Forsyth County School System

CHILD STUDY TEAM

PARENT CONSENT FOR SCREENING

Date: _____

Dear Parent/Guardian:

Your child, _____, has been referred for a classroom observation or a school screening that will be helpful in determining specific problem areas. Test results will be used by the Child Study Team to plan remedial help, assist the teacher in designing alternative teaching techniques, or in determining the need for more comprehensive evaluation.

****

_____ I agree for my child to be screened/observed

_____ I do not agree

Child's name _____DOB _____

Parent's name_____ Parent's phone #_____

Parent's email_____

_____ Date _____
Parent's Signature

Preschool/Day care _____ Days and times attending_____

Revised 10/26/17

For office use only: Date Sent_____
Date Received_____

Forsyth County School System
Early Childhood Programs
Developmental Evaluation Referral Questionnaire

GENERAL INFORMATION

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

Home Address:_____
(Street) (City) (Zip Code)
Home Phone Number: _____ Alternate Number:_____

Email Address: _____

Neighborhood Elementary School: _____

Referred By: _____ Relationship: _____
Address: _____ Phone Number: _____

Person completing form: (circle) Mother Father Stepmother Stepfather Other:_____

Qualities and characteristics that please you most about your child: _____
_____

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

How long has the problem(s) been of concern to you? _____
Goals for your child: _____
_____
Describe your child's favorite activities, toys, and interests: _____
_____

Does your child attend: ___Daycare ___ Preschool ___ Governor's Pre-K ___Head Start ___Early Intervention Program
Name/Address of the above:_____

Mother's Name: _____Age: _____ Education: _____
Occupation: _____Home Phone # _____Work Phone # _____
(___ Biological ____Adoptive ___Step ____Foster ___Guardian)

Father's Name: _____Age: _____ Education: _____
Occupation: _____Home Phone # _____Work Phone # _____
(___ Biological ____Adoptive ___Step ____Foster ___Guardian)

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 child when this occurred? _____

Primary language spoken at home: _____
Other language spoken in the home: _____

List all siblings/other relatives, foster children, friends currently living in household:

Name	*Relationships to the child*	*Age*

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

Has your child been diagnosed with any syndromes or medical conditions? Yes No
If yes, please list or describe: _____

_____

_____

Please check any condition that any member or the immediate family has had. Please not 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 ( )	_____

PREGNANCY/BIRTH HISTORY

During pregnancy:
Was mother on medication? YES NO
(If yes, describe:_____)

Did mother smoke? YES NO
Did mother drink alcoholic beverages? YES NO
Did mother use drugs? YES NO
(If yes, list: _____)
Did mother experience problems with: ___chronic disease __poor nutrition __trauma
___ vaginal bleeding __toxemia __viral infection
___premature labor __hypertension
___gestational diabetes ____other _____
Were forceps used during delivery? YES NO
Was vacuum suction used during vaginal delivery? YES NO

PREGNANCY/BIRTH HISTORY (continued)

Was a Cesarean Section performed? YES NO
(If yes, state reason _____)
Was the child breech (feet first)? YES NO
Was the child premature? YES NO
(If so, by how many weeks _____)
Were there any birth complications? YES NO
If yes, please describe: _____
Was there any special care needed following birth? ___incubator ____ oxygen ____monitors ___other
If other, please describe: _____

Birth weight:_____ Was baby discharged with mother? YES NO
If no, how long was the baby hospitalized? _____

Were there any feeding/swallowing problems? YES NO
If yes, please describe: _____
Were there any sleeping problems? YES NO
If yes, please describe: _____
As an infant, was the child more quiet than typical? YES NO
Did the child like to be held? YES NO
Was the child alert? YES NO
Were there any special problems during the first few years of life? YES NO
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 behavior. If you are not certain of the age, but have some idea write the age followed by a question mark.

Behavior	Age	Behavior	Age
Showed response to parent	____	Put several words together	____
Rolled over	____	Fed self	____
Sat alone	____	Dressed self	____
Crawled	____	Became toilet trained	____
Walked alone	____	Stayed dry at night	____
Babbled	____	Rode tricycle	____
Spoke first word	____		

MEDICAL/HEALTH INFORMATION

Please specify any of the following that apply to your child's medical history:

Illness/Condition	Age	Illness/Condition	Age
Allergies	____	Cleft Palate/Lip	____
Asthma	____	CMV	____
Bleeding Disorder	____	Concussion	____
Cerebral Hemorrhage	____	Craniofacial Deformities	____
Chronic Colds	____	Diabetes	____

MEDICAL/HEALTH INFORMATION (continued)

