Dear Parent,

Thank you for your interest in Preschool Special Education services.

Enclosed is a Preschool referral packet. Please fill out all forms completely and send them to pattifriedman@pickenscountyschools.org

You will also need to register for Pickens County Schools. See the directions on the next page.

Testing cannot be scheduled until registration is completed and this packet is received.

The state of Georgia requires that a child pass a hearing and vision screening before a school system conducts an evaluation. Your pediatrician or the health department may be able to complete the Form 3300 for you. If you cannot get a hearing and vision screening completed please let our office know.

Please call the special education department at 706-253-1772 x 22 with any questions or concerns.

Thank you,

Preschool Team

100 D.B. Carroll Street • Jasper, Georgia 30143 • (706) 253-1700 • Fax: (706) 253-1705

www.pickenscountyschools.org

You must complete registration with Pickens County Schools in order to have the evaluation completed.

Central Registration

Our office is open by appointment only.

Located at:
100 D.B. Carroll Street,
Jasper, GA 30143
Lower level of the building

If you have registration related questions, please call 706-253-1770

If you have a child that needs to enroll in the Pickens County School System, please use the steps below. Please email Central Registration at registration@pickenscountyschools.org if you have questions.

Step 1: Gather Documents

You will be asked to upload the documents listed below electronically (scanned copy, picture via phone, etc.). If you do not have the Immunizations or health form we ask that you go ahead and complete the registration process.

Documents Needed:

1. Parent/Guardian ID
2. 2 current proofs of residence
3. Custody documents (if applicable)

The items below are related to your child:

1. Birth certificate
2. Social security card and/or waiver form
3. Georgia immunizations (Form 3231) and/or waiver form
4. Georgia Health Form (Form 3300)

New Student Registrations

Please visit the website below.

https://campus.pickens.k12.ga.us/campus/OLRLogin/pickens

If you need information or assistance, please email:
registration@pickenscountyschools.org

Children's Assessment and Preschool Services
100 D.B. Carroll Street
Jasper, GA. 30143
706-253-1772

REQUEST FOR PRESCHOOL STUDENT SUPPORT

Date:______________________________

Child's Name:__________________________________ Date of Birth:_________________

Parent/Guardian:_______________________________ Home Phone:_________________

Address:_______________________________________ Cell Phone:__________________

_______________________________________ Work Phone:_________________

School District:_________________________________

Current Preschool Program:____

Type of Preschool Program: _____ Headstart 3y/o _____ Headstart 4 y/o _____ Headstart 5 y/o

____ Lottery Funded GA PreK _____Other PreK program ____ Stays at Home

Person Making Request:____

Phone Number:___________________________

Please check ALL areas of concern:

_____Medical Condition _____Physical/Motor
_____Social/Behavior _____Speech/Language
_____Pre-Academic Skills (Learning Abilities)

Please provide a detailed explanation of the areas of concern:

____

____

____

____

____

____

Has parent been notified of request?_________Yes ____________ No

Signature:____

Background Information Form

(To be completed by parent or guardian)

Dear Parent: We would appreciate your help in completing this information regarding ________________________ and returning it to the school. This information will help us in working more effectively with your child. The information on this form will be treated in a confidential manner.

Child's Name______________________________ Birthday________________

Address:____

City:______________________ State_______ Zip__________

Name of Parent/Guardian with whom child lives:______________________________

Home Phone:________________ Work Phone:________________

Cell Phone:________________ May we text? _____Yes ____ No

Email Address:______________________ Can we email ____Yes ____ No

Ethnic Background: (check all that apply) ☐White/Caucasian ☐ Native Hawaiian or Pacific Islander ☐ Hispanic/Latino ☐Black/African American ☐ American Indian or Alaska Native ☐Other________________

Agencies or providers that have worked with this child or his/her family:

☐ Mental Health Clinic ☐Family Physician ☐Social Worker ☐Psychologist ☐Psychiatrist ☐Other__________

Please give the following information for all agencies/providers:

NAME	TITLE	ADDRESS	DATE SEEN

Family Data

Mother's Name:________________ Age:________ Education:________________

Place of Work:________________ Active Military _______ Work Phone:________________

Father's Name:________________ Age:________ Education:________________

Place of Work:________________ Active Military _______ Work Phone:________________

Stepparent's Name:________________ Age:________ Education:________________

Place of Work:____________________________ Work Phone:________________

Marital Status of Parents:__________If separated/divorced, how old was child when the separation occurred?__________

