Early Intervention Program (EIP)
Encinitas Union School District

The EUSD Early Intervention Program serves preschool children ages 3-4, with disabilities and who require Special Education Services. You are very important in the process that will determine eligibility and needs for your child. The process starts with your recent inquiry, then moves to an assessment of your child, a determination of his/her eligibility, the development of an Individual Educational Plan (IEP), and the provision of appropriate special educational services. Each step in this process is mandated by law, governed by timelines and designed to fully include you as parents.

The enclosed packet of information was developed to assure the sharing of information critical to obtaining a clear understanding of your child and the difficulties he/she is presently experiencing.

***Please note all of the following items must be completed, signed and returned before the EIP Team can proceed to an assessment of your child:

- Complete the registration forms
  - Preschool Registration
  - Parent Survey

- REQUIRED documentation:
  - Birth Certificate or passport
  - Two (2) Proofs of Residency
  - Current student immunizations

- Additional Health Documents for EIP Process
  - Please compete the Health and Development History form
  - To assist the assessment process please have your physician complete

EUSD welcomes you as an important and critical member of our Special Education team and is committed to a partnership that will ultimately result in greater success for your child. The following items are provided for your review, to understand your rights and the assessment process. Please keep these for your records.

• Notice of Procedural Safeguards – Overview of Special Education Laws related to the provision of Free and Appropriate Special Education Services to children with disabilities.
• Summary of fourteen (14) Federal Handicapping Conditions to establish eligibility for Special Education.
• Overview of the assessment, eligibility and IEP process.
• Required Annual Notifications

The team has carefully thought out this referral packet with a desire to answer your questions and move the process along in a timely manner. If there are areas of this packet that you do not understand, or if you require assistance in completing the forms, please call 760-944-4300 ext. 1145.

Please email, fax, mail or hand deliver all required forms and information to:

email: EIP@eusd.net
Fax: 760-942-9471
Mail: Encinitas Union School District 101 South Rancho Santa Fe Encinitas, CA 92024
Attention: Early Intervention Program

The EIP team looks forward to meeting with you and working together in partnership to serve the educational needs of your child.

Sincerely, Encinitas Union School District Early Intervention Team

SCHOOL YEAR
20 - 20

Stu ID #: _____

EUSD PRESCHOOL STUDENT REGISTRATION FORM

_____ ☐ Male ☐ Female
LAST NAME FIRST NAME MIDDLE

_____ _____ _____
Birthdate Birthplace Home Phone

_____ _____
Street Address of Residence City Zip Code

_____
Mailing Address if different

School of Residence _____

☐ Mother ☐ Father ☐ Stepparent ☐ Guardian ☐ Foster

Name_____
Lives at primary residence with child? ☐ YES ☐ NO

Cell phone:_____

Email _____

☐ Mother ☐ Father ☐ Stepparent ☐ Guardian ☐ Foster

Name_____
Lives at primary residence with child? ☐ YES ☐ NO

Cell phone:_____

Email _____

PARENT #1 EDUCATION (check one):

1. Graduate School / Post Graduate ☐
2. College Graduate ☐
3. Some College ☐
4. High School Graduate ☐
5. Not High School Graduate ☐

PARENT #2 EDUCATION (check one):

1. Graduate School / Post Graduate ☐
2. College Graduate ☐
3. Some College ☐
4. High School Graduate ☐
5. Not High School Graduate ☐

ETHNIC AND RACE DESIGNATION

Part A: Ethnicity -- Is this student Hispanic or Latino?
☐ No, not Hispanic or Latino
☐ Yes, Hispanic or Latino

The above part of the question is about ethnicity, not race.
No matter what you selected above, please continue.

