LIVERMORE
SCHOOL DISTRICT

Livermore Valley Joint Unified School District

Special Education

685 East Jack London Boulevard, Livermore, CA 94551

Tel (925) 606-3225 Fax (925) 606-3443

Dear Parents,

Thank you for contacting the Livermore Valley Joint Unified School District in regards to an assessment for your child.

Included please find the following documents, which you will need to submit to the Special Education Department:

- List of Documents Required for Enrollment
- Assessment Request for Preschool Speech/Language Screening, fill out if applicable.
- Student Health History
- Proof of Immunizations

Once we received all of the required documents, the referral will then be sent to the appropriate assessor(s).

Please feel free to contact the Special Education Department if you have any question,

Thank you,

Frank Selvaggio
Director of Special Education

Livermore Valley Joint Unified School District
685 E. Jack London Blvd.
Livermore, CA 94551
www.livermoreschools.org

Documents Required for New Student Enrollment

Bring one document from <u>each</u> of the four categories below:

Proof of Birth Date

- Birth Certificate (preferred)
- Statement by local registrar or county recorder certifying date of birth
- Passport

Parent or Guardian Picture ID

- Driver's License
- California Issued ID
- Passport

First Proof of Residence

(one from the list on the right)

- Current mortgage statement (escrow papers that show close of sale no later than seven (7) days after the student's first day of school)
- Grant Deed
- Property Tax Bill
- Lease/Rental Agreement including property address, name of occupants, and signatures of both parties

Second Proof of Residence

(one from the list on the right)

- Current PG&E bill with name and address listed
- Current garbage bill with name and address listed
- Current cable bill with name and address listed
- Current water bill with name and address listed

Proof of Immunizations - Please bring original and a copy of the most current immunization record signed or stamped by a doctor.

For questions or more information, contact Student Services at 925-606-3207

LVJUSD ASSESSMENT REQUEST FOR PRESCHOOL SPEECH & LANGUAGE SCREENING

Date:_____

Student Name:_____ DOB:_____ Age:_____ Gender:_____

Parent/Guardian:_____ Address:_____

Telephone: _____ Preschool:_____Primary Language:_____

Person Making Referral:_____Physician Name:_____

Basic Area of Concern:_____

_____

When was the problem first noted?_____ By Whom?_____

Has the problem changed since it was first noted?_____If yes, how:_____

_____

Is the Child aware of the problem?_____ If yes, how do they feel about it?_____

_____

At what age did your child start to talk: _____ Do you, as parents, understand your child?_____

Do people who are not familiar with your child understand him/her when speaking?_____

How does your child communicate? (Check all that apply)

☐ Words ☐ Gestures ☐ Signing ☐ Does Not Communicate ☐ Other:_____

Describe your child's speech and language problems:_____

_____

Determine if your child has:

	Don't know	No	Sometimes	Always
Trouble making sounds.	☐	☐	☐	☐
Difficulty being understood.	☐	☐	☐	☐
Difficulty understanding what is said.	☐	☐	☐	☐
Difficulty following directions.	☐	☐	☐	☐
Difficulty putting words together to express him/herself.	☐	☐	☐	☐
Difficulty answering questions appropriately.	☐	☐	☐	☐

Fill out both sides of paper

Motor Skills:	Yes	No
Does your child walk?	☐	☐
Does your child play with toys?	☐	☐

Attention Span:	Yes	No
Does your child listen to a story?	☐	☐
Does your child imitate your actions if you show them how to do something?	☐	☐

Are there any medical concerns?_____

_____

Has your child had multiple ear infections?_____ If yes, how frequently?_____

Is your child toilet trained?_____

Are there any other agencies or clinics involved?_____ If yes, name them:_____

_____

Are there any previous reports that would be useful for screening your child?_____

How many siblings?_____ Have any siblings had communication problems? _____

Have any siblings received special education?_____ If yes, who, where, when?_____

_____

If the child's primary language is other than English:

What language does your child speak?_____What language do the parents speak?_____

Where was your child born?_____If not born in the U.S., how long has your child been in this country?_____

Do you suspect a problem in their primary language as well as English?_____

Do you have any other concerns?

_____

_____

_____

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685 East Jack London Boulevard, Livermore CA 94551
Tel (925) 606-3200 Fax (925) 454-5638

STUDENT HEALTH HISTORY

SCHOOL: _____
GRADE: _____

STUDENT NAME: _____ BIRTHDATE: _____

CURRENT MD: _____ CURRENT DENTIST: _____

Child's current health status: Poor _____ Fair _____ Good _____ Excellent _____

Parent/guardian: Please circle "YES" or "NO" and describe if "YES".

Yes No ALLERGIES: Seasonal _____ Food _____ Medication _____

Other Allergens: _____

Yes No Regular MEDICATION(S) (besides vitamins): Name, Dose, Frequency? _____

_____

Yes No Problems at birth or in infancy: _____

Yes No HOSPITALIZATION(S)/SURGERY: Date/Reason? _____

Yes No DEVELOPMENTAL problems: _____

Yes No Current BEHAVIORAL problems: _____

Yes No EMOTIONAL issues: _____

Yes No HEARING problems: _____

Yes No VISION problems: _____

Yes No HEADACHES: Type/Frequency? _____

Yes No HEART PROBLEMS or Defect? _____ Restrictions _____

Yes No ASTHMA: _____

Yes No DIABETES: Type 1 or 2? Medication and method of delivery: _____

Yes No SEIZURES or CONVULSIONS: _____

Yes No PHYSICAL DISABILITY: _____

Yes No DIGESTIVE PROBLEMS: _____

OTHER HEALTH CONCERNS/ISSUES: _____

_____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

If your student has a life threatening health condition or allergy, please contact your school nurse for health care planning at school. http://www.livermoreschools.com/healthservices