children with disabilities in need of special education services.

Who is eligible for screening/evaluation?
Children between the ages of 2 years, 9 months and 5 years (prior to September 1 of current school year) of age, who reside within Amphitheater School District Boundaries.

There is no cost for this service.

Why screen and evaluate preschool children?
When developmental learning challenges are identified at a young age, early intervention and therapies can significantly improve the child's overall development and readiness for kindergarten.

What to watch for...
Children who are showing significant developmental difficulties with any of the following areas may be eligible:

- Speaking/understanding of language
- Vision or hearing
- Self-help skills
- Behavior/social skills
- Cognition/pre-academics
- Physical skills: manipulating small objects/drawing/pre-writing, walking/running/balance

How to schedule a screening:
Call (520) 696-6860. A brief intake will be taken over the phone and a screening appointment will be scheduled within 45 days. Screenings are conducted approximately twice monthly on Wednesdays from 8:00 a.m. to 2:30 p.m.

What happens at the screening appointment?

- The screening appointment takes approximately 1 hour.
- An audiologist will check your child's hearing.
- A vision screener will be used to check your child's vision.
- Team members will briefly screen your child in all developmental areas, to include speech/language, cognitive/ pre-academics, physical (gross/fine motor), adaptive (self-help), and social/behavioral.
- A team member will share the screening results.
- If further evaluation is necessary, an appointment will be arranged for a multidisciplinary comprehensive developmental evaluation, which may include a speech/language pathologist, preschool psychologist, preschool special education teacher, occupational therapist, and/or a physical therapist, or other professionals as necessary.

What if my child is less than 3 years of age?
If you have concerns about a child that is between Birth and 2 years, 9 months of age, contact the Arizona Early Intervention Program at (520) 325-6495 or (877) 222-5432.

Screening Form

Student:
Date of Birth:

Permission To Screen

Type of Screening: Preschool Child Find Screening

Your child is being referred for an individual screening to assist in planning a program of instruction and as a part of considering eligibility for special education.

The screening we are proposing may include a variety of tests and screening methods. These may include individual tests of hearing and vision, fine and gross motor, cognitive (pre-academics and learning), speech/language, social/ emotional/behavioral, and adaptive (self-help).

For questions, please contact the coordinator assistant listed below:

	520-696-6860 and AMPHICHILDFIND@amphi.com
Coordinator Assistant	*Telephone Number and Email*

I have been fully informed of all information relevant to the proposed screening and have had an opportunity to ask questions about the proposed screening. I understand that all collected information is confidential. I understand that my consent is voluntary and I may withdraw this consent at any time. I understand that this screening will be scheduled within 45 days of signing, upon the return of this document.

My signature below authorizes, or refuses to authorize, district personnel to conduct an individual screening:

AUTHORIZE
I authorize an individual screening:

Parent/Guardian or *Surrogate Signature: _____ Date:_____

REFUSE TO AUTHORIZE
I refuse to authorize an individual screening:

Parent/Guardian or *Surrogate Signature: _____ Date:_____

** Surrogate must attach copy of court document*

****Please complete this form for the developmental screening/evaluation process. This information will be treated confidentially and will not be released without your written permission.**

Amphitheater School District
Student Services/Preschool Special Education
Rillito Center
266 E. Pastime Rd.
Tucson, AZ 85705

PRESCHOOL DEVELOPMENTAL/HEALTH HISTORY

Child's Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Ethnicity: _____ Current Preschool/Daycare: _____Today's Date:_____

Person Completing Form: _____

Signature: _____Email: _____

Home Address: _____ Home Phone: _____
(Street)

Cell Phone(s): _____

_____
(City) (Zip code) **Work Phone(s): _____**

Primary Language Spoken in Home: _____ Used by the Child: _____

Other Languages Spoken in Home: _____

What are your primary concerns about your child's development at this time? _____

_____

Who referred you to us? ☐ Myself (parent(s) ☐ Pediatrician/other medical provider ☐ AzEIP/DDD service coordinator
☐ Preschool/daycare provider ☐ Head Start ☐ Other (please list) _____