Part B: Race (mark all applicable races)

☐ American Indian or Alaska Native
☐ Black or African American ☐ White
☐ Chinese ☐ Japanese ☐ Korean
☐ Vietnamese ☐ Asian Indian ☐ Laotian
☐ Cambodian ☐ Filipino ☐ Hmong
☐ Other Asian
☐ Hawaiian ☐ Guamanian ☐ Samoan
☐ Tahitian ☐ Other Pacific Islander

SPECIAL SERVICES

Is your child participating in any special services? ☐ Yes ☐ No
If "yes" please check:

☐ Private testing (i.e. psychological, speech, occupational therapy)
List: _____
☐ Private services (i.e. speech, occupational therapy)
List: _____
☐ HOPE Infant
☐ Regional Center
☐ Other _____

ATTENDS PRESCHOOL? ☐ Yes ☐ No
Name of preschool _____

REFERRED BY: _____

OTHER CHILDREN LIVING AT HOME:

Name:_____ Birthdate:_____

Name:_____ Birthdate:_____

Name:_____ Birthdate:_____

PARENT/GUARDIAN SIGNATURE:_____**DATE:**_____
Parent/Guardian signature indicates agreement with above statements.

revised 10.2024

ENCINITAS UNION SCHOOL DISTRICT PUPIL INFORMATION CARD - PreK

_____ ☐ Male ☐ Female _____
STUDENT'S LEGAL LAST NAME FIRST NAME MIDDLE BIRTHDATE (MM/DD/YYYY)

PRIMARY PHONE _____ HOME PHONE (if not primary) _____

PRIMARY RESIDENCE _____ _____ _____
STREET ADDRESS CITY ZIP CODE

MAILING ADDRESS _____ _____ _____
(*If different than above)* STREET ADDRESS CITY ZIP CODE

Is either a new address? ☐ NO ☐ *YES Siblings/Birthdates _____

As the parent/guardian, I declare under penalty of perjury that my child and I reside at the above address. ☐ YES

☐ **Mother** ☐ **Father** ☐ **Stepparent** ☐ **Guardian** ☐ **Foster**
(Documentation will be required for guardianship or foster care)

In case of emergency, contact this person first ☐

NAME _____

Lives at primary residence with child? ☐ YES ☐ NO ☐ Deceased

Has contact information changed? ☐ NO ☐ *YES

_____
Home Address (if different than above)

Work Phone # _____

Cell Phone # _____

EMAIL **(required)** _____

Employer / Occupation _____

☐ Active Military ☐ Reserve/National Guard

☐ **Mother** ☐ **Father** ☐ **Stepparent** ☐ **Guardian** ☐ **Foster**
(Documentation will be required for guardianship or foster care)

In case of emergency, contact this person first ☐

NAME _____

Lives at primary residence with child? ☐ YES ☐ NO ☐ Deceased

Has contact information changed? ☐ NO ☐ *YES

_____
Home Address (if different than above)

Work Phone # _____

Cell Phone # _____

EMAIL **(required)** _____

Employer / Occupation _____

☐ Active Military ☐ Reserve/National Guard

OTHER PERSONS AUTHORIZED TO PICK UP MY CHILD IN AN EMERGENCY (Must be at least 18 years of age):

1)_____ 2)_____
FULL Name Phone # Relationship FULL Name Phone # Relationship

DURING SCHOOL HOURS, ACCESS TO AND/OR THE RELEASE OF STUDENTS MAY BE TO THE PARENTS, APPROPRIATE SCHOOL PERSONNEL, THOSE HAVING LEGAL AUTHORIZATION FROM THE COURTS AND/OR THOSE AUTHORIZED IN CASE OF EMERGENCY.

*** Name(s) of person(s) authorized by <u>current</u> COURT ORDER (<u>must provide copy to school office</u>) who DO <u>NOT</u> have access to student:**

_____ _____
Name / Relationship to Student Name / Relationship to Student

Physician_____ Phone # _____ Dentist _____ Phone # _____

If your child is seriously ill or injured and you cannot be contacted, **<u>911 WILL BE CALLED</u>** and your child will be transported by ambulance to the hospital.

