Appling County School System

Special Education Program

Pam Thomas— District Program Director

249 Blackshear Highway

Baxley, GA 31513

Phone: (912)367-8600 Fax: (912)367-1011

Child Find Notice:

In accordance with IDEA regulations, the Appling County School system seeks to ensure that all disabled students (ages birth-21) who are in need of special education, or Section 504 services within its jurisdiction are identified, located, and evaluated, including those attending private school and home school. Final identification of students with disabilities and programming for such students occurs only after an appropriate evaluation and a determination by a Multidisciplinary Placement Team. If the "child find" process indicates that a student may require special education/504 and supportive services in order to benefit from regular education, the student shall be referred to the Multidisciplinary Placement Team to determine the student's eligibility for special education services/504. If you know a child with a disability that is not being served, please notify the appropriate contact listed below.

Children birth through age three:

When a child who is birth through age three suspected of having disabilities is identified through any child find activities (e.g. parent-teacher conference, community referral, parent mentor activities, migrant program), the Special Education Director should be notified so that an appropriate referral may be made to Babies Can't Wait for screening and evaluation. Additionally, Appling County Special Education Preschool Intervention Teacher(s) will participate in Babies Can't Wait Transition meetings to ensure a special education evaluation, eligibility, and IEP are in place by the child's third birthday.

Babies Can't Wait (Southeast Health District): BCW Coordinator—Tracy Weeden / 1-800-429-6307

Preschool children, ages 3-5:

The following activities shall be conducted to identify preschool children ages 3-5 suspected as having disabilities: Appling County School Pre-Kindergarten Program (Bright from the Start) will participate in Response to Intervention as part of Appling County Schools. Written notices in the form of a brochure are provided on our district website and in the community (which include) : Private Preschools, Appling County Health Department, BCW, local physician offices, etc…. The attached application/referral packet may be completed and returned to the ACSS Special Education Department for Preschool aged children (ages 3-5) or (served by BCW) for screening/evaluation for the Preschool Intervention Program. PIP-Preschool Intervention Program: SPED Director—Pam Thomas / 912-367-8600 ext 162

PIP Referral Processing—Karen Tharpe, Parent Mentor / Office: 912-705-8166 / Cell: 912-278-4736 / Fax: 912-367-1011

Children in Appling County:

Children currently enrolled in Appling County School will be identified through Response to Intervention, 504 and parent referral. Written notification is provided on the district website as well as in the student handbook. Screenings and evaluations are provided for any child, in Appling County, parentally placed in a private school or receiving home school who is suspected as having a disability. Information is provided in the local newspaper annually, on the district website, or by contacting the Pam Thomas—Special Education Director at the Appling County Board of Education Office.

(PIP) Preschool Intervention Program Application

Your PIP Application will be processed once everything below has been completed and the appropriate documents have been returned to the Appling County Board of Education (249 Blackshear Hwy. Baxley, GA). **If you have additional questions or need assistance with the PIP application, please contact:**

Special Education Department
Pam Thomas
ACSS SPED Director
Office: (912)367-8600 ext. 162
E-mail: Pam.Thomas@appling.k12.ga.us

PIP Referral Processing
Karen Tharpe
ACSS Parent Mentor—SPED
Office: (912)705-8166
Cellphone: (912)278-4736
E-mail: Karen.Tharpe@appling.k12.ga.us

Child's Legal Name:_____ **Nickname**(optional):_____**DOB**: _____

Parent/Guardians Name:_____ **Cell phone#**_____ **Other#**_____

Physical Home Address:_____

Email Address:_____

Primary Language Spoken:____ **English** ____ **Spanish** ____ **Other** _____

Do you need an Interpreter for meetings? _____ YES _____ NO

Paperwork:

- Complete/Answer all questions on the ACSS PIP application.
- Complete/Sign a ACSS Medical Release for each of your Child's medical providers.
- Complete the ACSS Parent Questionnaire/Social History
- Complete the ACSS Behavioral Checklist.
- Complete the ACSS SPED Sensory Checklist.

Required Documents:

- Copy of your child's birth certificate
- Copy of your child's social security card
- Copy of PASSED Hearing & Vision Screening for your child (Preferably Form 3300 completed within 6 months prior to scheduled evaluation)
- Copy of your child's immunization record

If available:

- Copy of Medical Records
- Documents from BCW: IFSP / Hearing & Vision Screenings/ Assessments and/or Evaluations completed, and provider or clinical notes to assist with transition and evaluation process, etc.

