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ABSTRACT

The diagnostic and educational services components of the Austin Early Childhood Special Education Program is reviewed. It is explained that the project's educational planning and curriculum are based on interdisciplinary assessments. Discussed are such diagnostic activities as the initial comprehensive evaluation, instructional arrangement, and the home program. Traced are six steps in the assessment/evaluation process: referral, screening, diagnostic placement, program implementation, program evaluation, and post-program placement. Included are flow charts of assessment and evaluation, and sample forms for referral and diagnostic summaries. Educational services are explained to involve classroom organization and placement according to the student's social competence. Social functioning is reported to be based on four basic classifications: the self involved child; the annoying, disruptive, or clinging child; the child with beginning small group capability; and the child with beginning large group capability. (CL)

The Austin Early Childhood Special Education Program

DIAGNOSTIC AND EDUCATIONAL SERVICES

Outreach Project
Austin Early Childhood Special Education
Austin Independent School District

Fall, 1976

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Diagnostic Services

Diagnostic Services

Overview

In order to insure that a child experiences an orderly progression from one stage of development to the next, educational planning and curriculum development in the Austin Early Childhood Special Education (AECSE) Program are based on the assessment process. Such assessment is the result of the combined efforts of several individuals. As the person most closely associated with the child, the classroom teacher is in the best position to supply pertinent, reliable assessment data. Other assessment data are generated when the child is seen individually by the speech pathologist, occupational therapist, educational diagnostician or psychological associate, and if necessary, the physical therapist.

To ensure effective coordination of all assessment data, AECSE employs the concept of the assessment team. While it is difficult to completely separate a child's functioning abilities in different areas, each member of the assessment team has a fairly specific role in assessing these abilities.

Under the direction of the educational diagnostician, the assessment personnel meet as a team, present their data, and compile a total evaluation of the child's abilities. This procedure insures that a child is seen as a whole person, rather than a

series of splintered strengths and weaknesses. Using this system the assessment team establishes an educational plan that will meet a child's individual needs. If a child's family demonstrates specific needs, the parent coordinator and/or coordinator of community services become members of the team and aid in planning a program that will meet the family's needs as well as the needs of the child.

Within AECSE, assessment/evaluation is considered one of the most important steps in the educational process. The data gathered by the assessment team is used for educational planning, obtaining a baseline for measuring a child's progress, evaluation of the specific treatments used with a child, and evaluation of the AECSE Program.

The educational diagnostician follows a child completely through the program from referral to dismissal. He coordinates the referral process of new children coming into the program, the diagnostic screening of the children referred, in-depth assessment of children's abilities during the first few weeks they attend the program, and the implementation of an educational plan based on the in-depth evaluation of a child's specific needs and, later, progress in the program.

Goals and Objectives

The main goal of the diagnostic services component is to provide a comprehensive assessment of the child in all areas as a basis for designing an effective, individualized instructional program and to keep such assessment up to date. Specifically, objectives for the diagnostic component are:

1. To ensure that within 40 days of entrance into the program, each child receives a non-biased, in-depth comprehensive evaluation which covers: 1) intellectual functioning, 2) receptive and expressive language abilities, 3) social and behaviorial abilities, 4) pre-academic and academic skills, 5) fine and gross motor skills, and 6) self-help skills.

2. To ensure that all children enrolled in the program meet the state eligibility criteria to receive special education services.

3. To provide information to the Admission, Review, and Dismissal Committee to determine the best educational instructional arrangement for the child.

4. To provide data to formulate a viable, pertinent, educational program that meets the needs of each individual child.

5. To provide a baseline as well as criteria to continually assess and evaluate the progress of a child in the program.

6. To provide data that will aid in evaluating the program as a whole.

7. To provide data to the parents of each child to ensure that they have a clear understanding of their child's strengths and weaknesses and his needs as determined by the evaluation process.

8. To provide data to establish a program to be carried out by the parents in the home if this is considered necessary.

Activities

Initial Comprehensive Evaluation

As the assessment team coordinator, the educational diagnostician or psychological associate has primary responsibility for ensuring that time lines are met by the members of the assessment team. Initial evaluation of the different areas of a child's functioning is performed by the appropriate staff members. The educational diagnostician is charged with the assessment of a child's intellectual functioning and his social/behavioral skills. The speech pathologist assesses speech and language and coordinates hearing screening. The occupational therapist assesses sensorimotor integration skills, gross and fine motor coordination and visual-perceptual skills. The classroom teacher assesses social/emotional skills, pre-academic performance abilities, and the general language and motor skills needed by a child to function in a public school setting.