Health Insurance? ☐ Yes ☐ No Insurance provider _____ Policy # _____

☐ **Glasses**: Distance ☐ Reading ☐ All times ☐ ☐ **Hearing Loss**: Right ☐ Left ☐ Both ☐

Health Problems: (Please check all areas concerning your child's current health) **Name of Medication** (check if required at school)

☐ Food allergies_____ _____ ☐
Anaphylaxis: ☐ Yes ☐ No
☐ Other allergies – specify_____ _____ ☐
Anaphylaxis: ☐ Yes ☐ No
☐ Diabetes – since age _____ ☐ Injection ☐ Pump _____ ☐
☐ Asthma – ☐ Mild ☐ Moderate ☐ Severe _____ ☐
☐ Seizures – describe_____ _____ ☐
Since Age _____ Date of Last Seizure _____
☐ Heart problems – describe_____ _____ ☐
☐ Kidney problems – describe_____ _____ ☐
☐ ADD/ADHD_____ _____ ☐
☐ Physical restrictions – specify_____ _____ ☐
☐ Other – specify_____ _____ ☐

IF A MEDICATION IS TO BE GIVEN AT SCHOOL, THE LAW REQUIRES A WRITTEN ORDER FROM PHYSICIAN AND PARENTAL CONSENT.

ABOVE MEDICAL INFORMATION MAY BE SHARED WITH APPROPRIATE SCHOOL STAFF.

I allow the release of my child's name/photo image/information (for TV/newspaper/internet/video) to the news media and other similar parties. ☐ Yes ☐ No

Parent Signature: _____ Relationship ☐ Mother ☐ Father ☐ Other _____

ENCINITAS UNION SCHOOL DISTRICT
EARLY INTERVENTION PROGRAM

STUDENT INFORMATION SURVEY

Student Name: _____

Birth Date: _____ Gender: _____

Mother's Name: _____Father's Name: _____

Address of Student: _____

City: State: Zip:

School of Attendance (the public school your child would attend for kindergarten)
_____

Does your child currently attend or has he/she attended a preschool program ☐ ☐
Name of preschool and days/times attending:
_____

Best phone number and email address to contact you: _____

Describe your child's development in the following areas (i.e. about average, above average, delayed):

Speaking/Language: _____

Learning: _____

Fine (hands) and Gross (Body) motor movement: _____

Self-Help (toileting, feeding, etc.) _____

Health: _____

Vision/Hearing: _____

Play Skills with Other Children: _____

Primary Concerns: _____

Strengths/Interests: _____

Please elaborate on any of the above areas where you feel your child's development is significantly different from peers of the same age: _____

Please identify doctors, psychologists, speech and language therapists, occupational and/or physical therapists, social workers, and preschool teachers who have worked with your child. Provide complete names, addresses, and phone numbers for **each** of these specialists on the **Exchange of Information** forms provided in this packet. This allows the EIP staff to discuss your child and to obtain records with each specialist. If you have copies of reports or records, please make EIP a copy and attach to this survey.

Please complete this survey, the appropriate Releases of Information, and attach reports or records and return to EIP with other appropriate documents in the packet.

_____ _____

Parent Signature Date

ENCINITAS UNION SCHOOL DISTRICT
VERIFICATION OF RESIDENCE FORM

In order to verify District residence, the parent/legal guardian/foster parent/custodial relative or caregiver with which the student is residing on a full-time basis (person establishing residency) must present one (1) document from Category 1 and one (1) document from Category 2 of the below listed items:

Category 1 – Only Use One

- SDG&E Utility Service Billing Statement from within the last 30 days
- SDG&E Letter of Service dated within the last 30 days
- Letter from lessor or owner and a signed copy of a current rental Agreement or Rental Agreement Addendum stating that utilities are included.

Category 2 – Only Use One

- Grant Deed or property tax payment receipts
- Income Tax Document (current tax year)
- Cable Service Billing Statement within the last 30 days
- Residential Water Service or Waste Management Billing Statement within the last 30 days
- Payroll check stub with name and address within the last 30 days
- Voter Registration Card
- Social Services Document or Correspondence from a government agency within the last 30 days

If you are not able to provide any of the documents listed above but believe that you reside in the district. Please contact your school front office for assistance.

Falsification of any information or documents required for this verification will result in revocation of registration for the students, and may be subject to legal penalties for perjury.

