Amphitheater Public Schools
Student Services Department
AzEIP Transition Appointment

Amphitheater Public Schools
Student Services Department
701 W. Wetmore Road

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 Zoom meeting scheduled for you and your service coordinator.

Childs Name:

Date of Meeting:

Time:

Location: **Zoom (online)**
Please send copies of your child's birth certificate and immunization records to AMPHICHILDFIND@amphi.com. We also need a proof of residency. Feel free to take pictures of these documents to email.

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.

The team looks forward to meeting with you.

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

Screening Form

Student:
Date of Birth:

Permission To Screen

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

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)