For ACSS PIP Processing Dept.

Completed Paperwork Received:

Received / Date: _____

Received / Date: _____

Received / Date: _____

Received / Date: _____

Received / Date: _____

Required Documents Received:

Received / Date: _____

Received / Date: _____

Received / Date: _____

Received / Date: _____

Other Documents Received:

Received / Date: _____

Received / Date: _____

Appling County School System
Special Education Program
249 Blackshear Highway
Baxley, GA 31513
Phone: (912)367-8600
Fax: (912)367-1011
www.appling.k12.ga.us

For PIP Referral Processing Use Only	
Referred By:	_____ BCW _____ Parent _____ Other:_____

Preschool Intervention Program Application

Child's Legal Name:_____ **Nickname**(optional):_____**DOB**: _____

Age:_____ **Sex**: _____**Race**: _____**Social Security Number**: _____

Physical Home Address:_____

Parent/Guardians Name:_____ **Cell phone#**_____ **Other#**_____

Email Address:_____

Primary Language Spoken by the Parent: ____ **English** ____ **Spanish** ____ **Other** _____**Interpreter Needed**: _____ **YES** _____ **NO**

Primary Language Spoken by the Child: ____ **English** ____ **Spanish** ____ **Other** _____ **Interpreter Needed**: _____ **YES** _____ **NO**

Other agencies, specialists, or schools that have been involved with this child:

Name	Address	Phone#	Type of Service

ALL of the documents/information listed below must be received in order to process this referral application:

Birth Certificate(copy) Social Security Card(copy) Medical Release(s) (signed) Current Immunization Record(copy)

REFERRAL REQUEST FOR ASSISTANCE

I, _____ (Parent/Guardian Name) request the Appling County (School System PIP) Preschool Invention Program to provide me assistance by screening/evaluating my child _____ for special education and/or related services. I will listen to all of the strategies and try all ideas suggested to help my child. I will complete the documentation form(s) within this PIP application and I understand I must submit all of the documentation required to process my request. Once I submit my PIP application, I understand I must contact the Appling County School System SPED PIP Processing Dept. to inform them of any change in my physical address, contact numbers, and email address.

_____ _____ _____ _____

Parent/Guardian Signature Date PIP Representative Signature Date

Please check the appropriate behaviors and/or concerns that best describes this child:

COMMUNICATION

_____My child does not use words to communicate.

_____My child's speech is not understood.

_____My child does not understand what I tell him/her.

_____My child does not follow simple one-step directions.

ADAPTIVE

_____My child does not undress / dress himself/herself.

_____My child does not feed himself/herself.

_____My child is not toilet trained.

_____My child can not wash / dry his/her hands alone.

GROSS MOTOR

_____My child can not walk alone.

_____My child can not walk up and down stairs alone.

_____My child can not stack blocks.

_____My child does not follow simple one-step directions.

FINE MOTOR

_____My child can not hold a spoon to feed himself/herself.

_____My child can not use their fingertips to pick up small objects.

_____My child can not fasten his/her clothes.

_____My child does not turn the pages in a book alone.

PERSONAL-SOCIAL

_____My child does not like to play with other children.

_____My child does not like to listen to simple stories.

_____My child does not like to share.

_____My child does not separate well from either parent.

_____My child does not identify himself/herself in a mirror.

_____My child does not state his/her name.

_____My child does not know his/her age.

_____My child has severe temper tantrums.

_____I can not control my child's behavior.

COGNITIVE

_____My child does not name at least 20 things seen in pictures.

_____My child does not point to any body parts when named.

_____My child does not use crayons to make marks on surfaces.

_____My child does not understand the concept of three.

_____My child can not point to colors named.

_____My child does not sing songs such as the ABC song.

Any additional information that may be helpful for the screening/evaluation team:

_____

_____

_____

_____

_____

_____ _____

Parent/Guardian Initials Date

Appling County School System - Parent Questionnaire/Social History - Confidential Information

