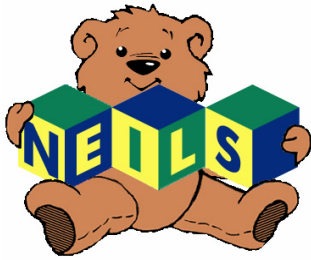




27977



Teacher ID:  
Teacher Name:  
School ID:  
School Name:  
School Year: 2002 to 2003  
Child Name:  
Child Birthdate:

## NATIONAL EARLY INTERVENTION LONGITUDINAL STUDY

### SECTION B: SPECIAL SERVICES

*Directions: This section of the questionnaire is to be completed **only for children with IEPs or 504 plans** (this includes an IEP for speech services).*

*It is to be completed by the teacher or specialist most familiar with the child's special education program or 504 plan.*

*If the child does not have an IEP or 504 plan, check the box below, complete the last page if you wish, and return the questionnaire in the enclosed envelope.*

This child does not have an IEP or 504 plan.



**Please use a BLACK pen; pencils or red and blue pens cannot be read by our scanners.  
When asked to mark boxes, make an "X" through the boxes.**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a request for information unless it displays a valid OMB control number. The valid OMB control number for this survey is 1820-0616. The time required to respond to this information request is estimated to average 15 minutes per response for Section A (general education program and child progress) and 5 minutes per response for Section B (special services), including the time to review instructions, search existing data resources, gather the data needed, and submit the information. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Office of Special Education Programs, Washington, D.C. 20202-4651 or call 202-205-9364. Approval expires December 31, 2003.



27977



**Please use a BLACK pen; pencils or red and blue pens cannot be read by our scanners.  
When asked to mark boxes, make an "X" through the boxes.**



B1. In what capacity (or capacities) are you involved with this child? *PLEASE MARK BOXES FOR ALL THAT APPLY.*

- Provide instruction directly to this child
- Provide related services directly to this child
- Provide consultation to child's teacher(s)
- Provide case management (e.g., program monitoring) for this child
- Program administrator/supervisor
- Supervise instructional assistant assigned to work with this child
- Other (describe):

B2. What is your **main** role in this school? *PLEASE MARK ONE BOX ONLY.*

- General education classroom teacher
- Special education teacher
- Related services provider (e.g., speech therapist)
- Program specialist (e.g., full-inclusion specialist)
- Case manager
- School psychologist
- School counselor
- Other (describe):

B3. How many years have you been working with children with special needs?   years

B4. Who participated in the most recent IEP or 504 plan development or review for this child? *PLEASE MARK ALL THAT APPLY.*

- General education academic subject teacher(s)
- General education vocational teacher(s)
- Special education teacher(s)
- School administrator (e.g., principal, special education director, program coordinator)
- School counselor or psychologist
- Related services personnel (e.g., speech therapist/pathologist, occupational therapist, physical therapist)
- Parent/guardian(s)
- Child
- Staff of outside service agency or outside consultant
- Advocate
- Other (please specify):
- Don't know



27977

B5. In column A, please mark **ALL** of this child's disabilities.  
*PLEASE MARK ALL THAT APPLY IN COLUMN A.*

In column B, please mark the child's **primary** disability.  
*PLEASE MARK ONE BOX IN COLUMN B.*

	<b>A</b> All disability categories (Mark <b>ALL</b> that apply)	<b>B</b> Primary disability category (Mark <b>ONE</b> )
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Deaf-blindness	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Developmental delay	<input type="checkbox"/>	<input type="checkbox"/>
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>
Mild mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
Moderate/severe mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
Multiple disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic impairment	<input type="checkbox"/>	<input type="checkbox"/>
Other health impairment	<input type="checkbox"/>	<input type="checkbox"/>
Serious emotional disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Speech or language impairment	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/>
Visual impairment/blindness	<input type="checkbox"/>	<input type="checkbox"/>
Other: <input style="width: 150px; height: 15px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

B6. Does the child use any medical devices that require school staff attention during any part of the school day? (Medical devices could include suctioning equipment, oxygen, catheters, etc. Do not include nonmedical devices such as communication devices, electronic equipment, etc.) *PLEASE MARK ONE BOX.*

Yes                       No

B7. Is there an emergency medical plan for this child? *PLEASE MARK ONE BOX.*

Yes                       No                       Don't know



- B8. Were the following services provided to the child through the school system during the current school year? (Include services the school contracted from other agencies.) **MARK ONE BOX ON EACH LINE.**

	Yes	No	Don't know
a. Adaptive physical education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Assistive technology services/devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Audiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Behavior management program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Communication services (e.g., instruction in sign language or lip reading, Braille, augmentative communication)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Health services (e.g., administering of medication, oxygen, tracheostomy care, tube feeding, catheterization)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Learning strategies/study skills assistance by a special educator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Mental health services, personal/group counseling, therapy, or psychiatric care provided <b>to the child</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. One-to-one paraeducator/assistant (e.g., teacher aide, nurse's aide, full-inclusion assistant, behavioral assistant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Reader or interpreter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Service coordination/case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Social work services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Special transportation because of disability (e.g., help in travel or special equipment such as lifts, ramps)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Speech or language therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Training, counseling, and other supports/services provided <b>to the child's family</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Tutoring/remediation by a special education teacher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Vision services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Other (specify): <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



27977

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B9. For this school year, what are the primary goals for this child?

*PLEASE MARK ALL THAT APPLY.*

- Improve overall academic performance
- Improve academic performance in a specific area:
- Build social skills
- Improve appropriateness of general behavior
- Improve adaptive behavior or self-help skills
- Improve speech and communication skills
- Improve fine motor skills
- Improve gross motor skills
- Other (please specify):
- Don't know

B10. Which of the following accommodations, modifications, or learning aids are provided to this child as part of his/her IEP or 504 plan? *PLEASE MARK ALL THAT APPLY.*

- Modified grading standards
- Slower-paced instruction
- Additional time to complete assignments
- Shorter assignments
- Physical adaptations (e.g., preferential seating, special desks)
- Books on tape
- Communication aids (e.g., Touch Talker, manual printing board)
- Use of spell checker
- Computer software designed for children with disabilities
- Computer hardware adapted for child's unique needs (e.g., alternative keyboards, switch interface)
- Other:
- None of these provided**



27977

### OPTIONAL

Is there anything else you want to tell us about this child or his/her program?  
(Please write your comments in the box below.)

Date completed:

/  /   
m m      d d      y y

THANK YOU FOR COMPLETING THIS SECTION OF THE QUESTIONNAIRE.  
PLEASE RETURN BOTH SECTIONS IN THE POSTAGE-PAID ENVELOPE TO:

THE NATIONAL EARLY INTERVENTION LONGITUDINAL STUDY

SRI International, BS 158  
333 Ravenswood Avenue  
Menlo Park, CA 94025

We need your name and address if you are interested in participating in the  
selection for the gift certificate. PLEASE PRINT.

First Name

Last Name

Number & Street Address

City

State

Zip Code

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27977

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