Traumatic Events with Date(s) of occurrence:________________________________

LIST ALL PEOPLE LIVING IN HOUSEHOLD

Name	*Relationship to Child*	*Age*

If any brothers or sisters are living outside the home, list their names and ages:

Name	*Age*	*Name*	*Age*

Does custodial parent work outside the home?________Yes ____ No

If yes, who is the primary caregiver when the parent(s) is away?________________________________

In the case of older students, does the student work outside the home?__________Yes ____ No

If yes, how many hours does he/she work during the week?__________________ On the weekend?________________________

SCHOOL HISTORY

Years attended this school (circle one) 1 2 3 4 5 6 7 8

Did the student attend preschool? ____Yes ____ No

Grades Repeated ________________

Names of all Schools Attended________________________________

____

List any subjects that are especially difficult________________________________

____

Describe any serious problems your child has experienced at school________________________________

____

Describe any serious problems your child has experienced at home________________________________

____

Describe your child's study habits at home________________________________

____

Who is the primary person who helps with homework?________________________________

____

How much time is spent on homework each night?________________________________

BIRTH HISTORY

List any illnesses or accidents occurring during pregnancy________________________________

____

Full Term: ☐Yes ☐No Birth Weight________________ Duration of Labor________________________________

Delivery: ☐Normal ☐Breech ☐Cesarean

Was there any evidence of injury at birth? ☐Yes ☐No

Were any of the following experienced before the child's second birthday?

☐Feeding problems ☐Convulsions ☐High Fever ☐Fainting ☐Serious accidents ☐Head Injuries

Please give additional information on any item checked above:________________________________

____

____

____

____

DEVELOPMENTAL DATA

Does your child have a history of ear infections ☐ Yes ☐ No

At what age did each of the following behaviors first occur? (if you are unsure of exact age please indicate if there was a delay or if the behavior was on time as you recall).

________ Crawled

________ Sat Alone

________ Walked Alone

________ Said first words besides "Ma-Ma" and "Da-Da"

________ Speech was clearly understood by others outside the family

________ Toilet Trained during day

________ Toilet Trained during night

________ Tied Shoes

________ Dressed Self

Describe early childhood care (baby-sitter, nursery school, mother, etc.). Include child's age.

____

____

____

PHYSICAL CONDITION

My Child's general condition is:

☐ Seems to be in good health
☐ Overweight
☐ Underweight
☐ Tires easily, listless, lacks energy
☐ Sleeps too much
☐ Sleeps too little
☐ Overly active; always on the move
☐ Awkward in running, walking, or playing

List any physical handicaps, serious illnesses, hospital stays, accidents, or head injuries with date of occurrence (vision, hearing, speech, seizures, operations, diseases, etc.):______________________________

____

____

Please list any medications your child is currently taking:______________________________

____

Please list any additional medications your child has taken in the past six (6) months:______________________________

____

If your child is taking medications, are there any problems getting the child to take them?______________________________

____

Please indicate any problems your child is having now. If yes, please describe how often and whether or not they are being treated.

Problem	Yes	No	Treatment	Problem	Yes	No	Treatment
Heart Condition				Frequent diarrhea			
Heart Murmur				Stomach pain			
Shortness of breath				Pain while urinating			
Asthma				Excessive urination			
Hay Fever				Urination in pants/bed			
Sinus Condition				Seizure/convulsions			
Chronic Cough				Has tics/twitches			
Frequent Colds				Speech defects			
Frequent Rashes				Accident prone			
Bruises easily				Bites nails			
Sores				Sucks thumb			
Itchy skin (eczema)				Grinds teeth			
Excessive vomiting				Bangs head			
Constipation				Other			

BEHAVIORAL CHECKLIST

(Please circle the behaviors most characteristic of your child)

☐ Feel happy w/him/herself	☐ Sucks his/her thumb	☐ Can be trusted
☐ Demands excessive attention	☐ Overly dependent on others	☐ Wets the bed
☐ Plays well with other students	☐ Overly anxious to please	☐ Cries often
☐ Exhibits uncooperative attitude	☐ Tries to control others	☐ Poor self-control
☐ Has few close friends	☐ Relates well to adults	☐ Friendly
☐ Lacks motivation, lazy	☐ Aggressive	☐ Sad or depressed often
☐ Does not adjust readily to change	☐ Fearful	☐ Shy, withdrawn
☐ Loud	☐ Easily frustrated	☐ Daydreams often
☐ Openly affectionate to family	☐ Restless	☐ Jealous of siblings
☐ Acts younger than other children his/her age		

