

**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:

**F.O. HOLAWAY ELEMENTARY SCHOOL**  
**3500 N CHERRY AVE**  
**TUCSON, AZ 85719**

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 certified vision screener will 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:

### Permission To Screen

Date of Birth:

**Type of 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:

\_\_\_\_\_  
*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**

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

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.

<u>Family Member</u>	<u>Family Member</u>
____ Autism	____ Cerebral Palsy
____ Asperger Disorder	____ Tourette's Syndrome
____ Speech Disorder	____ Depression
____ Learning Disability	____ Schizophrenia
____ Cognitive Impairment	____ Obsessive/Compulsive
____ Seizure Disorder (Epilepsy)	____ Disorder
____ Down Syndrome	____ Sensory Integration
____ ADHD	____ Disorder
____ 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

<u>Age (months/year)</u>	<u>Age (months/year)</u>	<u>Age (months/year)</u>
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)

<u>Age (months or year)</u>	<u>Age (months or year)</u>
_____ 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) <input type="checkbox"/> wetting <input type="checkbox"/> 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:

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

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

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### **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.

<b>Behavior</b>	<b>NO</b>	<b>YES, Somewhat concerned</b>	<b>YES, Very concerned</b>
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?**

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

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

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Student Name \_\_\_\_\_ District Student ID \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSID \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

District or Charter \_\_\_\_\_

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)