State Eligibility

The comprehensive evaluation occurs during an initial 40 day period in which the child is placed in the program on a diagnostic basis. At the end of this 40 day period the educational diagnostician calls for an Admission, Review, and Dismissal (ARD) Committee staffing on the child. Information

presented by teachers and support staff at this meeting determines whether the child qualifies for special education services according to eligibility criteria of the Texas Education Agency. Signatures of ARD Committee members on the ARD Committee Recommendations form (see Appendix A) verify that these individuals have reached agreement on the best possible plan for the child.

Instructional Arrangement and Educational Program

Once the ARD Committee has decided a child should be admitted to the program, they use the information presented at the meeting along with their knowledge of program classrooms to evaluate the appropriateness of his placement. A final task completed at the meeting is the determination of the child's school program. This includes writing an educational plan for the child and scheduling him for speech, occupational and/or physical therapy if required.

Occasionally the Program ARD Committee decides not to formally enroll a child at the end of the 40 day assessment period. When this occurs, the educational diagnostician provides assessment information on the child to the central (district) ARD Committee. This information is then used to help determine an appropriate placement for the child. Children may thus benefit from assessment conducted at Early Childhood Special Education even if they are not subsequently formally enrolled in the program.

Baseline, Assessment Criteria, and Program Evaluation

The data gathered by the assessment team provides a comprehensive picture of a child's abilities in many areas at a given point in time. Besides being the basis on which the educational plan is developed, this initial description of the child serves as a baseline against which his future progress can be measured. This baseline is set down in objective, behavioral terms, thus progress may be easily measured by observing the child's behavior in a specific area at a later time.

Individually, child progress toward stated objectives is a sign of effective classroom programming. Collectively progress of children throughout the program is the primary method of evaluating the success of the program as a whole.

Parent Understanding of Child's Abilities

Conferences with the child's parents are held at least twice a year. The first major conference is attended by the educational diagnostician, teachers, parent coordinator, and therapists. Here parents are informed of the recommendation of the ARD Committee, and diagnostic information concerning evaluation, objectives, and planned activities for their child is shared. Other conference(s) are later held to inform parents of classroom progress and any particular program being carried out by the classroom teacher and/or

therapists working with the child.

Whenever a particular problem is encountered by the classroom teacher and a remedial program is established, the parents are called to determine their attitude toward the proposed program and to encourage consistent adult behavior towards the problem both at home and at school. While the teachers may meet frequently with the parents, other members of the assessment team meet with them only when they have new information to share or when requested to do so by either parents or teachers.

Home Program

In some cases it is deemed advisable to involve parents in a home program designed to supplement the child's school program in a particular area. A home program is generally written by the staff member who works with the child in that particular area at school. The parent is encouraged to observe the staff member working with the child, either live or on video tape. The staff member then discusses the school program with the parent and provides written suggestions for a home program. Conferences are held throughout the year to update the home program as necessary.

The Assessment/Evaluation Process

The AECSE assessment/evaluation process has five major stages: referral, screening, program definition, program implementation, and program evaluation. Each one of these components will be discussed individually although in some cases it is difficult to separate them.

Referral

Children are referred to AECSE by community agencies, professionals in the community, other Austin Independent School District (AISD) programs, and parents. In each case the educational diagnostician attempts to gain as much pertinent information about a child as possible before the child is actually seen for screening. A Referral Form (see Appendix A) is completed on the child and the referring agency or person is asked to have the child's parents contact the AECSE Program for a screening appointment. When the parents call to make this appointment, the following information is obtained: 1) confirmation of the child's birthdate, 2) services received from other agencies, 3) self-help skills demonstrated in the home, 4) number and ages of playmates at home, 5) why the parent feels the child needs special education services, 6) other information requested on the referral form which the referring agency or person cannot supply.

The parents are requested to schedule these appointments for the morning so they may become familiar with the operation of the program while the child is being screened. Parent participation in the referral process alleviates confusion about the referral itself and leads to a greater degree of commitment on the part of the parents to having their child placed in a program for handicapped children.