Please complete the following questions: **Date Complete:**_____

Child's Name:_____ **DOB:** _____ **Age:** _____ **Gender:** _____

Name of Parent/Guardian completing this form: _____ **Contact#** _____

Demographic Family Information

Mother's Name: *Legal guardian: _____ Yes _____ No	Father's Name: *Legal guardian: _____ Yes _____ No	Other Guardian's Name: *Legal guardian: _____ Yes _____ No
Cell phone#:	Cell phone#:	Cell phone#:
Work #:	Work #:	Work #:
Home#:	Home#:	Home#:
Email Address:	Email Address:	Email Address:
Occupation:	Occupation:	Occupation:
Marital Status: ____ Single ____ Married ____ Divorced ____ Separated ___ Other	Marital Status: ____ Single ____ Married ____ Divorced ____ Separated ___ Other	Marital Status: ____ Single ____ Married ____ Divorced ____ Separated ___ Other
(If applicable) Step-Parent's Name:	(If applicable) Step-Parent's Name:	Relationship to child:

Please list ALL adults living in the home and their relationship to the child:_____

_____

Please list ALL children living in the home and their relationship to the child:

Child's Name:	Age	Grade	Relationship to the child applicant	List any medical or mental diagnoses

Has your child attended (or is the child attending) a daycare or preschool program? _____ YES _____ NO

If YES, Please list the name of the daycare or preschool program:_____

Do you grant permission for a PIP Representative to contact the daycare or preschool program for additional information about your child? _____ YES _____ NO If NO, please explain:_____

Current Medical Information

Does your child have any **significant health concerns, major childhood illnesses/disease**, or a **diagnosed syndrome**?
_____ YES _____ NO If YES, please explain here: _____

_____

_____

Does your child have any **motor/coordination/mobility needs or adaptive medical needs** such as a wheelchair, leg braces, walker, feeding tube, etc? _____ YES _____ NO If YES, please explain here: _____

_____

_____

List any past or current medical diagnosis that your child has received from a physician, medical provider, psychologist, etc.:

_____

_____

Does your child take medication on a regular basis? _____ YES _____ NO If YES, please list them below:

List/Name of Medication (taken)	Why/Reason/Purpose of Medication	Dosage

Please list your child's medical provider (s):

Medical Provider/ Doctor's Name	Phone #	Fax #	Address

Describe any services and/or interventions that have been provided to your child (such as: BCW, Speech, PT, OT, Mental Health, etc)

_____

_____

_____

_____

Describe your child's developmental history below:

Give approximate milestone times in months/years

Sat alone @ _____ months _____ years Crawled @ _____ months _____ years Said first word @ _____ months _____ years Walked alone @ _____ months _____ years Completely Toilet trained @ _____ months _____ years	Comments: _____ _____ _____ _____ _____ _____ _____

Pre and Post-natal Information

Describe the mother's health during her pregnancy with this child: _____

_____

Please list any medications that were taken by the mother during this pregnancy and the reason for use: _____

_____

List the physical activities of the mother during this pregnancy: _____

_____

Describe the mother's pre-natal care: _____

_____

Number of pregnancies: _____ Number of births: _____ Any Problems: _____

_____

Please answer the following:

Did either parent smoke: Mother: _____ Yes _____ No Father: _____ Yes _____ No

Did either parent drink frequently? Mother: _____ Yes _____ No Father: _____ Yes _____ No

Did either parent take/use drugs? Mother: _____ Yes _____ No Father: _____ Yes _____ No

If any problems, what kind (check all that apply):

_____ Chronic Disease _____ Poor Nutrition _____ Vaginal Bleeding _____ Toxemia _____ Diabetes

_____ Accidents, Trauma, Emotional Upsets —What Kind/cause: _____

_____

_____ Virus/Infection—What Kind: _____

_____ Other (please describe): _____

Labor and Delivery: Full Term: _____ Yes _____ No What was this child's birth weight? _____

_____ Natural or _____ Caesarean Labor Induced: _____ Yes _____ No Labor Difficult: _____ Yes _____ No

Mother's condition/problems during delivery: _____

Child's condition/problems during delivery: _____

Complications at birth: _____ Trouble Breathing _____ Jaundice _____ Blue Color _____ Needed Oxygen

_____ Umbilical cord wrapped around neck _____ Incubator or special care

Your child's condition following delivery and any complications/hospitalizations, etc: _____

_____

Infancy

Did your child experience any illnesses/surgeries during the first several months? Explain/describe: _____

_____

Please check the appropriate items below: As an infant was your child? was :