DISCIPLINE USED AT HOME

1.	Child is disciplined:	☐ frequently	☐ occasionally	rarely
2.	Punishment is administered by:	☐mother	☐ father	Others
3.	What type of discipline is used?	☐ spanked	☐ restricted	deprived of privileges
		☐ isolated	☐ talking	rewards
4.	Reactions to discipline:	☐ becomes angry	☐ cries	withdraws
		☐ sulks and pouts	☐fights back	
5.	Effectiveness of discipline:	☐ behavior improves	☐ remains the same	☐behavior worsens

1. What do you do together as a family?____
____
2. Describe any chores your child does around the house.____
____
3. Bedtime hour:____________________ Time of getting up in the morning:____________________
4. What concerns you most about your child?____
____
5. List your child's major interests (sports, hobbies, activities):__________________________________
____
6. What do you enjoy most about your child?____
____
7. Has your child ever been involved with the Department of Juvenile Justice, Department of Corrections, or other law enforcement agencies? (if yes, please explain)____
____

FAMILY HEALTH HISTORY

Please check any of the problems that have been experienced by a member of your family and specify the relationship to this child.

Yes	Problem	Relation	Yes	Problem	Relation
	Cancer			Cystic fibrosis	
	Diabetes			Heart Disease	
	High Blood Pressure			Kidney disease	
	Migraine Headaches			Multiple Sclerosis	
	Physical handicap			Stroke	
	Tuberculosis			Alzheimer’s disease	
	Hemophilia			Huntington’s Chorea	
	Muscular dystrophy			Parkinson’s disease	
	Sickle-cell anemia			Tay-sachs disease	
	Tourette’s Syndrome			Birth defect	
	Cerebral Palsy			Alcohol abuse	
	Drug Abuse			Behavior disorder	
	Manic-depression			Bi-polar disorder	
	Mood Disorder			Specific Learning Disability	
	Emotional disturbance			Mental illness	
	Mental retardation			Nervousness	
	Seizures or epilepsy			Reading problem	
	Math problem			Writing Problem	
	Speech problem			Language problems	
	Food allergies			Other Allergies	
	Severe head injury			Depression	
	ADD / ADHD			Eating Disorder	
	Autism/Asperger’s/Pervasive Developmental Disorder			Other: Describe	

For those items checked please indicate specific difficulties with that subject and any coping strategies the individual who had the problem found helpful.____

____

____

If you wish to add additional information, please add it below or attach to this form.____________________

____

____

____

____

________________________________ ______________________

Parent/Guardian Signature *Date*

Pickens County Department of Exceptional Students
100 D.B. Carroll Street, Jasper, GA. 30143

Notice/Authorization to Release Information

I hereby authorize:

(School, Doctor, Agency, Facility, etc.) ______________________________
Address:______________________________
City/State/Zip:______________________________
Phone:________________ Fax:________________

To obtain and/or release confidential information and/or records for:

Student:______________________________
Date of Birth:________________ Grade:________________
Current School:______________________________

To: **Pickens County Board of Education**
Attention: Department of Exceptional Students
100 D.B. Carroll Street
Jasper, GA. 30143
Telephone: 706-253-1772 Fax: 706-253-1712

Please send records to the attention of: Preschool Team

It is understood that the party to whom this information is released will not release it to a third party without appropriate consent.

RECORDS TO BE RELEASED:

____ Original/Initial Consent for Placement
____ Original/Initial Consent for Evaluation
____ Psychological Assessments
____ Special Education Placement/Minutes
____ IFSP/IEP/Annual Review
____ Medical Records
____ Eligibility Report
____ Allow two way communications between a third party and the School District
____ Allow two way communications between the physician and the School District
____ Other______________________________

REASON(S) FOR RELEASE:

____ Educational Planning Purposes
____ Other______________________________

I understand and agree to the above statement.

Signature:______________________________ Date:________________

Dear Parents,

Georgia's Medicaid Plan has developed a program especially for school services called Children's Intervention School Services Program (CISS). The program encourages school systems to receive Medicaid reimbursements for services that are provided by our school system including speech therapy, occupational therapy, physical therapy, and other services. This program involves **no cost to you or to the State of Georgia**.