Screening

At the time parents call to refer their child for services, an appointment for screening is made. The parents are requested to bring their child for screening while they observe the program. When the parents and child arrive for screening, they meet the project supervisor and the educational diagnostician. The project supervisor explains the program philosophy and rationale to the parents and gives them a tour of the facilities while the educational diagnostician screens the child.

Screening involves direct interaction with the child to assess his cognitive, language, fine and gross motor skills, and social interaction with adults, and, if possible, with peers. This is done informally by observing the child in a classroom setting and formally by administering the Peabody Picture

Vocabulary Test, the Beery Developmental Test of Visual-Motor Integration, and selected items from the Merrill Palmer Scale of Mental Tests. This process takes 30 to 45 minutes. Notes are made on the back of the Referral form.

Should a child be referred for specific problems, such as fine motor or language problems, the appropriate therapists are notified in advance of the screening appointment so they can observe the child during this time.

After the testing and observation, the educational diagnostician interviews the parents to obtain further information concerning the child's performance in various developmental areas. Questions posed during the interview are generally related to observations made during the screening of the child.

Following the screening appointment, the project supervisor, educational diagnostician, and any other staff member who examined the child determine if the child should be admitted to the program on a diagnostic basis. If it is decided that the child does not need the services of the program, the parents are so notified. If it is felt that the child could benefit from the program, the parents are told that their child is eligible for placement.

If a child is to be admitted to the program, further information is obtained from the parents about other agencies

they have contacted in the course of obtaining services for their child, and they are requested to sign a release authorizing other agencies to send information to the AECSE Program upon request (see Appendix A). The parents are also given a registration packet which must be completed before the child can enter the program (see Appendix A).

The screening procedure for a child who is currently enrolled in another AISD program is a little different than described above. Should a child be referred by an AISD kindergarten teacher or another AISD program, the educational diagnostician travels to the referring school prior to the parent visit and observes the interaction between the teacher and the child and the child's general level of functioning within the classroom.

After observation of the child in the classroom, a conference (Local Support Team meeting) is held with the classroom teacher and other professionals in the school who have contact with the child, such as the counselor and the principal. If the situation warrants placement, the home school determines eligibility and receives permission from the parents to refer the child for placement in the early childhood program. The eligibility folder is sent to the Central ARD for final review and approval.

Program Definition (Diagnostic Placement)

After registration forms are completed and returned by the parents, diagnostic placement is initiated by the Early Childhood Placement Committee. This committee consists of an occupational therapist, speech pathologist, educational diagnostician, psychological associate, and the project supervisor. Initial classroom assignment is determined by information obtained during the referral process, information provided by the parents on the registration forms, and information gained during the screening process.

The Texas Education Agency allows 8 weeks (forty consecutive student attendence days) for diagnosis and evaluation of a child considered for special education; AECSE works within this guideline. During this forty day period, testing is performed by the speech pathologist, the occupational therapist, and the educational diagnostician. No testing or structured observation is begun until after the child has been in the classroom two weeks. This two week period allows the child to familiarize himself with the classroom teacher and his peers, and gives each member of the assessment team time to establish rapport with the child.

During the diagnostic placement period the classroom teacher begins to function as an integral member of the assessment team. Through daily interaction with the child, the teacher has, or can obtain, information necessary to confirm or reject hypotheses about the child which have been developed through formal testing by other

team members. The teacher completes an observation checklist on the child (the Casis/Teacher Checklist or the Checklist of Coping Skills) which covers all phases of his social and adaptive behavior within the school environment. Through the use of the checklist and developmental guidelines, the teacher is able to determine the child's level of development in all pertinent areas.

After the standardized testing has been carried out and the teacher observation is completed, the educational diagnostician calls for a formal ARD Committee staffing on the child. The ARD Committee, as established by Texas law, must consist of one person from administration, one person from classroom instruction, and one person from appraisal. Since AECSE believes in the assessment team concept, the AECSE ARD committee consists of the educational diagnostician, the speech pathologist, the occupational therapist, the classroom teacher, and the project supervisor. From the information presented (see the Summary Psychological Report of Individual Testing in Appendix A) this committee decides whether the child meets eligibility criteria. They also discuss whether he can best be served in the AECSE Program, another program within AISD, or an outside agency. A summary of information discussed at this meeting is kept on a Child Diagnostic Summary Sheet (see Appendix A).

