GWINNETT COUNTY PUBLIC SCHOOLS

THE MISSION OF GWINNETT COUNTY PUBLIC SCHOOLS *is to pursue excellence in academic knowledge, skills, and behavior for each student, resulting in measured improvement against local, national, and world-class standards.*

437 Old Peachtree Road, NW
Suwanee, GA 30024-2978
678-301-6000
www.gwinnett.k12.ga.us

Attention

This is the list of documents that need to be returned with your packet in order to have the child tested.

Failure to submit proper documentation will only delay the process.

We only need copies of documents, not originals.

1. **An *official* document showing proof of birth.**

   Birth Certificate, Birth Registration, state or federal form with date of birth and showing relationship of child with parent.

2. **Proof of residency in attendance zone.**
   We must obtain 2 proofs.
   2nd page of this packet has information on what is acceptable.

   If you live with a family member or a friend and need to request a residency affidavit, please call 678-301-7244.

3. **Vision, Hearing, and Dental exams obtained in the past year Form #3300** (available from the health department or your physician and dentist.)

4. **A Georgia certificate of immunization Form #3231** must be completed by the health department or your private physician. A valid form must be marked in the box with either "Complete for School Attendance" or "Date of Expiration." By state law, a valid immunization form or immunization exemption (for medical or religious reasons) is required. Please call 678-301-7244 if you need a exemption to take to your Dr. to have filled out.

5. **Proof of custody/guardianship. Only if necessary** A Letter of Guardianship is required **if** the adult the child is living with is not the birth parent. To learn more, contact Gwinnett County Probate Court at 770-822-8265.

6. **Copy of the child's Social Security card.** State law requires that this number is asked for however, parents may sign a waiver. You may sign waiver when you come in to evaluation.

7. **IF YOUR CHILD HAS HAD ANY PRIVATE EVALUATIONS, IT IS HELPFUL THAT YOU SEND COPIES OF THOSE ALONG WITH YOUR PAPERWORK.**

Once you are ready to submit your paperwork, you may do so the following way:

Mail:
Instructional Support Center
Building 200
Department of Special Education/Early Childhood Program
437 Old Peachtree Rd. NW
Suwanee, GA 30024-2978

Fax:
678 301-6663

Email:
ecp@gwinnett.k12.ga.us

If you have any questions, please call 678 301-7244

GWINNETT COUNTY PUBLIC SCHOOLS

Proof of Residency
Important Please Read

It is very important that we receive 2 proofs of residency in order to continue with process.

Both proofs have to be under either parent's name

FOR PROOF OF RESIDENCY: School officials must require the parent or guardian to provide proof of residency in the district and attendance zone where they reside. Whatever is chosen to provide *Proof of Residency* should show the street address and name of the person living at that address.

Please submit one of these items:

Items acceptable are listed below.

- A non-Contingent Sales Contract
- Current lease/rental agreement
- Most recent income tax return
- Current paycheck stub
- Current residential property tax statement or bill
- Current warranty or quick claim deed
- Current home purchase agreement
- Third person affidavit of residency (notarized)
- Current homeowner's insurance policy

Please submit one of these items:

A CURRENT GAS, WATER OR ELECTRIC BILL
(Phone and cable bills are not acceptable)

We must obtain one item from each section. We cannot accept two bills.

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DATE COMPLETED_____

Gwinnett County Public Schools
Early Childhood Program
SPECIAL EDUCATION EVALUATION REFERRAL QUESTIONNAIRE
GENERAL INFORMATION

Child's Name: _____ Date of Birth: _____ Age: _____
(First) (Middle) (Last)
Sex: (circle) Male Female

Please answer **both parts** of this two-part question.

1. Is the child Hispanic or Latino? (Circle one) No, not Hispanic/Latino Yes, Hispanic/Latino
2. Please select child's race(s) from the list below (Circle one or more that apply)
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Native Hawaiian or Other Pacific Islander
   - White

Home Address: _____
(Street) (City) (Zip)
Home Phone Number: _____ Neighborhood Elementary School: _____
Referred by: _____ Relationship: _____
Address: _____ Phone Number: _____
Person filling out form: (circle) Mother Father Stepmother Stepfather Other: _____

Reason for referral (describe what concerns you most about your child and your reason for referral):

_____
Describe your child's current difficulties_____
How long has the problem(s) been of concern to you? _____
When was the problem first noticed? _____
Has your child been diagnosed with any syndromes or medical conditions: Yes No If yes, please list or describe:

_____
Does you child attend: _____Daycare _____Preschool _____Governor's Pre-K ____Head Start _____Early Intervention Program/BCW_____
Name/Address/Phone # of the above: _____