_____ Average _____ Overactive _____ Quiet _____ Did not want to be held _____ Irritable _____ Colic

Developmental Information

If you answer YES to any of the questions below, please explain:

Responded to his/her name when called? _____ Yes _____ No _____

Did not want to be held? _____ Yes _____ No _____

Preferred to always play alone? _____ Yes _____ No _____

Did your child attend?: _____ Headstart _____ Daycare(Name)_____
_____ Preschool Program (Name):_____

Did your child receive services from Babies Can't Wait?: _____ Yes _____ No If Yes, explain the type of services your child received:_____

_____

Language: Any noticeable speech problems?: _____ Yes _____ No If Yes, explain: _____

_____

Did your child being using words/talking later than expected?: _____ Yes _____ No If Yes, explain: _____

_____

Did your child have language skills and then lose them?: _____ Yes _____ No If Yes, explain: _____

_____

Health Information

VISION

Does your child have difficulty seeing?: ___ Yes ____ No

Check any that apply: ____ rub eyes frequently ____ squints

____holds objects close to eyes ____ complains about vision

Does your child have a Rx to wear glasses? ___Yes ___No

If Yes……..

Do they wear them regularly? ____ Yes ____ No

Are they glasses broken or lost? ____ Yes ____No

Does your child have a PASSED Vision Screening?

____Yes ____No If Yes, Date PASSED:_____

HEARING

Do you feel like your child has difficulty hearing?:
___ Yes ____ No

Check any that apply: ____ frequent ear infections or colds
____ tubes in ears ____seizures ____ pulls/tugs at ears

Does your child have hearing aids or cochlear implants?
___Yes ___No If, Yes…….

Do they wear them regularly? ____ Yes ____ No

Are they glasses broken or lost? ____ Yes ____No

Does your child have a PASSED Hearing Screening?

____Yes ____No If Yes, Date PASSED:_____

Serious Illnesses: Has your child ever been hospitalized? _____ Yes _____ No If Yes, How old was your child? _____
How long was the hospital stay?_____ Explain reason for being hospitalized? _____

_____

Has your child ever been in an accident or had a serious injury? If so, explain/describe: _____

_____

Additional Information

Child's Sleeping Habits: Bedtime @ _____ Awakens @ _____ Is he/she difficult to wake? _____ Yes _____ No

Does he/she wet the bed?: _____ Yes _____ No If Yes, possible cause (s)_____

Describe any unusual sleeping habits?_____

Has your child ever been received any testing/screenings/evaluations outside of the school system? (such as from a psychologist, psychiatrist, physical therapist, speech therapist, neurologist, educational specialist, etc.) _____ Yes _____ No

Explain: _____

_____

_____

_____

_____

Parents

Did you or anyone in your family experience any problems in school?: _____ Yes _____ No If Yes, explain: _____

_____

_____

Does anyone in the immediate family have any of the following?:	**If Yes ...Who?**	**Explain:**
Medical Problems		
Physical handicaps		
Emotional problems		
Hearing difficulties		
Speech problems		

Please complete the Behavior Checklist and Sensory Checklist on the following pages.

_____ _____

Parent/Guardian Initials Date

Child's Name:_____ DOB:_____ Age:_____

Name of the individual completing this form & relationship to child: _____

Behavior Checklist

(Please check those behaviors that are most characteristic of your child)

_____Relates well to adults	_____Assumes leadership in a group
_____Appears happy	_____Plays well with other children
_____Seems well adjusted emotionally	_____Sad, depressed
_____Puts forth best effort but continues to fail	_____Overly anxious to please
_____Appears unhappy	_____Has few close friends at school/outside the home
_____Shy, withdrawn	_____Emotional outbursts
_____Fearful	_____Disturbs other students/children
_____Overly sensitive	_____Behavior unpredictable
_____Tries to control others	_____Displays bullying
_____Exhibits uncooperative behavior	_____Does not adjust readily to change
_____Aggressive towards others	_____Careless about physical appearance
_____Loud, boisterous	_____Seems more immature than classmates/peers
_____Demands excessive attention	_____Overly dependent upon others
_____Restless	_____Easily distracted
_____Daydreams	_____Needs much individual assistance
_____Easily frustrated	_____Disorganized work habits
_____Poor self control/impulsive	_____Seldom completes assignments or tasks on time
_____Fidgety/Overly Active	_____Has difficulty following directions
_____Works at a slower pace than peers	_____Unable to copy from book or board correctly
_____Reverses or rotates letters or words	