Chronic Ear Infections	____	Ear Tubes/Surgery	____
Encephalitis	____	Fragile X	____
Fevers over 104 degrees	____	Genetic Disorders	____
Head Injuries	____	Heart Problems	____
Shunts	____	Sinus	____
Spina Bifida	____	Sickle Cell Anemia	____
Meningitis	____	Tremors (location:_____)	____
Vocal Nodules	____	Tonsillitis	____
Other: _____	____		
_____	____		
_____	____		

List any additional operations, hospitalizations, or injuries your child has had:

AGE

_____ _____

_____ _____

Does your child use any assistive/adaptive devices? ___glasses ___braces ___wheelchair ___walker/crutches ___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: _____

		Presently Involved	No longer Involved
Physical Therapist _____	Phone: _____	_____	_____
Occupational Therapist _____	Phone: _____	_____	_____
Speech/Language Therapist _____	Phone: _____	_____	_____
Other: _____ (e.g. special Instruction, Music Therapy)	Phone: _____	_____	_____
BCW Service Coordinator _____	Phone: _____	_____	_____

LANGUAGE/MOTOR/BEHAVIOR/COGNITIVE DEVELOPMENT

Please indicate which of the following describes your child and/or concerns you:

___Speech /Language Difficulty

___Gestures/points instead of using words	___Uses jargon (unrecognizable words)	___Unable to repeat 2, 3, 4 word phrases
___ Speech appeared to develop and then stopped	___ Inability to produce speech sounds Specify: _____	___Inability to be understood
___ Uses babbling (baba, dada)	___ Inability to follow directions	___Not combining words into sentences
___ Stuttering	___ Inability to understand words/sentences	___ Difficulty answering questions
___ Hoarseness	___ Other _____	

Please indicate the number of words your child uses spontaneously
__0-10 ___10-20 ___20-50 ___50-100 ___more than 100 ___too many to count How many signs: ___
(*If your child uses less than 50 words or signs, it would be helpful if you brought a list of those words to the evaluation.)*

Please describe how your child's speech/language difficulties affect his/her daily life:

_____
_____

___ Motor Concerns

___ Difficulty with coordination	___Inability to sit without support	___ Difficulty with puzzles/Manipulative toys
___ Difficulty walking, running	___ Falls/trips frequently	___ Difficulty with balance, jumping, hopping
___ Clumsiness	___ Difficulty dressing, buttoning zipping	___ Difficulty negotiating stairs, curbs, playground
___ Difficulty eating	___ Difficulty using pencils, crayons, Scissors	___ Other _____

___ Behavior/Social Concerns

____Bullies other children	___Is shy or timid	___Difficulty with changes or routines
____Prefers to be alone	___Is aggressive	___Highly sensitive to sounds
____Is inattentive	___Restless/difficulty sitting still	___Highly sensitive to textures
____Is impulsive	___Has frequent tantrums	___Distracted by lights or visual stimuli
____Cries easily	___Tells lies	___Insensitive to pain
____Is obedient	___Worries about many things	___Plays repetitively with certain toys
____Is cruel to animals/people	___Unhappiness/sadness	___Mouths toys frequently
____Bites nails/fingers	___Fussy or over particular	___Seeks out rocking, spinning, swinging
____Easily frustrated	___Difficulty playing with other children	___Head banging
____Is stubborn	___Is noncompliant	___Biting
____Unusual fears	___Does not separate easily	___Twitches/mannerisms/tics of face or body
____Gives up easily	___Kicks, bites, hits others	___Will not work in a group
____Doesn't have any friends	___Has wet/soiled this year	___Destroys others' belongings
____Having behavior difficulty at Preschool/daycare		
____Other: _____		

___Cognitive Concerns

____Inability to imitate simple games (pat-a-cake, peek a boo)
____Difficulty ___learning ABC's___ rote counting___ matching/naming: ___colors ___shapes
____Difficulty understanding a variety of concepts such as "big/small", "same/different", etc.
____Difficulty following instructions related to daily routines
____Difficulty following simple directions
____Does not seem to understand well
____Does not appear to be learning as well as other children
____Other: _____

___Hearing Concerns

Does the child display an awareness of noisemaker/speech (such as eye widening, eye blink, smiling, laughing, assuming a listening posture, cessation of activity, etc.)? If yes please elaborate. _____	Yes	No
Does the child respond to a sound outside his field of vision? (e.g. turns head or eyes in the General direction of the sound)	Yes	No
Does the child directly localize the source of sound from a noisemaker or person	Yes	No
Does the child respond to or imitate babbling/nonsense syllables?	Yes	No
Does the child respond auditorily to his/her name?	Yes	No
Does the child point to specific people, objects, or pictures when asked?	Yes	No
Do you have any vision concerns? If yes, explain: _____ _____ _____	Yes	No

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

If you have any questions or need assistance in any way, please call Mary VanBavel at 770-887-2461 ext. 310100

Forsyth County School System
Parent/Guardian
Medicaid and or PeachCare Consent Form

Student Name _____ DOB _____
Last First Middle

Phone Number_____

Medicaid Number _____ Peach Care Number _____

Address_____

City_____ State _____Zip Code_____

Health Insurance Company Name_____ Policy No. _____

Health Insurance Address_____

Primary Care Physician Name _____

Physician Address _____
Street City State Zip

_____Copy of Medicaid Card Attached _____Copy of Peach Care Card Attached

The School System is providing the health-related services to your child in accordance with his/her Individual Education Program or Physician Plan of Care. Medicaid and or PeachCare are required to cover the cost of certain services to eligible students.

