BURBANK UNIFIED SCHOOL DISTRICT

REFERRAL TO PRE-SCHOOL TEAM

"PARENT QUESTIONNAIRE"

School Year _____
Date _____

PART A – IDENTIFICATION DATA

Pupil Name_____Sex_____Birth date_____C.A._____C.A.G.P._____
Last First I.

School of Attendance_____Grade_____Primary Language_____LEP ☐ FEP ☐

Telephone: Work _____
Parent Name_____Address_____Telephone: Residence _____

Referral Source _____
Name Title Signature

PART B – AREAS OF CONCERN
(Check only those items that apply)

ACADEMIC ACHIEVEMENT
Performs significantly below age level in the following areas:
( ) a. Reading comprehension.
( ) b. Reading accuracy.
( ) c. Math computation.
( ) d. Math reasoning.
( ) e. Written expression.

SPEECH/LANGUAGE SKILLS
( ) a. Has difficulty in understanding directions, questions, and commands.
( ) b. Has difficulty in expressing thoughts and feelings and/or in formulating sentences.
( ) c. Exhibits articulation and/or voice problems.
( ) d. Appears to stutter

PSYCHOMOTOR/PERCEPTUAL SKILLS
( ) a. Has difficulty in handwriting/printing.
( ) b. Displays difficulty in eye/hand movements.
( ) c. Poor balance.
( ) d. Exhibits reversals, distortions, has difficulty in matching designs, etc.
( ) e. Has difficulty in performing large muscle activities.

INTELLECTUAL/COGNITIVE ABILITY
( ) a. Appears to have at least average abilities, but exhibits low academic achievement.
( ) b. Appears to be a slow learning child with few areas of relative strength.
( ) c. Appears to be very bright.

SOCIAL/EMOTIONAL DEVELOPMENT
( ) a. Demonstrates inadequate self-concept.
( ) b. Has difficulty with peer relationships.
( ) c. Exhibits behavior problems: (underline those appropriate) defiant, destructive, easily distracted, short attention span,
( ) d. Cannot work independently.
( ) e. Lacks motivation.
( ) f. Shows signs of excessive nervousness (tics, bites nails, fidgets, etc.)
( ) g. Exhibits cyclical behavior (good days, bad days, etc.)

PRE-VOCATIONAL/VOCATIONAL SKILLS
( ) a. Is often absent
( ) b. Is often tardy.
( ) c. Poor work habits (classroom, homework, etc.)
( ) d. Lacks responsibility (Describe) _____
_____

HEALTH AND DEVELOPMENT
( ) a. Has known medical problem(s) _____
( ) b. Is receiving medication (Name and purpose) _____
_____
_____
( ) c. Appears to have vision problem.
( ) d. Appears to have hearing problem.

COMMENTS:_____
_____
_____
_____
_____
_____
_____
_____

CHILD_____NICKNAME_____BIRTHDATE _____

PARENT(S)/GUARDIAN(S) _____

PLEASE LIST ALL PERSONS LIVING IN THE HOME:

NAME	SEX	AGE	RELATIONSHIP TO CHILD

CHILD'S PRIMARY LANGUAGE_____LANGUAGE(S) IN HOME _____

Does a parent not living in the home have custody/visitation?

NO_____YES_____NAME _____

Is Your child regularly cared for by anyone else? (e.g., grandparent, sitter, daycare?)

NO_____YES_____Number of hours/day_____Language(s) used by caregiver _____

REASON FOR REFERRAL: _____

PREVIOUS EVALUATIONS AND RESULTS: _____

HAS YOUR CHILD BEEN GIVEN ANY DIAGNOSIS? NO_____YES_____DIAGNOSIS: _____

PARENTAL HISTORY

Condition of Mother's health during pregnancy: _____

Complications/Illnesses/Accidents during pregnancy: _____

Medications/Other Substances taken during pregnancy: _____

Type of delivery NORMAL _____ CAESAREAN _____ BREECH _____ FORCEPTS _____

Length of pregnancy_____Birth weight _____

Did the baby have any complications at or right after birth?