FAMILY INFORMATION

Names of People in Home	Age	Relationship to Child (Parent/Guardian/Foster/ Grandparent/Sibling/Half-/Step Sibling	Education/ Highest Grade Completed	Current Profession/Occupation
List Family Members Not in Home				

1. Is this child: ☐ Biological ☐ Adopted ☐ Foster If adopted or foster placement, enter adoption /placement date: _____

2. If foster child, who has custody of child? □ DCS □ Relative □ Tribal entity

3. Parent status: □ Married □ Separated □ Divorced □ Never Married If separated or divorced, what was child's age at the time: _____

4. If separated or divorced, is custody of the child: □ joint □ sole. If sole custody you may be asked to provide court documents.

5. Does other parent have visitation rights with the child? □ yes □ no If yes, how often? (e.g., weekly/monthly) _____

6. Is there a no contact order for: □ mother □ father?

7. Has the child lived in other cities/states/countries? □ yes □ no If so, please list: _____

8. Please indicate whether any member of the child's immediate biological family (i.e., parents/siblings) have experienced any of the following learning, behavioral, neurological or other mental health problems. Please check all that apply.

	Family Member		Family Member
☐ Autism	_____	☐ Cerebral Palsy	_____
☐ Asperger Disorder	_____	☐ Tourette's Syndrome	_____
☐ Speech Disorder	_____	☐ Depression	_____
☐ Learning Disability	_____	☐ Schizophrenia	_____
☐ Cognitive Impairment	_____	☐ Obsessive/Compulsive Disorder	_____
☐ Seizure Disorder (Epilepsy)	_____		
☐ Down Syndrome	_____	☐ Sensory Integration Disorder	_____
☐ ADHD	_____		
☐ Drug/Alcohol Addiction	_____	☐ Hearing/Vision Impairment	_____

☐ Other (Please list condition and in which family member): _____

PRENATAL/BIRTH/INFANT HISTORY

1. Please indicate whether any of the following occurred during the mother's pregnancy (check all that apply).

☐ Limited or no prenatal care
☐ Illnesses/Complications (please list)_____
☐ Birth defects diagnosed in utero (please list) _____
☐ Use of: □ alcohol □ cigarettes □ other drugs (please list) _____
☐ Medications taken during pregnancy (please list)_____

2. Was your child premature? □ yes □ no If yes, how many weeks gestation was your child at birth? _____

3. How was your child delivered? □ vaginal birth □ Cesarean-section □ forceps needed □ vacuum extraction needed

4. Infant's weight at birth: _____ 5. Length of hospital stay: _____

6. Did your child pass newborn hearing screening? □ yes □ no

7. Please indicate whether any of the following occurred during/after the child's birth (check all that apply).

☐ Lack of oxygen	☐ Jaundice (___bilirubin treatment required)	☐ Feeding/sucking difficulties
☐ Umbilical cord problems	☐ Infantile seizures	☐ Feeding tube
☐ Low heart rate	☐ NICU hospitalization # of days _____	
☐ Incubation	☐ Ventilation	

☐ Other (please list any other medical difficulties and surgeries incurred at birth or while hospitalized, including birth defects which were diagnosed at birth):

_____

8. Please check whether any of the following occurred during the child's infancy (birth to one year of age):

☐ Difficulty breast or bottle feeding	☐ Difficulty gaining weight	☐ Lack of cooing or babbling
☐ Difficulty eating baby or solid foods	☐ Failure to thrive	☐ Lack of gesturing (pointing, waving, grasping)
☐ Reflux	☐ Diarrhea	☐ Lack of eye contact with caregiver
☐ Colic, excessive irritability or fussiness	☐ Sleep difficulties	☐ Torticollis

☐ Positional plagiocephaly (☐ helmet used)
☐ Motor problems (e.g., difficulty sitting, rolling, crawling, walking, grasping objects):_____
☐ Other (please describe):
_____