PARENT/LEGAL GUARDIAN STATEMENT

I, _____, am the parent or legal Guardian of
Print name of parent/legal guardian

_____
Student(s) name

_____
Street address City Zip Code

The above named student(s) actually live(s) at the above address. The telephone number_____

_____ _____
Parent/Guardian Signature Date

FOR OFFICE USE ONLY

I, _____, hereby certify that I am a representative of the Encinitas Union School District and that the documents, or a photocopy of said documents indicated by a check mark next to the appropriate line, have been verified, and that I know of no evidence that would cause me to doubt the validity of said documents.

_____ _____
Signature of District representative verifying documents Date

Supporting documents attached, if available.

Date Sent to Parent	Date to be Returned	Sent by	Date Returned to School

ENCINITAS UNION SCHOOL DISTRICT
HEALTH AND DEVELOPMENT HISTORY
(USE ONLY FOR INITIAL EVALUATION)

CONFIDENTIAL

Child's Name _____ Sex _____ Birthdate _____ Age _____
Last First
School _____ Grade preK Teacher _____

Address _____ Home Phone _____

Cell Phone _____Email _____

Your answers to the following questions will help us to better understand your child. However, any questions may be left unanswered if you wish.

Please answer the following questions. Fill in the indicated blanks or check the items that apply. Feel free to add any explanations or other information along the side. THANK YOU.

Birth Parent	Full Name	Age	Education	Occupation	Place of Birth
Father					
Mother					
Step-Parent					
Father					
Mother					
Adoptive Parent (optional)					
Father					
Mother					
Other					
Father					
Mother					

Please record the names and ages of all family members with whom the child lives. If there are 2 households, list the members of each, and the usual division of the child's time between the two.

Household with Mother		Household with Father (if different)	
Name and Relationship	Age	Name and Relationship	Age
When child is in this household		When child is in this household	

Please list in order any evaluations which have previously been done and attach a copy. If this is your only copy, check "Return" so we can copy and return the original to you. If you do not have a copy, please include the address and/or phone number where it was done and sign the **Authorization for Exchange of Information** for request of outside records.

DATE **WHERE (Place or Person)** **TYPE OF EVAULATION** **RETURN**

a) _____ ☐

Address/Phone _____

b) _____ ☐

Address/Phone _____

c) _____ ☐

Address/Phone _____

Please include reports from previous schools. If you are returning this questionnaire to staff at the current school for them to coordinate this evaluation, you do not need to return your copy of any prior evaluations done by this school.

Please list all school attended:

School name and location	Grade(s)	Dates attended

FAMILY HISTORY

Please check any of these which occurred in the child's family (include the child's aunts, uncles, first cousins, grandparents, and great-grandparents, as well as parents, brothers, and sisters.

	Relationship to Child		Relationship to Child
☐ Diabetes	_____	☐ Difficulty with academics	_____
☐ Learning problems	_____	☐ Deafness	_____
☐ Drug or Alcohol Abuse	_____	☐ School Drop-out	_____
☐ Poor Concentration	_____	☐ Mood Disorders	_____
☐ Psychotic Disorders	_____	☐ Motor or Vocal Tics	_____

Are there special problems in your family, which might worry, anger, or sadden your child? [ ] Yes [ ] No
If "yes", please describe:_____
_____

Have there been any unusual family events, such as:

	YES	NO	Explain "YES" items	Date
Serious illness				
Hospitalizations				
Deaths				
Divorces				
Frequent moves				
Other				

PERINATAL HISTORY

PREGNANCY WITH THIS CHILD:
Any exposure to external agents during pregnancy, such as medications to control nausea, smoking, alcohol…?

Any health problem during this pregnancy, such as vaginal bleeding, high blood pressure, excessive vomiting, infections, weight gain) under 15 lbs. or over 40 lbs., gestational diabetes, injury, …? _____
_____

Any other health concerns, such as too much or too little amniotic fluid, too much or too little fetal activity, sudden change in fetal growth or activity _____

Any concerns with other pregnancies? _____

LABOR AND DELIVERY:
Any illnesses or complications of labor and delivery, such as fever, excessive bleeding, general anesthesia, fetal heart irregularities?
_____

Did the baby have any problems during delivery, such as need for Caesarian, breech, long labor, umbilical cord around neck, knotted, prolapsed?
_____