HOME AND FAMILY INFORMATION

Mother's Name: _____ Age: _____ Education: _____
Occupation: _____ Home Phone #: _____ Work Phone #: _____
Cell Phone #: _____
E-Mail Address: _____ PREFERRED MEANS OF COMMUNICATION_____
(____Biological _____Adoptive _____Step _____Foster _____ Guardian_____)
Father's Name: _____ Age: _____ Education: _____
Occupation: _____ Home Phone #: _____ Work Phone #: _____
Cell Phone #: _____
E-Mail Address: _____
(____Biological _____Adoptive _____Step _____Foster _____ Guardian_____)
Stepparent's Name: _____ Age: _____ Education: _____
Occupation: _____ Home Phone #: _____ Work Phone #: _____
Cell Phone #: _____
E-Mail Address: _____ PREFERRED MEANS OF COMMUNICATION_____
Child lives with: (circle) Both parents Mother Father Other _____
Marital Status of Parents: (circle) Married Separated Divorced Widowed Single
If parents are separated or divorced, how old was the child when this occurred? _____
Primary language spoken in the home: _____
Other languages spoken in the home: _____
Is email ok to communicate with you?_____
Primary language spoken by the child_____
Is an interpreter needed for parent_____; for child_____. What language_____

List all people currently living in the household:

Name	*Relationship to the child*	*Age*

If any brothers or sisters are living outside the home, list their names and ages: _____

Please check any condition that any member of the immediate family has had. Please note the member's relationship to the child.

Condition:	*Relationship to the child:*
_____ Learning Problems	_____
_____ Speech/Language Disorder	_____
_____ Attention Deficit Disorder	_____
_____ Hearing or Vision Impairment	_____
_____ Other ( )	_____

EARLY INTERVENTION SERVICES

Did your child receive Babies' Can't Wait Services? (circle one) YES No (If yes, list services?)

BCW Service Coordinator _____ Phone: _____

Service	Therapist Name	Presently Involved	No Longer Involved	Hrs/ per wk
Speech	_____	_____	_____	_____
Occupational Therapy	_____	_____	_____	_____
Physical Therapy	_____	_____	_____	_____
Special Instruction	_____	_____	_____	_____

PREGNANCY/BIRTH HISTORY:

During pregnancy:
Were there any complications during pregnancy/birth? If yes, please indicate. _____

YES NO

Yes No Did mother experience problems with: _____chronic disease _____poor nutrition _____vaginal bleeding _____toxemia _____viral infection _____trauma _____premature labor _____hypertension _____gestational diabetes _____other _____

Yes No Was mother on medication?
(If yes, describe: _____)

Yes No Did mother smoke?

Yes No Did mother drink alcoholic beverages?

Yes No Did mother use drugs?
(If yes, please list: _____)

Yes No Were forceps used during delivery?

Yes No Was a vacuum suction used during delivery?

Yes No Was a Cesarean Section performed?

Yes No Was the child breech (feet first)?

Yes No Was the child premature?

Yes No If so, how many weeks? _____

Yes No If yes, please describe: _____
Birth Weight: _____

Yes No Was baby discharged with mother?
If no, how long was the baby hospitalized? _____

Yes No Were there any feeding/swallowing problems?

If yes, please describe: _____

Yes No Were there any sleeping problems:

If yes, please describe: _____

Yes No Were there any special problems during the first few years of life?

If yes, please describe: _____

DEVELOPMENTAL HISTORY

The following is a list of infant and preschool behaviors. Please indicate the age at which your child demonstrated each of the following.

Behavior	*Age*	*Behavior*	*Age*
Rolled over	_____	Fed Self	_____
Sat alone	_____	Dressed Self	_____
Crawled	_____	Became toilet trained	_____
Walked alone	_____	Stayed dry at night	_____
Babbled	_____		
Put several words together	_____		

MEDICAL/ HEALTH INFORMATION

Please circle any of the following that child has or had in the past.

Allergies	Chronic Headaches	Anemia
Craniofacial Deformities	Pneumonia	Reflux
CMV	Cerebral Hemorrhage	Croup
Diabetes	Chronic Colds	Diphtheria
Chronic Ear Infections	Ear Tubes/ Surgery	Seizures
Encephalitis	Heart Problems	Fevers Over 104 Degrees
Head Injuries /concussion	Bleeding Disorder	Tonsillitis
Vocal Nodules		Men ingitis

List any additional operations, hospitalizations or injuries your child has had and at what age:

_____ _____

_____ _____

Does your child use any assistive/adaptive devices? _____glasses _____braces _____walker/crutches