No complications _____ Lack of oxygen _____ Incubator_____Seizures _____ Other _____

Parent Educational Level:

Parent/Guardian Name_____ ☐Graduate Degree or Higher ☐College Graduate☐ Some College or Associates Degree

☐High School Graduate☐Not a High School Graduate☐Decline to State

Parent/Guardian Name_____ ☐Graduate Degree or Higher ☐College Graduate☐ Some College or Associates Degree

☐High School Graduate☐Not a High School Graduate☐Decline to State

DEVELOPMENTAL HISTORY

At what age did your child do the following :

Sit _____ Finger feed _____

Crawl _____ Dress self _____

Stand _____ Bladder trained _____

Walk _____ Bowel trained _____

Any concerns about your child's physical development? NO_____YES_____If yes, explain: _____

Does your child show an interest in drawing, coloring, working with his hands? NO_____YES_____If so, what does (s)he like to do? _____

Do you have any concerns about your child's ability to walk, run, jump, throw, kick, etc.? NO_____YES_____CONCERN: _____

Do you have any concerns about your child's eating, sleeping, or toileting progress? NO_____YES_____CONCERN: _____

CHILD'S HEALTH HISTORY

General Health: GOOD _____ FAIR _____ POOR _____

Diseases/Chronic conditions: _____

Any ear infections? NO_____YES_____FREQUENCY _____

Are you concerned about your child's hearing? NO_____YES_____Was his/her hearing ever tested? NO_____YES _____

RESULTS _____

Are you concerned about your child's vision? NO_____YES_____Was his/her vision ever tested? NO_____YES _____

RESULTS _____

Has your child had: Serious accident_____Operations_____Seizures_____High fever (over 104)_____Please explain: _____

CHILD'S PEDIATRICIAN _____

ADDRESS_____PHONE _____

Is your child taking any medications? NO_____YES _____

Other health issues: _____

SPEECH/LANGUAGE HISTORY

Do you have concerns about his/her speech and language? NO_____YES_____Please describe your child's speech and language:

_____

_____

At what age did your child:

Babble_____ Say first word _____

Put two words together_____ Use complete sentences _____

Age of child when you became concerned about speech/language: N/A_____AGE _____

Please check all that apply to your child:

_____mispronounces words
_____stutters
_____talks to fast
_____adds extra sounds
_____responds to noises in the environment (doorbell, TV, etc.)
_____leaves out sounds in words
_____leaves out words in sentences
_____leaves endings off words
_____uses gestures instead of speech

What do you do when you can't understand your child? _____

_____

How does your child react when you can't understand him/her? _____

_____

Which of the following describes your child's ability to understand speech?

_____does not understand what is said
_____understands what is said if speaker uses gestures
_____understands clearly everything said
_____understands little of what is said
_____understands familiar statements or questions

Which of the following describes your child's ability to express him/herself?

_____does not use speech or gestures to communicate
_____uses speech, primarily single words
_____sentences are understood by others
_____speech is clearly understandable
_____uses gestures or motions but zero speech
_____sentences are understood by people who know him/her well but not by others

Childs voice quality: NORMAL_____TOO SOFT_____TOO LOUD _____

Other concerns about your child's ability to communicate? _____

_____

_____

What have you done to help your child? _____

_____

_____

GENERAL BEHAVIOR

Do you have significant concerns about your child's behavior or social skills? NO_____YES_____CONCERNS: _____

Is your child easy/difficult to manage? _____

What are your child's favorite activities? _____

What does (s)he do with his/her favorite toys? _____

How does your child behave in public places? _____

Please check any of the following that apply to your child:

_____nervous	_____sucks thumb	_____unusual fears
_____peers not available	_____overactive/restless	_____stubborn
_____plays well with peers	_____nightmares	_____cries easily
_____temper tantrums	_____shy	_____destructive
_____short attention span	_____likes school	_____friendly
_____demands much attention	_____easily frustrated	_____sensitive

Who spends the most time with your child? _____

Who disciplines your child? _____

How do you discipline your child? _____

Have other professionals expressed any concerns to you about your child? NO_____YES_____CONCERN(S): _____

Do you anticipate moving out of Burbank within the next year? NO_____YES_____

Any additional information: _____

PRINT NAME _____ SIGNATURE _____ DATE _____

Burbank Unified School District
Enrollment Information - Ethnicity Survey

Federal and State government agencies require us to report statistical data relative to total student population of district schools. The following information will be handled confidentially and will appear only as a code on other records.

Please Print

Date _____ School _____

Student Name _____
Last First Middle

Birthdate _____ Country of Birth _____

WHAT IS YOUR CHILD'S ETHNICITY? (Please check one):

☐ **Hispanic/Latino** -(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

☐ **Not Hispanic or Latino**

WHAT IS YOUR CHILD'S RACE? (Please check up to five racial categories):

The above part of the question is about ethnicity, not race. No matter what you selected above, you must answer the following by marking one or more boxes to indicate what you consider your child's race to be.