BIRTH DATA:
Birth Weight _____ Length _____

Born more than a week sooner or later than due (40 weeks)?
☐ Early (how many weeks? _____)
☐ Late (how many weeks? _____)

Was newborn in hospital after mother discharged home? ☐ Yes ☐ No
If yes, how long _____, why _____

Diagnosis of maternal post partum depression? ☐ Yes ☐ No If yes, how long_____

Any infant problems in the first weeks at home, such as vomiting, colic, diarrhea, breathing problems, surgery needed?
_____

Feeding problems in infancy, such as difficulty latching, poor eater, poor weight gain?
_____

DEVELOPMENT

Please indicate **age and rate** at which your child achieved the following:

Age	Slow	Average	Fast	
				Smile
				Sit without help
				Crawl on hands and knees
				Walk alone (10-15 steps)
				Feed self
				Demonstrate hand preference (right ____ left ____)
				Speak first words other than mama, dada
				Put two words together
				Speak clearly so strangers understand
				Dry in daytime
				Dry at night
				Separate from parent without crying
				Read words
				Read simple book

MEDICATIONS

Please list any MEDICATIONS which have been prescribed for allergies, seizures, attention, or other CHRONIC problems.

Dates	Name of Medication	Dose/Time of day	Reason and result

HEALTH / MEDICAL CONCERNS

Please check areas that apply to your child.

Frequent and/or significant infections?

- ☐ Strep Tonsillitis (total number _____ last infection _____)
- ☐ Ear infection (total number _____ number past year _____)
- ☐ Sinus infection (total number _____ number past year _____)
- ☐ Bronchitis/pneumonia (when _____)
- ☐ Meningitis/encephalitis (when _____)
- ☐ Tuberculosis (when _____)
- ☐ Hepatitis (when _____)
- ☐ Mumps (when _____)
- ☐ Chicken pox (when _____)
- ☐ Whooping cough (when _____)
- ☐ Rubella (when _____)
- ☐ Measles (when _____)
- ☐ Urine infection (total number past year _____ last urine test _____)

HEALTH / MEDICAL CONCERNS (continued)

Please indicate specific problem or condition that affects your child.

Any blood problems?
Such as anemia, low blood counts; requiring blood transfusions, or excessively easy bruising
_____ Date / Age _____ Cause _____

Any general complaints?
Such as leg pains, trouble walking, tires very easily, stuttering, trouble falling asleep, trouble staying asleep, nightmares, or excessive weight gain or loss
Indicate Complaint_____ Onset Date / Age _____ Cause _____

Problems related to the head, nerves, and muscles?
Such as headaches, migraine headaches, loss of consciousness, difficulty with speech, Cerebral palsy, unusual movements (tremor, jerk, twisting), involuntary noises or tics, muscle weakness, or awkward, clumsy, asymmetrical in movements, or significant head injury, dizziness or fainting,
Indicate Problem _____ Onset Date / Age _____
Abnormalities shown on special studies (MRI, CT, EEG, etc.) Study _____ Date _____
If problems with Seizures: How Frequently_____ Type _____
When Occur (Occurred) _____ Describe Seizure _____

Problems with vision or hearing?
☐ Near sighted ☐ Glasses (when _____)
☐ Far sighted ☐ Glasses (when _____)
☐ Strabismus (cross-eyed)
☐ Astigmatism (Right ☐ Left ☐)
☐ Cataract (Right ☐ Left ☐)
☐ Nystagmus (dancing eyes)
☐ Blurred vision
☐ Hearing problem (hearing aid since what age _____ Right ☐ Left ☐)

Heart or lung problems? Such as: heart murmur, abnormality of heart rate, congenital heart defect, shortness of breath, turning blue (cyanosis), or stopped breathing
Indicate Problem _____

Urinary or genital problems? Such as bed-wetting or wetting pants, painful or excessively frequent urination, discolored urine/blood in urine, menstrual problems, or undescended testicle
Indicate Problem _____

Abdominal problems? Such as stomach aches, vomiting, nausea, loss of appetite, constipation, stool soiling, hernia, ulcers, appendicitis, or blood in bowel movement
Indicate Problem _____