_____wheelchair _____hearing aide _____other: (please specify: _____)

Please list any medication your child is presently taking:

Medication	*Dosage*	*Reason for Taking*
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL/OTHER SERVICE PROVIDERS

Pediatrician _____ Phone: _____

Cardiologist _____ Phone: _____

Neurologist _____ Phone: _____

Gastroenterologist _____ Phone: _____

ENT _____ Phone: _____

Orthopedist _____ Phone: _____

Psychologist/Psychiatrist _____ Phone: _____

Ophthalmologist _____ Phone: _____

MOTOR DEVELOPMENT

Yes No Does your child have difficulty with walking, balance, stairs, jumping. If yes, please explain._____

_____

Yes No Does your child have difficulty with coordination?

Yes No Does your child use a wheelchair/walker?

Yes No Is your child able to stack blocks, hold a crayon or marker; copy simple lines/shapes; able to manipulate puzzle pieces and small toys?

COMMUNICATION

Do you have concerns about your child's communication development?
Explain: _____

_____

My child:

Yes No Gestures/points instead of using words
Yes No Uses Babbling (ex. baba, dada) , jargon (sounds like real words but are not)
Yes No Is difficult to understand? for family , unfamiliar people
Parent understands child's speech : none some about half most all
Yes No Uses words to communicate?
How many (circle) 0, 1-10, 10-20, 20-50, 50-100, more than 100
Yes No Uses phrases or sentences to communicate.
Circle: 2 word phrases, 3 word phrases, 4 word phrases, 5+ word phrases
Yes No Answers questions with words circle: who?, what?, where?, yes/no ?
Yes No Tells about a recent activity/event (ie: "I fell down.", " I saw dog.")
Yes No Points to pictures in a book on request.
Yes No Answers questions about a story?
Yes No Follows simple directions
Yes No Tell what is happening in a picture.
Yes No Speech appeared to develop and then stopped.
Yes No Does your child stutter? Is there a family history of stuttering problems? Yes No
Yes No Is your child's voice usually hoarse/ raspy?

How does your child communicate his wants and needs most often? _____.
How do your child's communication difficulties affect their daily life/ or participation in daycare?
_____.
What strategies have you used to improve these skills? _____.

SOCIAL

Yes No Do you have concerns about your child's socialization?
Yes No Does your child enjoy being around other children?
Yes No Does your child tolerate others in his personal space?
Yes No Does your child take turns when playing with others?
Yes No Does your child follow directions related to his/her daily routine at home or school?
Yes No Does your child get frustrated easily?
Yes No If "yes", what behaviors occur? (ie. Tantrums, refusal to participate? _____

_____

How often?_____
When does your child usually get frustrated? _____
Yes No Does your child experience anxiety (ie. Worry, bites nails, thumb sucks)?
If "yes", please describe: _____

_____

Yes No Does your child have difficulty paying attention?
Yes No Is your child aggressive toward others (ie. physical and/ or verbal aggression)
If "yes", please describe_____
Yes No Is cruel to animals
Yes No Difficulty with changes in routines
Yes No Highly sensitive to sounds
Yes No Highly sensitive to textures
Yes No Mouths toys frequently
Yes No Biting
Yes No Seeks out rocking, spinning, swinging
Yes No Head banging

What things have you tried to help your child with these behaviors ?_____

_____

Please list your child's strengths or what you enjoy about your child or what pleases you. Favorite activities or things to do at home.

_____

_____

COGNITION

Yes No Do you have any academic concerns ?
explain_____

_____

Yes No Does your child appear to be learning preschool concepts (big/small) (more/less) ; prepositions?
Yes No Does your child appear to be learning rote preschool concepts (colors, numbers, shapes)?

Please include copies of any therapy reports or evaluations which might be helpful in our evaluation of your child.*

Once you are ready to submit all necessary documents please do so the following:

Mail:

Gwinnett County Public Schools
Department of Special Education/ Early Intervention Program
Bldg 200
437 Old Peachtree Rd., N.W.
Suwanee, GA 30024

Fax:
Fax: 678-301-6663

Email:
ecp@gwinnett.k12.ga.us

If child is too young and you are being told that they cannot perform Hearing, Vision, and Dental we still need this noted on the Georgia Form #3300.

Medical office or Health Center has to mark
"Too young to test" or "Unable to test" sign it and date it.
This will be sufficient to consider the file complete.