☐ American Indian or Alaskan Native (100)	☐ Laotian (206)	☐ Samoan (303)
☐ Chinese (201)	☐ Cambodian (207)	☐ Tahitian (304)
☐ Japanese (202)	☐ Hmong (208)	☐ Other Pacific Islander (399)
☐ Korean (203)	☐ Other Asian (299)	☐ Filipino/Filipino American (400)
☐ Vietnamese (204)	☐ Hawaiian (301)	☐ African American or Black (600)
☐ Asian Indian (205)	☐ Guamanian (302)	☐ White (700)

If you have questions regarding this information, please go to the following link: http://www.cde.ca.gov/ds/dc/es/refaq.asp - Frequently Asked Questions for the New Federal Standards for Collecting and Reporting Race and Ethnicity Categories.

The Burbank Unified School District is committed to providing a safe school environment where all individuals in education are afforded equal access and opportunities. The District's academic and other educational support programs, services and activities shall be free from discrimination, harassment, intimidation, and bullying of any individual based on the person's actual race, color, ancestry, national origin, ethnic group identification, age, religion, marital or parental status, physical or mental disability, sex, sexual orientation, gender, gender identity, or gender expression; the perception of one or more of such characteristics; or association with a person or group with one or more of these actual or perceived characteristics. Specifically, state law prohibits discrimination on the basis of gender in enrollment, counseling, and the availability of physical education, athletic activities, and sports. Transgender students shall be permitted to participate in gender-segregated school programs and activities (e.g., athletic teams, sports competitions, and field trips) and to use facilities consistent with their gender identity. The District assures that lack of English language skills will not be a barrier to admission or participation in District programs. Complaints of unlawful discrimination, harassment, intimidation, or bullying are investigated through the Uniform Complaint Process. Such complaints must be filed no later than six months after knowledge of the alleged discrimination was first obtained. For a complaint form or additional information, contact the director of Human Resources.

Signature of parent/guardian _____ Date _____

Health and Developmental History

Dear Parent/Guardian,
In preparation for the upcoming IEP meeting to review your child's special education program, updated health information will assist us to better serve your child's needs in school. Please answer ALL of the following questions regarding your child's health. If applicable, please attach any recent medical specialist reports. Thank you,

Amy Choi, RN
School Nurse

PLEASE FILL OUT BOTH SIDES Once completed, please email to amychoi@burbankusd.org

Student:_____Birthdate:_____Today's Date: _____

Person completing form:_____Relationship: _____

Preferred phone number: ( )_____Email: _____

Current Primary Physician:_____Phone: ( )_____

Other Physician(s):_____Phone: ( )_____

Current counselor/therapist (if applicable)_____Phone: ( ) _____

Additional specialists involved in your child's care:_____

_____

List the types of services your child currently receives (i.e. speech, PT, OT etc.):_____

_____

How many meals does your child eat daily? _____

Is your child on a special diet? If yes, please specify _____

Does your child eat a variety of foods (fruits, vegetables, meat, etc.)? _____

Do you have any concerns about your child's nutrition? _____

Normal school night bedtime_____PM Normal weekend bedtime _____

Normally awakens at_____AM ☐ on own ☐ with alarm clock ☐ by parent/guardian

My child has ☐ no sleep problems ☐ difficulty falling/staying asleep ☐ difficulty waking up ☐ frequent nightmares

Does your child wear glasses? ☐ No ☐ Yes, for: ☐ Distance ☐ Reading ☐ All day use

Date of last eye exam:_____ By whom:_____ Results:_____

Date of last hearing exam:_____ By whom:_____ Results:_____

Has your child had ear infections, tubes, or other hearing problems?_____

Does your child wear any assistive listening device? ☐ No ☐ Yes:_____

Do you have concerns about your child's vision or hearing? ☐ No ☐ Yes:_____

Does your child have any dental problems? _____ Date of last dental exam:_____

Does your child have any activity restrictions?