Any additional behavior concerns or comments:

_____

_____

_____

_____

_____

_____ _____

Parent/Guardian Initials Date

Child's Name:_____ DOB:_____ Age:_____

Name of the individual completing this form & relationship to child: _____

Sensory Processing Checklist

X	Auditory Processing	X	Visual Processing
	Holds hands over ears to protect ears from sound		Prefer to be in the dark
	Is distracted or has trouble functioning if there is a lot of noise around		Expresses discomfort with or avoids bright lights (Example: hides from sunlight through window in
	Can't work with background noise (Example: fan, refrigerator, radio)		Is bothered by bright lights after others have adapted to the light/covers eyes or squints to protect
	Appears to not hear what you say (Example: Does not "tune in" to what you say, appears to ignore you)		Has a hard time finding objects in competing back-grounds (Example: shoes in a messy room, favorite
X	**Vestibular Processing**	**X**	**Oral Sensory Processing**
	Becomes anxious or distressed when feet leave the ground		Avoids certain tastes or smells that are typically part of children's diets
	Dislikes activities where head is upside down (Example: somersaults, roughhousing)		Will only eat certain tastes
	Avoids playground equipment or moving toys (Example: swing set, merry-go-round)		Limits self to particular food textures/temperatures (picky eater)
	Dislikes riding in a car		Routinely smells nonfood objects
	Becomes disoriented after bending over sink or table (Example: falls or gets dizzy)		Shows strong preference for certain smells
	Seeks out all kinds of movement activities (Example: being whirled by adults, merry-go-rounds, play-		Shows strong preference for certain tastes
	Twirls/spins self frequently throughout the day (Example: likes dizzy feeling)		Craves certain food
	Rocks unconsciously (Example: while watching TV)		Chews or licks on nonfood objects
X	**Multisensory Processing**	**X**	**Multisensory Processing**
	Gets lost easily		Has difficulty standing in line or close to other peo-ple
	Looks away from tasks to notice all actions in the room		Touches people and objects to the point of irritating others
	Seems oblivious within an active environment (Example: unaware of activity)		Displays unusual need for touching certain toys, sur-faces, or textures (Example: constantly touching ob-
	Walks on toes		Decreased awareness of pain and temperature
	Becomes irritated by shoes or socks		Avoids wearing shoes; loves to be barefoot
	Reacts emotionally or aggressively to touch		Doesn't seem to notice when face or hands are messy

Any additional behavior concerns or comments:

_____

_____

_____ None of the items listed on this sensory checklist pertain to my child.

_____ _____

Parent/Guardian Initials Date

Appling County School System

HIPAA Compliant Release of Information Form

Authorization to Release Protected Health Information

This form gives Appling County School Representatives who work with your child the permission to communicate (verbally or share written documents) with outside agencies to discuss student progress or provide needed documentation. This form also gives the Appling BOE Representatives permission to communicate (verbally or share written documents) with the outside and in-side agency/system representatives that work with your child. Outside agencies include but are not limited to doctors, counselors, therapists, and other related professionals. **Directions: Please make sure that all 5 boxes below are completed.**

1.Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Contact# _____

Child attends: School _____ Daycare_____ HOME

TO RELEASE/EXCHANGE INFORMATION REGARDING THE ABOVE NAMED STUDENT WITH:

2.Doctor/Agency/Providers: _____

Address: _____

Fax #: _____ Phone # _____

Purpose of disclosure: Continued health in school, Educational Progress, Accommodations, Student Placement

3.Specific information to be exchanged: Academic Other:_____

_____ Medical Diagnosis/Records _____ Vision &/or Hearing _____ Immunization Record

SEND REQUESTED HEALTH RECORD INFORMATION TO:

4. Appling County School System—SPED Dept : _____PIP Referral Processing ____ Other

Attn: Karen Tharpe—Parent Mentor **Fax:** (912)367-1011 **Phone:** 912-367-8600 ext. 166

This release is valid for one calendar year from the date of signature.

5. Parent/Guardian Signature: _____ Date: _____

Request made of parent by: _____ PIP _____SPED _____ RtI _____504 _____Pre-K _____ Other