Changes in state Medicaid and or PeachCare policy allow school systems to be reimbursed for some of the cost of rehabilitative services provided by the school. The School System can not provide these services to your child or bill Medicaid/PeachCare without your consent. If you allow the school system to bill Medicaid or PeachCare for the health related services that your child is receiving in accordance with his/her IEP or Physician Plan of Care, please check the "Yes" boxes and sign below.

☐ **YES** I authorize the School System to bill Medicaid and or PeachCare for the health related services listed in my child's IEP or Physician Plan of Care and to send the appropriate IEP Documentation to the physician allowing the physician to give the school system the necessary referral or script for treatment as per IEP.

☐ **NO** I do not want Medicaid and or PeachCare billed for the health related services my child is receiving.

☐ My child does not qualify for Medicaid or PeachCare.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____Date _____

It is my responsibility as a parent to notify the school system's special education department in writing if I ever decide to withdraw this consent allowing the school to seek reimbursement from Medicaid and or PeachCare. I understand this consent is for the school lifetime of my child.

If you have any questions, please call: Tricia McCraw @ 770-887-2461 ext. 202324 or email pmccraw@forsyth.k12.ga.us

Forsyth County School System
FORMULARIO DE PERMISO PARA COBRARLE A MEDICAID Y/O PEACHCARE

Nombre del Estudiante_____ Fecha de Nacimiento (DOB)_____
Apellido, Primer Nombre Segundo

Escuela (School) _____ Grado (Grade) _____ Maestra (Teacher) _____

Teléfono _____

Número de Medicaid # _____ Número de PeachCare #_____

Dirección(Address)_____

Ciudad (City)_____ Estado _____ Código Postal_____

Nombre de la compañia de seguro médico _____Número de Póliza (Policy)_____

Dirección del Seguro Médico _____

Nombre del Doctor General/Primario _____

Dirección del Doctor (Physician's Address)_____
Calle Ciudad Estado Código Postal

_____ Copia de la Tarjeta de Medicaid Agregada _____ Copia de la Tarjeta de Peach Care Agregada

El condado escolar le está proveyendo servicios especiales de acuerdo a las provisiones del plan individual o el plan médico. Medicaid y/o PeachCare estan obligados a pagar el costo de ciertos servicios a estudiantes que son elegibles.

Cambios en las pólizas estatales de medicaid permiten al sistema escolar ser reembolsado por algunos de los costos de terapias y/o servicios médicos que han sido proveídos por el sistema escolar para aquellos estudiantes que son elegibles. El Sistema Escolar no será reembolsado por Medicaid y/o PeachCare por esos servicios provistos a su hijo (a) sin su consentimiento.

☐ **SI** Le autorizo al condado escolar cobrarle a Medicaid y/o PeachCare por los servicios detallados en el plan individual (IEP) o plan medico. (I authorize the School System to bill Medicaid and or PeachCare.). Le autorizo al condado escolar de comunicarse con el doctor de mi hijo/a para discutir su progreso y necesidades. Esto incluye permitir que el doctor le de al condado escolar el referido necesario o receta de tratamiento como esta detallado en el plan individual (IEP). (I authorize the school system to communicate with my child's primary care physician.)

☐ **NO** No quiero que el condado escolar le cobre a Medicaid y/o PeachCare por los servicios detallados en el plan individual (IEP) o plan medico. (I do not want Medicaid and or PeachCare billed.)

☐ Mi hijo no califica para Medicaid o Peach Care. (My child does not qualify for Medicaid and/or PeachCare.)

Padre/Guardian (Letra Legible) _____

Firma del Padre/Guardian _____ Fecha _____

Es mi responsabilidad como padre para notificarle al departamento de educación especial del distrito escolar si decido retirar a mi hijo/a de esta lista que le cobra al Medicaid o PeachCare por servicios especiales. Entiendo que esto estará en efecto hasta que mi hijo/a se gradúe del distrito escolar.

Si tiene preguntas llame a Tricia McCraw al 770-887-2461, ext. 202324 o mande email al pmccraw@forsyth.k12.ga.us