Has your been child observed or hospitalized because of a head injury or concussion? ☐ Yes ☐ No

If yes, please explain _____

Has your child had any serious illness, injury, surgery, or hospitalization? ☐ Yes ☐ No

If yes, please explain, including approximate date, treatment, outcome. _____

_____

_____

_____

_____

_____

Please list current medical & psychiatric diagnoses below, or check ☐ **NONE**

Diagnosis	Name of treating doctor/clinic	Date of last visit

Please list current medications below, or check ☐ **NONE**

Name of medication	Prescribed for (e.g., asthma, allergies, ADHD, seizures)	Dose (mg, puffs)	When taken (morning, as needed, twice a day, bedtime)

Please list known allergies (environment, food, insect, medication, etc.) below, or check ☐ **NONE**

Allergic to:	Reaction (runny nose, itchy, hives, rash, trouble breathing, vomiting, etc.)

Prenatal History

Check any of the complications mother experienced during this pregnancy:

☐ unusual weight gain/loss	☐ vomiting after 3rd month	☐ heart problems	☐ anemia
☐ elevated blood pressure	☐ epilepsy/seizures	☐ infections	☐ bleeding
☐ injuries/accidents	☐ gestational diabetes	☐ toxemia	☐ illness

Describe any of the above checked items: _____

Birth History

☐ vaginal ☐ cesarean Birth place _____ Number of weeks at birth _____ Birth weight & length _____

Check any complications that may have occurred at the time of birth:

☐ cord around neck	☐ difficulty breathing	☐ need for resuscitation	☐ birth defects

Describe any of the above checked items: _____

Was baby discharged from hospital with mother or sent to NICU? If yes, indicate length of stay and reason: _____

Neonatal History

Check any complications that may have occurred during the first month following birth:

☐ Jaundice	☐ poor sucking reflex	☐ fever 103 or higher	☐ colic	☐ allergies
☐ Illness	☐ hospitalizations	☐ surgeries	☐ infection	☐ poor weight gain

Describe any of the above checked items: _____

Developmental Milestones indicate the age your child was able to do the following:

sit alone:	Run:	First words:
crawl:	Feed self w/spoon:	3-word sentence:
walk:	Dress self:	Toilet trained:

Check any areas in which your child had difficulty:

☐ speech/language	☐ behavior	☐ feeding	☐ sleep

Family History check if you or any family members have had any of the following, indicate their relation to your child:

☐ cancer	☐ epilepsy	☐ diabetes
☐ asthma	☐ high blood pressure	☐ alcoholism
☐ drug use	☐ learning problems	☐ other

Temperament/behavior check any of the following that describes your child's present temperament:

☐ unpredictable	☐ tantrums	☐ acts without thinking	☐ shy/timid
☐ problems completing tasks	☐ can't follow directions	☐ daydreams or tunes out	☐ quick to cry
☐ easily irritated	☐ quick to anger	☐ fights with others	☐ gives up easily
☐ is a worrier	☐ nightmares	☐ poor coordination	☐ poor appetite
☐ bites nails	☐ sucks thumb	☐ head banging	☐ sleep problems

County of Los Angeles Public Health
Tuberculosis Control Program

Pediatric Tuberculosis (TB) Risk Assessment

This tool is used to identify asymptomatic **children** for latent TB infection (LTBI) testing.

Check appropriate risk factor boxes below based on patient response.
Refer to pediatrician for LTBI testing (skin or blood test), if any of the 3 boxes below are checked.
If a LTBI test result is positive, and active TB disease is ruled out, LTBI treatment is recommended.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-US born persons ≥2 years old

☐ **Immunosuppression,** current or planned

- HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥2 mg/kg/day, or ≥15 mg/day for ≥2 weeks) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease at any time

- The Centers for Disease Control and Prevention indicates that the investigation of contacts and treatment of infected contacts is an important component of the U.S. strategy for TB elimination.

- Re-testing should only be done in persons who previously tested negative and have new risk factors since the last risk assessment. *If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older.*
- For children with TB symptoms or abnormal chest x-ray consistent with active TB disease →Evaluate for active TB disease *with a chest x- ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing.*
- *A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.*
- Do not treat for LTBI until active TB disease has been excluded.

See the **Pediatric TB Risk Assessment User Guide** below for more detailed information about this tool.

Provider: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

(Place sticker here if applicable)

For the most current version, go to the PEDIATRIC TB RISK ASSESSMENT at: http://publichealth.lacounty.gov/tb/TBTesting.htm

Tuberculosis Clearance Form

This satisfies requirements in the California Education Code, and the California Health and Safety Code.

Certificate of Completion of Tuberculosis Risk Assessment and/or Examination

Date of TB risk assessment and/or examination: _____month/____day/_____year

First and Last Name of the patient assessed and/or examined: _____

Date of Birth: _____month/____day/_____year

The patient named above has submitted to a pediatric tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has had a TB skin test (TST) or TB blood test (IGRA), and chest x-ray (CXR) if indicated, and upon exam determined to be free of infectious tuberculosis. The patient is cleared to attend school.