This meeting results in a formal written document indicating the recommendations of the ARD Committee. If these recommendations include formal placement in the AECSE Program, the classroom assignment of the child is reconsidered for possible change, and a formal educational plan is established for the child (see Appendix A).

The educational plan includes the relative strengths and weaknesses of the child, his level of development, the child's best learning modalities, and a classroom behavior management plan for the child if this is considered necessary. Formal and informal assessment data is used to eatablish long range goals in the areas of language development, cognition, psychomotor/perception, and social-behavioral skills. The developmental objectives established by the teachers to meet these goals are broken down into weekly objectives which are further divided into small enough increments that the child can show progress toward the objective within a period of five days. The educational dignostician supervises the writing of the educational plan.

Following the ARD Committee meeting, a parent conference is held to inform the parents of the committee's findings and recommendations.

Program Implementation

Once a child's classroom assignment is decided and his educational plan is written, he continues in the classroom program and meets with a speech, occupational, and/or physical therapist as scheduled. His educational plan is kept up to date through a re-evaluation of objectives on a biweekly basis. The diagnostician's role during this time is to ensure that the paperwork on each child is kept up to date, to monitor child progress, and conduct further assessment as necessary. More detailed information on this phase of a child's program is given in the Educational Services section of this booklet.

Program Evaluation

The educational plan is used as a standard for evaluating a child's progress. This plan is kept current through a biweekly staffing coordinated by the diagnostician. All members of the assessment team attend to ensure that the planning includes objectives that are pertinent to the assessment data gathered by each member. Goals and objectives are reviewed for applicability and as a way of monitoring the child's progress. The educational diagnostician spends at least an hour observing the child in the classroom on the

day of staffing and provides consultation to teachers on classroom problems based on his observations. The basic decisions made during the biweekly staffing sessions are:

1. To dismiss a child from the program whose progress and current status indicate that he does not need the continued services of the program.
2. To continue the established program for the child.
3. To change or modify the long range goals or the established developmental objectives.

The classroom teachers are responsible for monitoring each child's progress on the goals and objectives established in his educational plan. The teachers determine when the child meets the success criteria for an objective and enter that date beside the objective on the plan itself. Thus the length of time it takes a child to achieve success, as well as the amount of progress the child makes, can be quickly determined. Should a child have difficulty achieving success, the teachers call upon the appropriate staff member to help determine the cause of the delay.

Post-Program Placement

When a child leaves AECSE, (due to age, parents moving, or failure to meet eligibility criteria) another in-depth evaluation is performed by the assessment team. If he leaves at the end of the year, the standard end-of-year evaluation suffices. The Program ARD Committee meets to evaluate the data from the

assessment and makes a written recommendation for the child's placement after dismissal. The child's parents are then called in for a conference and informed of the decision of the ARD Committee. If the child is to be dismissed from special education entirely, the parent conference may be the last formal contact the parents have with the Austin Independent School District Special Education program unless problems appear after dismissal. After the parent conference and dismissal from special education, the child's folder is placed in the inactive files.

If the child is to be placed in another special education program within AISD or in another program for handicapped children in the community, all reports from the assessment team are forwarded to the AISD Central Admission, Review, and Dismissal Committee. The Central ARD Committee makes a placement decision based on this information, presented in the form of a summary psychological report containing all relevant psychological information as well as summaries of the findings of members of the assessment team. This committee has the ultimate determination of a child's placement after leaving AECSE.

In summary, the gathering of information during the referral, screening, program definition, program implementation, and program evaluation phases is an ongoing, continuous process. All members of the assessment team are involved--

teachers, therapists, parent coordinator, program supervisor, and educational diagnostician, the latter coordinating the team's activities. The educational diagnostician and program supervisor evaluate the assessment data gathered during the referral and screening phases. The assessment data is evaluated in a team setting during the program definition, implementation, and evaluation phases. The biweekly staffing meeting is the means to monitor a child's progress and to determine when the assessment team needs to re-evaluate the child.

Recommendation for diagnostic placement in the program is made by the educational diagnostician at the end of the screening phase. Decisions about the child's formal placement in the program are made by the assessment team during the program definition phase. A review of a child's placement within a particular classroom in the program is always in order and may be requested by any member of the assessment team. A parent conference is called after any change of placement decision has been made.

While time consuming, a team effort is the most effective method of ensuring that all the needs of the child are being met. Figures 1 and 2 illustrate the flow of children through the program in terms of the assessment data collected on them.