Public Health Department Centers

Buford Health Center
2755 Sawnee Ave
Buford, GA 30518
770-614-2401

Lawrenceville Health Center
455 Grayson Highway Suite 300
Lawrenceville, GA
770 339-4283

Norcross Health Center
5030 Georgia Belle Court
Norcross, GA 30093
770-638-5700

Gwinnett County Early Childhood Program
Early Childhood Program
Instructional Support Center
437 Old Peachtree Road, Building 200
Suwanee, GA 30024

Request for General Education Teacher Input

Date form completed:_____

Your assistance is requested in gathering information regarding _____. As his/her teacher, you have valuable knowledge of this child's ability to function within a preschool setting. Please respond to the following questions as completely as possible, especially in areas of most concern. If you have any questions about how to complete this form, contact the "Parent Referral Line" at 678-301-7244.

Note: PLEASE PROVIDE COPIES OF THE LATEST PROGRESS REPORT OR WSS DATA WHEN YOU RETURN THIS FORM. THANK YOU!

Teacher/Caregiver completing form:_____
Preschool/Daycare:_____
Address:_____**Phone:**_____
What age children are in your class? _____ **Number of children in your class** _____
Days per week this child attends your class_____ **Hours this child is present per day**_____
Approximately how long have you worked with this child?_____

1.Briefly describe the classroom set-up: (such as number of students, number of teachers, degree of structure, learning emphasis) _____
_____

2. What does this child like to do in your class? (favorite toys, activities, etc...) _____
_____

When is he/she most successful?_____
most frustrated?_____

3. What are your primary concerns about this child's developmental abilities?
_____
_____

4. Are there any behaviors which interfere with this child's learning? Please explain how these behaviors impact his classroom functioning: _____
_____
_____

5. Do the child's difficulties interfere with his/her ability to communicate/understand within your classroom? ___Yes ___No

*Child can make basic wants and needs known in appropriate ways. (please circle)
never rarely sometimes often almost always
Explain further: _____
_____

*Child typically communicates using (please circle all that apply): *gestures, single words, sentences.*
Explain further: _____

_____

*Child's speech is understood by peers and adults. (please circle)
never rarely sometimes often almost always
Explain further: (example: child's response when not understood): _____

_____

*Child asks which of the following types of questions: (please circle) *yes/no, what, where, who, why*
_____Child does not ask questions.
Explain further: _____

_____

*Child answers questions appropriately. (please circle)
never rarely sometimes often almost always
Explain further: _____

_____

*Child is able to tell about things that have happened. (please circle)
never rarely sometimes often almost always
Explain further: _____

_____

*Child engages in conversational exchanges with peers. (please circle)
never rarely sometimes often almost always
*Child engages in conversational exchanges with adults. (please circle)
never rarely sometimes often almost always
Explain further: _____

_____

*Child seems to understand age-typical vocabulary and concepts. (please circle)
never rarely sometimes often almost always
Explain further: _____

_____

*Child understands verbal directions related to classroom activities. (please circle)
never rarely sometimes often almost always
Explain further: _____

_____

*Please include any additional information about the child's communication skills you would like to share: _____

_____

6. Is the child able to follow the daily routine similarly to his/her peers? Please explain: _____

_____

7. Is the child successful in participating in and completing tasks, such as art activities? Please explain:

_____

_____

8. Does the child seem to learn preschool concepts (colors, numbers, etc.) as well as peers? Please explain:

_____

_____

9. Does the child require significantly more attention/time/assistance from an adult in order to successfully participate in your classroom than would be considered typical? _____

_____

10. Please check all that apply to the child during group activities:

___Stays seated without adult assistance. ___Attends to group activities.
___Requires verbal prompt to stay seated. ___Tends to leave group.
___Requires physical guidance/adult attention to stay seated.
___Participates in group activities such as songs, finger plays, stories...
___Does not attend to teacher during group activities.

Explain further about group activities if needed: _____

_____

11. Does the child engage in play with peers? Please explain: _____

_____

12. Does the child interact socially with peers to expected levels? Please explain: _____

_____

_____

13. Does the child engage in age appropriate self help activities (eating, dressing, toileting....)? Please explain any concerns: _____

_____

14. Does the child have any fine motor difficulties (i.e. copying lines/shapes, manipulating small objects...)? Please explain any concerns:_____

_____

15. Does the child have any difficulty physically navigating your classroom? If so, please explain:

_____

16. Can the child access playground equipment? Please explain: _____

_____

17. What things have you tried to address this child's developmental weaknesses?

_____

_____

18. What three skills do you feel would be most important for this child to realistically achieve within the next school year?_____

_____

Please return this form, as well as progress reports, as soon as possible by mail, e-mail or fax to:

Fax to: 678-301-6663
Email to: ecp@gwinnett.k12.ga.us

Gwinnett County Public Schools
Early Childhood Program
437 Old Peachtree Rd. Bldg. 200
Suwanee, GA 30024