School systems' pursuance of reimbursement for Medicaid funds will **not** affect your ability to use private provider health services. If your child receives services from a private therapist please let us know when they receive services and what they receive and we will work around your schedule. Many therapists believe that if you allow schools to bill for services than they will not be paid – this is INCORRECT. They are funded separately, we cannot perform the same service on the same day but we can both serve the students in order to help the student be successful**.**

Parental agreement is needed for school systems to pursue reimbursement. Services provided to your child by the school system will not change regardless of your decision; however, your participation would help our schools and our students with disabilities earn money in order to better our program.

Please complete and return the enclosed parental authorization form. We need this form filled out and sent back even if your child does not receive Medicaid/ Peachcare services or if you wish for us not to bill Medicaid/Peachcare for services. Please choose Yes or No, or that your child does not currently receive Medicaid, and then choose Yes or No if you agree to teletherapy/virtual therapy services. If your child receives Physical Therapy services and you do not want Medicaid/Peachcare billed, do you give us permission to contact the doctor for a prescription for those services. Physical Therapy requires a doctor's prescription whether we bill or not bill. If you have any questions, please contact Patti Friedman, at 706-253-1772 Option 2, 2. Thank you for your support and assistance.

Respectfully,

Patti Friedman

Patti Friedman
Compliance Specialist
Exceptional Student Services

August 11, 2015

NOTICE TO PARENTS REGARDING PUBLIC BENEFITS

In Accordance with IDEA (Individuals with Disabilities Education Act) Part B 34 CFR 300.154(d) – A Federal Law

General

Your consent must be obtained before your Special Education program discloses for billing purposes, your child's personally identifiable information to public insurance or benefits programs such as Medicaid and/or PeachCare.

1. Fees **may not** be charged to you for service coordination, child find referral services, evaluations and assessments, Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) development, and implementation of procedural safeguards (Family Rights).
2. The inability to pay for services will not result in a delay or denial of Special Education services.
3. Even if you do not provide consent for the use of insurance, you and/or your child will still receive Special Education services in the IFSP or IEP. The lack of consent to use your insurance may not be used to delay or deny any Special Education services.
4. You may withdraw consent to bill your public insurance at any time by notifying your Special Education program in writing. If you withdraw this consent it would apply to billing for services from that date forward.
5. Services authorized on the IFSP or IEP will be provided at no cost to you. Any co-payments or deductibles related to these services may be paid by your local Special Education Program.

Public Insurance or Benefits, Including Medicaid

1. If your child is not already signed up or enrolled in public insurance such as Medicaid, he/she is not required to be in order to receive Special Education services.
2. Special Education service providers must obtain your consent to use your public insurance such as Medicaid to pay for your child's Special Education services and any time your child's IFSP or IEP services are increased. Your public insurance such as Medicaid will not be used if that use would result in any of the following:
    a. Decrease in the available lifetime coverage or any other insured benefit for you or your child;
    b. Result in you paying for services that would otherwise be paid for by the public benefits or insurance program;
    c. Increase your premiums or cancel any of your public benefits or insurance; or
    d. Cause your family to no longer qualify for home and community-based waivers that are based on total health-related costs.

*For additional information please refer to the Parental Consent Form.

PICKENS COUNTY SCHOOLS

MEDICAID/PEACHCARE CONSENT FORM/TELEMEDICINE CONSENT FORM

STUDENT: ____DOB: ____________________ SSN: ________________________

STREET ADDRESS: ____ CITY: ___________________ ZIP CODE: _________

DR. NAME (student's physician):____

DR. PHONE NUMBER:_______________________________________ CITY:_____________________________

Reimbursement for services does require that a form be completed by a healthcare practitioner that has seen the child. Once you provide the contact information requested on this consent form, a document will be sent to the physician for completion. Should the healthcare provider that you indicate on this form be unable to complete the form for reimbursement of services, a healthcare practitioner provided by the school system will evaluate the student for services in their IEP. Your selection and signature gives or denies your permission for the School System to provide pertinent information pertaining to services provided in the student's IEP to their physician as required by Medicaid.

The School System is providing the health-related services to your child in accordance with his/her Individual Education Program or Individual Family Service Plan. Medicaid and/or PeachCare is required to cover some of the cost of certain services.

The School System cannot bill Medicaid/PeachCare without your consent. If you allow the school system to bill Medicaid or PeachCare for the health-related services that your child is receiving in accordance with his/her Individual Education Program or Individual Family Service Plan, check the "Yes" box and sign below.