Please print, place label or stamp with Health Care Provider information below:

_____

Name of Health Care Provider Completing the TB Risk Assessment and/or Examination

_____

Health Care Provider Signature

_____

Facility Name and Address

In order to protect the privacy of individuals, all information regarding this assessment is considered confidential. The facility and the Los Angeles County Department of Public Health cannot release the name(s) of any ill person(s).

Pediatric Tuberculosis Risk Assessment User Guide

Avoid testing persons at low risk

Routine testing of low risk populations is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Local recommendations, mandated testing and other risk factors

Several risk factors for TB that have been used to select children for TB screening historically or in mandated programs are not included among the 3 components of this risk assessment. This is intentional in order to focus testing on children at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Testing can also be considered in children with frequent exposure to adults at high risk of TB infection, such as those with extensive foreign travel in areas with high TB rates. Local recommendations should also be considered in testing decisions. **Providers should check with local TB control programs for local recommendations.**

Decision to test is a decision to treat

Because testing of persons at low risk of TB infection should not be done, persons that test positive for LTBI should generally be treated once active TB disease has been ruled out with a physical exam, chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification (NAAT). However, clinicians should not be compelled to treat low risk persons who test positive for LTBI.

When to repeat a risk assessment and testing

Risk assessments should be completed on new patients, patients thought to have new potential exposures to TB since last assessment, and during routine pediatric well-child visits. Repeat risk assessments should be based on the activities and risk factors specific to the child. High-risk children who volunteer or work in health care settings might require annual testing and should be considered separately. Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment (unless they were <6 months of age at the time of testing). In general new risk factors would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel.

Immunosuppression

The exact level of immunosuppression that predisposes to increased risk for TB progression is unknown. The threshold of steroid dose and duration used here are based on data in adults and in accordance with ACIP recommendations for live vaccines in children receiving immunosuppression.

Foreign travel or residence

Travel or residence in countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with infectious TB cases, high TB prevalence of TB in travel location, non-tourist travel). The duration of at least 1 consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after a child's return.

IGRA preference in foreign-born children ≥2 years old

Because IGRA has increased specificity for TB infection in children vaccinated with BCG, IGRA is preferred over the tuberculin skin test for foreign-born children ≥2 years of age. IGRAs can be used in children <2 years of age, however, there is an overall lack of data in this age group, which complicates interpretation of test results. In BCG vaccinated immunocompetent children with a positive TST, it may be appropriate to confirm a positive TST with an IGRA. If IGRA is not done the TST result should be considered the definitive result.

Negative test for LTBI does not rule out active TB

It is important to remember that a negative TST or IGRA result does not rule out active TB. A negative TST or IGRA in a patient with active TB can be a sign of extensive disease. Any suspicion for active TB or extensive exposure to TB should prompt a physical exam and an evaluation for active disease.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating latent TB infection have been shown to be as effective as 9 months of isoniazid and are more likely to be completed. Use of these shorter regimens is preferred in most patients, although the 12-week regimen is not recommended for children <2 years of age, children on antiretroviral medications, or pregnant adolescents. Drug-drug interactions and contact to drug resistant TB are other contra- indications for shorter regimens.

*The CDC currently recommends DOT for this regimen; however, preliminary data suggests that SAT is non-inferior to DOT in the United States. Many clinicians are using SAT or modified DOT.
**11-12 doses in 16 weeks required for completion

Los Angeles County (LAC) 3HP Fact Sheet: available on the LAC Tuberculosis Control Program website: 3HP for treatment of TB infection 2025.pdf (lacounty.gov) & 4R for treatment of TB Infection 2025.pdf

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine*	Weekly	12 weeks**

Refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and CXR repeated if it has been more than 3 months from the initial evaluation.

Symptoms that should trigger evaluation for active TB

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB: cough for more than 2-3 weeks, fevers, night sweats, weight loss, lymphadenopathy, hemoptysis or excessive fatigue.

ACIP= Advisory Committee on Immunization Practices; LTBI=latent TB infection; IGRA= Interferon gamma release assay (e.g., QuantiFERON-TB Gold, T-SPOT.TB); BCG=Bacillus Calmette-Guérin; TST= tuberculin skin test; DOT=Directly observed therapy; CXR= chest x-ray