ATTAINMENT OF DEVELOPMENTAL MILESTONES

*Mark N/A if not yet attained

	Age (months/year)		Age (months/year)		Age (months/year)
Sat alone	_____	Fed self with spoon	_____	Cooed/babbled	_____
Crawled	_____	Took off simple clothing	_____	Spoke first word(s)	_____
Walked	_____	Toilet trained	_____	Spoke 2-3 words together	_____

MEDICAL HISTORY

1. Illnesses/Injuries (please check all that apply)

	Age (months or year)		Age (months or year)
☐ Chronic ear infections	_____	☐ Febrile/Seizures	_____
☐ Ear tubes placed	_____	☐ Tuberculosis	_____
☐ Cancer/tumors	_____	☐ Measles	_____
☐ RSV	_____	☐ Fractures	_____
☐ Meningitis	_____	☐ Concussion	_____
☐ Traumatic Brain Injury	_____	☐ Physical abuse/neglect	_____

☐ Other childhood illness/disease/injuries _____

2. Chronic Health/Neurological/Behavioral Problems (please check all that apply)

☐ Frequent colds	☐ Tics or repetitive movements	☐ Wears glasses
☐ Asthma	☐ Seizures	☐ Cochlear implant
☐ Environmental allergies	☐ Staring spells	☐ Hearing Aids
☐ Attention problems	☐ Frequent stomachaches	☐ Urinary tract infections
☐ Excessive hyperactivity	☐ Diarrhea/constipation	

☐ Toileting issues (after having been potty trained) ☐ wetting ☐ soiling

☐ Adaptive equipment used (e.g., wheelchair, braces, orthotics, gait trainer, etc.)_____

☐ Sleeping difficulties (please describe)_____

☐ Eating difficulties (e.g., poor appetite, picky eater, overeats, etc.) _____

☐ Physical abnormalities (e.g., low tone, gait, balance problems, etc.) _____

☐ Vision abnormalities (e.g., near/farsightedness, strabismus) _____

☐ Sensory abnormalities (e.g., sensitive to touch, loud noises, etc.) Please describe: _____

_____

☐ Other medical conditions (e.g., heart, kidney, lung, skin conditions, etc.) Please describe:

_____

_____

3. Hospitalizations

Please indicate dates, at what ages, and for what illnesses/surgeries child has been hospitalized for: _____

_____

_____

4. Allergies

Please list any allergies to food, drugs, insects, etc., and if the allergy is severe:_____

Does the child need to carry an Epipen? ☐ yes ☐ no Are other precautions necessary? _____

5. Medications

Please list current medications, dosage, and for what condition(s): _____

6. Child's pediatrician: _____Other physicians treating your child (please list name and type of doctor):

_____

7. Has your child had a previous developmental, speech/language, neurological, psychological, occupational/physical therapy, or sensory evaluation? If so, please indicate what type(s) and resulting diagnosis:

_____

_ 8. Does your child still take naps? ☐ yes ☐ no If yes, when and for how long? _____

EDUCATIONAL HISTORY

1. Has your child received prior early intervention, therapy, or special education services (e.g., AzEIP/DDD, other state birth-3 or preschool agency, private speech/OT/PT, sensory)? □ yes □ no If yes, please list types of services/therapies and at what ages:

_____

_____

2. Please list previous daycares, public/private preschools, or Head Start programs your child has attended, including ages attended:

_____

_____

3. Has any daycare/preschool staff personnel related any concerns to you about your child's development or behavior? If so, please describe:

_____

DEVELOPMENTAL BEHAVIORS

Please indicate whether you have concerns about your child in the following areas. If YES, rate how severe the concern is compared with other children of the same age.