Should the school system utilize Telemedicine to consult with a healthcare provider for the purpose of evaluating your student for the services in their IEP/IFSP you understand the following:

1. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:
    a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
    b. A physical examination of you may take place.
    c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
    d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)
2. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
3. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telemedicine consultation.
4. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
5. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.
6. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

Your selection and signature (parent/guardian) gives or denies permission to the school to bill Medicaid/PeachCare and utilize Telemedicine for healthcare practitioner consultation/evaluation for the frequencies of services as defined in your child's IEP or IFSP beginning with the current school year.

YES I authorize the School System to bill Medicaid and/or PeachCare for the health related services listed in my child's IEP or IFSP.

NO I do not want Medicaid/PeachCare billed for health related services my child is receiving.

My child does not currently receive Medicaid, however, if they were in the future, I give The Pickens County Schools permission to bill for services.

YES I do want to participate in telemedicine services

NO I do not want to participate in telemedicine services.

YES Pickens County schools may contact my child's doctor for a prescription for Physical Therapy Services**.**

Parent/Guardian Name (PLEASE PRINT): ____

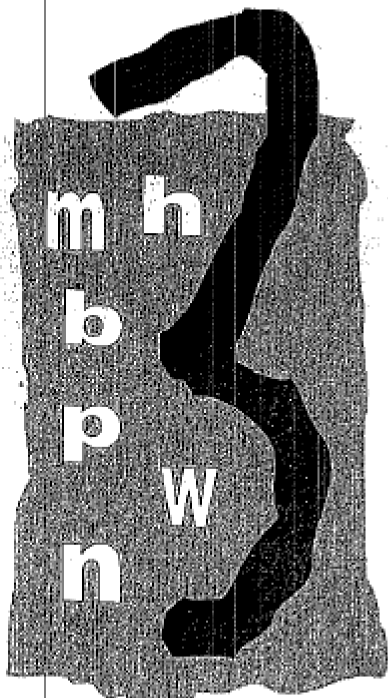
Parent/Guardian Signature: ____ **Date**: _________________

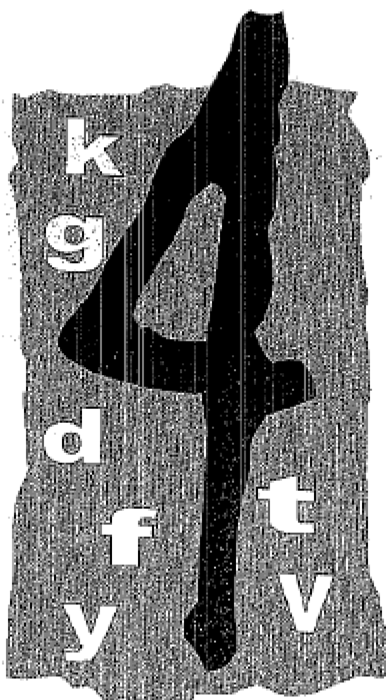
It is my responsibility as a parent to notify the school system's Special Education Department in writing if I ever decide to withdraw this consent allowing the school to seek reimbursement from Medicaid/PeachCare.

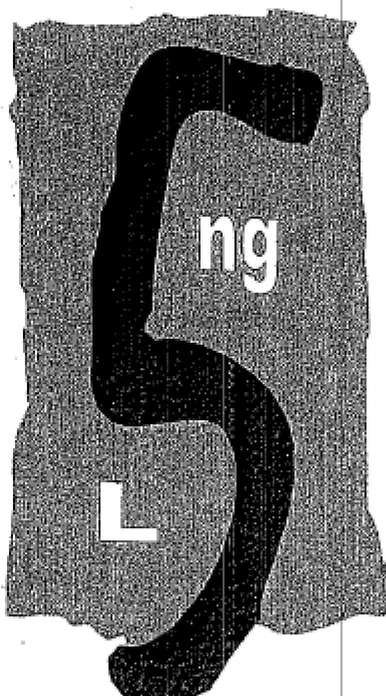
NOTE: As of April 1, 2003, the Children Intervention Services Program (CIS) and the Children Intervention Schools Service Program (CISS) have been separated. Students can receive medical services in both programs without impacting service limitations.

