

EXCEPTIONAL EDUCATIONAL SERVICES

INFORMATION FORM

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GENERAL INFORMATION:

Student _____ Date of Birth _____
Age _____ Birthplace _____
Name of Parent/Guardian: _____

Address _____ Date of Injury _____
_____ Referred by _____
_____ Ph# _____
Ph# _____

Student Ethnicity _____ Primary Language _____
Name of Home School District _____ Ph# _____
Address _____ City _____ State _____ Zip _____
Name of School _____ Ph# _____
Level: Pre-school _____ Elementary _____ Middle/Jr. High _____ High School _____
Present grade level in school _____ Last Grade completed _____

MEDICAL INFORMATION

Does the child have a diagnosed brain injury/neurologic disorder? Yes _____ No _____
Age when injury occurred _____
Type of injury _____
Cause of injury _____

Was child unconscious? No _____ Yes _____ For how long? _____
Medical Care: In-patient hospital _____ Out-patient hospital _____
Length of Hospital stay _____
Extent of damage: Mild _____ Moderate _____ Severe _____
What areas of the brain were affected? _____

Seizure Activity? Yes _____ No _____ Age of onset? _____
Frequency _____ Duration _____ Last incident _____
Describe in detail, seizure activity _____

Medications or management of seizures _____

What was the child's estimated cognitive and educational status before the injury?

Services/therapies received in the hospital:*

Social Work	_____	Home/Hospital Instruction	_____
Speech Therapy	_____	Psychological Services	_____
Occupational Therapy	_____	Counseling	_____
Physical Therapy	_____	Neuropsychological Test	_____
School Re-integration	_____	Visit from home school	_____

*Please attach any reports provided from above therapies/services**

SCHOOL INFORMATION:

Does the child's school district know that the child was injured?

No _____ Yes _____ Who was notified? _____ Date _____

Did a hospital Social Worker assist with school issues? Yes ___ No ___

Type of service from Social Worker _____

Were educational services provided to the child while he/she was in the hospital?

No _____ Yes _____ by _____ Ph# _____

Is the child able to attend school now? No _____ Yes _____

Date child re-entered school after injury _____

Number of hours per day _____

Is the child now on home instruction? No _____ Yes _____ For how long? _____

Is there a difference in educational performance since the injury? Explain. _____

List School Concerns/include any behavioral issues _____

Has the student been referred to the school district to determine if he/she is eligible for Special Education? Yes ___ No ___ Date of referral _____

Name of person referral was made to _____

Address _____ Ph#: _____

Was the child assessed? Yes ___ No ___ Date of assessment _____

Name of Psychologist _____ Ph# _____

Did you attend an IEP meeting? Yes _____ No _____ Date of meeting _____

Does the student have an active IEP? Yes _____ No _____

If yes, check below the Special Education classification(s) indicated on the IEP:

Autism	_____	Other Health Impairment	_____
Deaf-Blindness	_____	Orthopedic Impairment	_____
Deafness	_____	Emotional Disturbance	_____
Hearing Impaired	_____	Speech/Language	_____
Multiple Disabilities	_____	Learning Disability	_____
Mental Retardation	_____	Traumatic Brain Injury	_____
Visual Impairment	_____		

Type of school child is currently attending or most recently attended:

Public	_____	Private/Parochial	_____
County	_____	Home-Hospital Instruction	_____
Non Public	_____	Alternative	_____

Type of class child attends or most recently attended:

General Education _____
Special Education _____

◆ **Type of Special Education Services:**

RSP-Resource Specialist Program _____
(with mainstreaming in Gen Ed) _____
SDC-Special Day Class _____
(with mainstreaming in Gen Ed) _____
NPS-Non-public school _____
(with residential placement) _____

◆ **Supplemental Services: DIS-Designated Instructional /Related Services**

APE-Adaptive Physical Education _____
AST-Assistive Technology Services _____
AS-Audiological Services _____
BID-Behavior Intervention(Development & Modification) _____
BII-Behavior Intervention-Implementation of plan) _____
CG-Counseling & Guidance Services _____
EE-Early Ed. Program for Children w/Disabilities _____
HNS-Health & Nursing Services _____
HHS-Home & Hospital Services _____
LS-Language & Speech Development/Remediation _____
OT-Occupational Therapy Services _____
OM-Orientation & Mobility Instruction _____
PCT-Parent Counseling & Training _____
PT-Physical Therapy Services _____
PS-Psychological Services other than Assessment & IEP Dev. _____
RS-Recreation Services _____
SW-Social Worker Services _____
SDTI-Specialized Interpreting or Transcribing Services _____
Transportation _____
VS-Vision Services _____
OTH-Other (Identify Services) _____

EXCEPTIONAL EDUCATIONAL SERVICES

Present Self-Help Skills, Mobility & Social Skills

Name of student: _____

DOB: _____

PERSONAL CARE & HYGIENE:

Score the applicant’s ability on the items listed below using the rating scale indicated. Use N/A-not applicable when appropriate.

1. CANNOT perform skills independently or correctly
2. Requires MUCH ASSISTANCE to perform skill correctly
3. Requires SOME ASSISTANCE to perform skills correctly
4. Performs skill INDEPENDENTLY and correctly

TOILETING

- _____ Control of bowel & bladder needs
- _____ Can get on toilet
- _____ Can adjust clothing properly
- _____ Can use toilet paper appropriately
- _____ Can re-adjust clothing properly
- _____ Can flush toilet
- _____ Can change menstrual sanitary pad

HAND-WASHING

- _____ Can operate faucets on sink
- _____ Uses soap appropriately
- _____ Washes hands clean
- _____ Wipes hands appropriately

DRESSING

- _____ Can put on shirt
- _____ Can remove shirt
- _____ Can put on pants/shorts/dress
- _____ Can remove pants/shorts
- _____ Can button/snap clothing
- _____ Can put on slip-on shoes

- _____ Can put on shoes with laces
- _____ Can tie shoes
- _____ Can put on & buckle belt
- _____ Can put on coat
- _____ Can put on glasses

BRUSHING TEETH

- _____ Can use proper amount of toothpaste
- _____ Can use proper rinsing motions
- _____ Can rinse mouth

MOBILITY Circle the correct response:

- Yes No Walks freely without assistance
- Yes No Walks, but requires verbal encouragement
- Yes No Walks with physical assistance
- Yes No Non-ambulatory, but uses adaptive equipment to ambulate alone
- Yes No Non-ambulatory/uses adaptive equipment, requires assistance
With transfers
- Yes No Non-ambulatory, requires total assistance

EATING

Consistently

Sometimes

Never

Needs to be fed

Throws or plays with food

Properly uses spoon

Properly uses fork

Properly uses knife to cut

Drinks from a cup

COMMUNICATION

Speaks freely & easily

Initiates conversation

Stays on given topic

Articulates words properly

Uses appropriate volume/tone

Words are in correct order

Delayed response time

Slowed motoric speech

Becomes overloaded/confused

Perseverates on one topic

Has difficulty finding words

Talks mainly in phrases

Uses single words

Communicates with gestures

Uses communication device

Understands simple questions

Follows simple commands

Can express him/herself in writing

SOCIAL INTERACTION

Gets along with siblings

Gets along with other children

Shows app. interest in opposite sex

Accepts supervision from teachers

Accepts supervision from parents

Can attend to task 10-15 min

Tolerates 20-30 min. class time

Argumentative

Disrupts group activities

Causes property damage

Threatens harm to others

Threatens harm to self

Harms others

Injures self

Wanders/leaves area

Needs close supervision