Behavior	NO	YES, Somewhat concerned	YES, Very concerned
Putting on or taking off clothing	○	○	○
Toilet training	○	○	○
Eating with fork/spoon	○	○	○
Drinking from a cup or glass	○	○	○
Playing with others	○	○	○
Sharing toys/materials with others	○	○	○
Is impulsive, lacks self-control	○	○	○
Is hyperactive	○	○	○
Has difficulty paying attention/distractible	○	○	○
Fights or is aggressive towards others	○	○	○
Prefers to play alone	○	○	○
Frequent temper tantrums	○	○	○
Is easily over-stimulated during play	○	○	○
Is wary of new situations or people	○	○	○
Is often non-compliant to adult directions	○	○	○
Articulation (speech) difficulties	○	○	○
Difficulty using language to get needs met	○	○	○
Difficulty using language to communicate with adults/peers	○	○	○
Understanding/following directions	○	○	○
Learning shape/color/size concepts	○	○	○
Learning letters/numbers/counting	○	○	○
Gross motor skills (i.e., running, balance, ball skills)	○	○	○
Fine motor skills (i.e., cutting, grasping objects, writing, coloring)	○	○	○

DAILY ACTIVITIES/INTERESTS

1. How much time does your child engage in the following activities each day?

Being read to _____ Watching TV _____ Video/computer/i-Pad_____ Playing outside _____Playing with toys _____

2. What activities or toys does your child enjoy? _____

3. Describe your child's strengths: _____

weaknesses: _____

Arizona Department of Education
Arizona Residency Documentation Form

Student_____ School _____

School District or Charter Holder Amphitheater Public Schools

Parent/Legal Guardian _____

As the Parent/Legal Guardian of the Student, I attest* that I am a resident of the State of Arizona and submit in support of this attestation a copy of the following document that displays my name and residential address or physical description of the property where the student resides:

- ◯ Valid Arizona driver's license, Arizona identification card or motor vehicle registration
- ◯ Valid Arizona Address Confidentiality Program authorization card
- ◯ Real estate deed or mortgage documents
- ◯ Property tax bill
- ◯ Residential lease or rental agreement
- ◯ Water, electric, gas, cable, or phone bill
- ◯ Bank or credit card statement
- ◯ W-2 wage statement
- ◯ Payroll stub
- ◯ Certificate of tribal enrollment (506 Form) or other identification issued by a recognized Indian tribe in Arizona
- ◯ Documentation from a state, tribal or federal government agency (Social Security Administration, Veteran's Administration, Arizona Department of Economic Security)
- ◯ Temporary on-base billeting facility (for military families)
- ◯ Consular identification card issued by a foreign government as a valid form of identification if the foreign government uses biometric verification techniques in issuing the consular identification card
- ◯ I am currently unable to provide any of the foregoing documents. Therefore, I have provided an original affidavit signed and notarized by an Arizona resident who attests that I have established residence in Arizona with the person signing the affidavit.

_____ _____

Signature of Parent/Legal Guardian Date

*For members of the armed services, the provision of verifiable documentation does not serve as a declaration of official residency for income tax or other legal purposes. Armed service members may utilize a temporary on-base billeting facility as the address for proof of residency.

Arizona Department of Education

Office of English Language Acquisition Services

Home Language Survey

The responses to this Home Language Survey (HLS) are used by the school to provide the most appropriate instructional programs and services for the student. **The answers below will determine if a student will take the Arizona English Language Learner Assessment (AZELLA).** Please respond to each of the three questions as accurately as possible. If you need to correct any of your responses, this must be done **before** the student takes the AZELLA Placement Test.

1. **What language do people speak in the home *most* of the time?**

   _____

2. **What language does the student speak *most* of the time?**

   _____

3. **What language did the student first speak or understand?**

   _____

Student Name_____ District Student ID_____

Date of Birth_____ SSID_____

Parent/Guardian Signature_____ Date_____

District or Charter Amphitheater Public Schools

School_____

Please provide a copy of the Home Language Survey to the EL Coordinator/Main Contact on site. In AzEDS, please enter all three HLS responses.

These HLS questions are in compliance with Arizona Administrative Code (R7-2-306(B)(1),(2)(a-c). (Revised 01-2020)