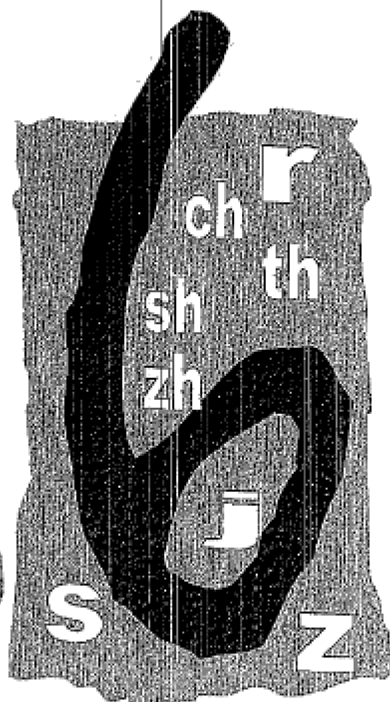
If you have any questions, please call: Patti Friedman, Exceptional Student Svcs Compliance Specialist at 706-253-1772 x22

Sound Development Ages









Sounds develop within the year on the chart.
Sounds are late the following year.

*Adapted for Pickens County from Templin, 1957; Wellman et al., 1931

Children's Assessment and Preschool Services (CAPS)

Referring Developmental Checklist

Please read carefully and check Yes or No about:

Child's Name:______________________________ Date:________________

Signature of Teacher or Parent Completing:______________________________

Yes	No	Speech/Language
		1. Uses at least 50 recognizable words (LD 3a)
		2. Uses at least 100 recognizable words (LD 3a)
		3. Difficulty in making age appropriate sounds of language (Pre K LD 2)
		4. Follows Simple Directives (LD 1a)
		5. Uses pronouns (I, you me…) (LD 3b)
		6. Uses Articles (a, an, the…) (LD 3c)
		7. Asks Who, What, Where and Why questions (LD1b)
		8. Answers Who, What, Where and Why questions (LD 1b)
		9. Puts 4 or more words together in simple sentences (LD 4c)
		10. Points to 10 pictures of common objects (LD 5d)

Yes	No	Motor
		1. Throws and catches a ball (HPD 1b)
		2. Immature balance when walking or running (HPD 1a)
		3. Ascends/Descends stairs alternating feet (HPD 1b)
		4. Strings 10 large beads (HPD 2b)
		5. Copies circle, square, cross and triangle with dominant hand use (MD 4b)
		6. Difficulty holding scissors or crayons (CD 1a)
		7. Cuts with scissors (HPD 2c)
		8. Kicks a ball (HPD 1b)
		9. Walks on tiptoes (HPD 1b)

Yes	No	Behavioral
		1. Behavior is impulsive (Pre K SE1)
		2. Difficulty in expressing affections (SE 3e)
		3. Overactive (Pre K SE 2)
		4. Makes choices when asked (SE 2c)
		5. Follows teacher request 50% of the time (SE 3b)
		6. Loses temper very suddenly with people or objects (SE 4c)
		7. Appears to be sensitive to environmental stimuli (touch, lights, colors, sounds…) (CD 1a)
		8. Very low tolerance to frustration (Pre K SE2)
		9. Resistance to change (SE 3d)
		10. Perseverates, repeats actions, sounds, phrases over and over (Pre K SE1)

Yes	No	Self-Help
		1. Is cooperative (Pre K SE2)
		2. Cleans up when asked (SS 1b)
		3. Easy to comfort and calm when upset (Pre K SE2)
		4. Avoids playing with other children (SE 2b)
		5. Resists going to preschool or daycare (SE 2a)
		6. Cries easily or often for no apparent reason (Pre K SE2)
		7. Feeds Self (HPD 3b)
		8. Washes hands and face (HPD 3a)
		9. Avoids hazards (sharp objects, open stairs, furniture corners) (HPD 3c)
		10. Potty trained (Pre K HPD 3.1)
		11. Demands unusual amounts of attention (SE 1c)
		12. Can dress/undress independently to meet school needs (HPD 2c)

Yes	No	Cognitive
		1. Can count 1-10 (MD 1c)
		2. Can match circle, square, triangle (MD 3b; MD 4a)
		3. Completes 2-3 piece formboard or puzzles (Pre K HPD2)
		4. Identify Colors (MD 3e)
		5. Gives full name, age, and gender (SE 1a)
		6. Places object – in, on, under – on request (SS 3c; MD 4c)
		7. Repeats rhymes or favorite story (LD 2b)
		8. Points to body parts on request (Pre K SE1)
		9. Stacks cubes in towers or train method (MD 2b; MD 5d)
		10. Can stay with one activity for extended periods of time (SE 2e)
		11. Understands – big/little, in/out, open/close (MD 4c; MD 5f)

Comments:____

____

____

____

____

____

____

____

____

____

____

____

From GA Early Learning Standards (gels #)