Any allergies? Specify to what and describe reaction
☐ Medication allergies (to what _____ describe reaction _____)
☐ Allergies to other substances (to what _____ describe reaction _____)
If possible anaphylaxis reaction indicate if EpiPen prescribed ☐ Yes ☐ No
☐ Food intolerance (to what _____ describe reaction _____)
☐ Insect allergies (to what _____ describe reaction _____)
☐ Asthma (Inhaler Prescribed ☐ Yes ☐ No (what, when used _____)
☐ Eczema ☐ Hives ☐ Stuffy nose/itchy eyes (hay fever) ☐ Contact dermatitis (poison oak, ivy)
☐ Behavioral: Drug allergies _____ Other allergies_____

HEALTH / MEDICAL CONCERNS (continued)

Chronic disease? Such as Sickle Cell disease, Thyroid problem or Diabetes _____)
Cancer (type _____)
Other genetic or metabolic problem or birth defect (what _____)

Any hospitalizations?
☐ Surgery (what, when _____)
☐ Other illness (what, when _____)

Any fractures or accidents? ☐ Yes ☐ No (what, when _____
_____

Later feeding concerns? Often puts non-food substances in mouth (what_____)
Gaining too much weight (age _____), Growing too slowly (age _____), Won't eat "healthy" food (age _____), Seems to have behavioral reaction to certain food _____
Known to have swallowed poisonous substance? ☐ Lead_____ ☐ Other _____

EDUCATION "CURRENT" FUNCTIONING

Please check the appropriate items and fill in the blanks indicated.

Preschool and school experience:
☐ Language other than English spoken in the home (_____)
☐ Participated in infant stimulation program
☐ Attended day-care (age _____)
☐ Attended preschool (age _____)
☐ Repeated a grade (which _____ why _____)
☐ Enrolled in special program (when _____ what _____)

Current Functioning – please check the box which best describes your child's functioning.

	Great difficulty	Some difficulty	Does pretty well	Does very well
Overall school performance	☐	☐	☐	☐
Study habits	☐	☐	☐	☐
Completing homework	☐	☐	☐	☐
Remembering assignments	☐	☐	☐	☐
Interest in school work	☐	☐	☐	☐
Behavior/feelings	☐	☐	☐	☐
Overall confidence/self-esteem	☐	☐	☐	☐
Relationship with brothers/sisters	☐	☐	☐	☐
Relationship with other children	☐	☐	☐	☐
Relationship with parents	☐	☐	☐	☐
Happiness in school	☐	☐	☐	☐
Worries	☐	☐	☐	☐
Happiness at home	☐	☐	☐	☐
Ability to handle frustration	☐	☐	☐	☐
Willingness to attend school	☐	☐	☐	☐
Acceptance of responsibilities	☐	☐	☐	☐
Handwriting	☐	☐	☐	☐
Getting homework to and from school/class	☐	☐	☐	☐
Understanding homework	☐	☐	☐	☐

EDUCATION "CURRENT FUNCTIONING" (continued)

Are you pleased with the program your child now has in school? [ ] Yes [ ] No [ ] Not sure

How would you like school services for your child to change? _____

_____

_____

_____

_____

_____ _____

Signature of person completing form Date

_____

Relationship to child

Revised April 2013

Vison and Hearing
PHYSICIAN INPUT TO IEP

We are required by Federal Law to consider your input in determining eligibility for Special Education services and developing an appropriate educational program for this student. Please return this form to the Encinitas Union School District as soon as possible.

Patient _____ DOB _____

Physician _____ Phone _____

Please list any current medical diagnoses:

Most recent physical examination
Conducted by _____ on _____

Results:

Most recent **vision** assessment
Conducted by _____ on _____

Distance Vision Results:

Near Vision Results:

Most recent **hearing** assessment
Conducted by _____ on _____

Results:

Please indicate any feeding or nutrition concerns:

Please indicate any limitations or restrictions to this child participating in an educational environment:

Other medical specialists or agencies that are currently involved in your patient's care:

Other concerns for our consideration:

_____

Physician's Signature Date