FIGURE 1

FLOW CHART FOR ASSESSMENT

AND EVALUATION

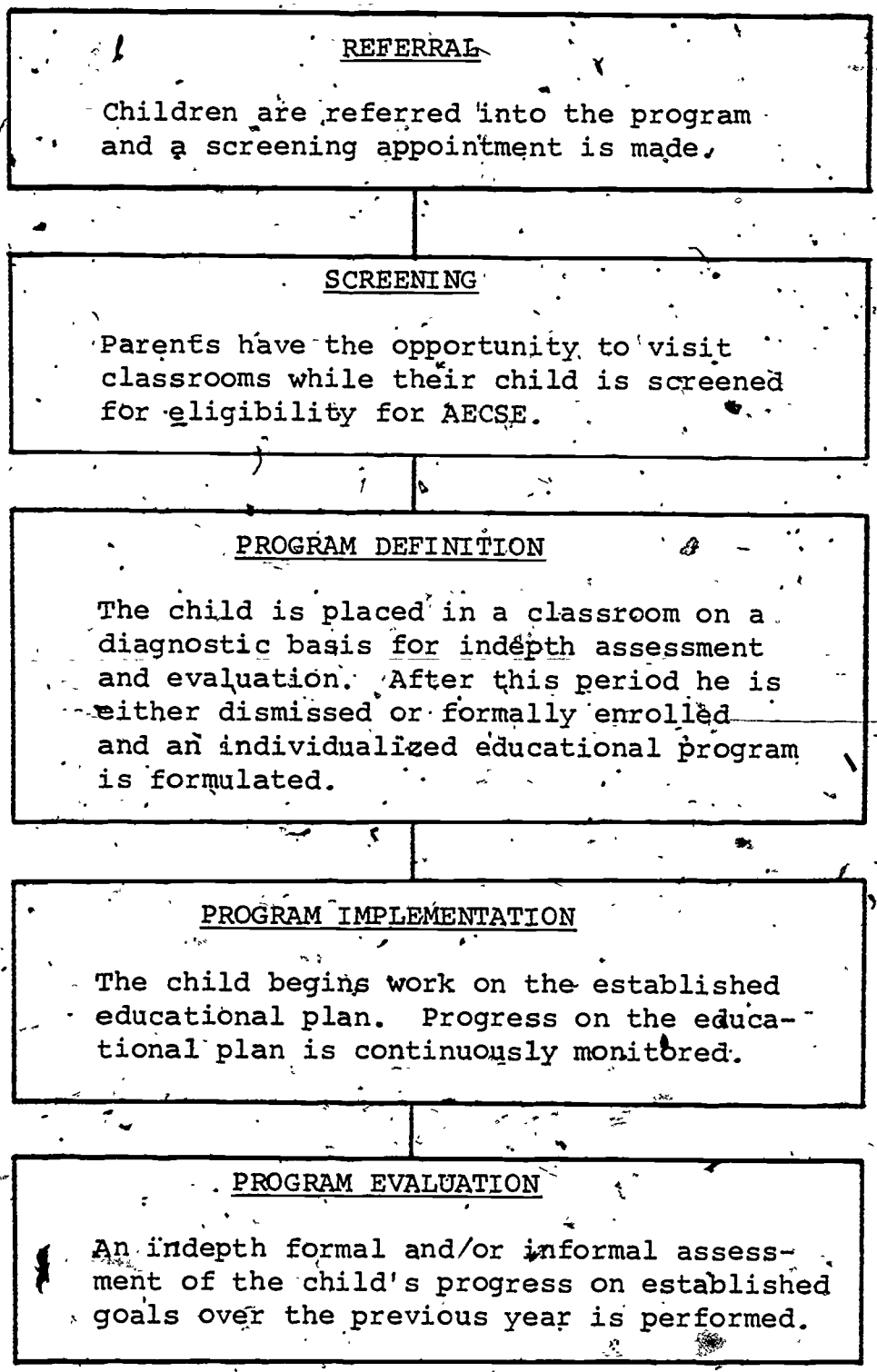

FIGURE 2

ASSESSMENT ACTIVITIES, DECISIONS, AND PARTICIPANTS

REFERRAL

Assessment Activities: Complete the referral form.
Decision Reached: Should a screening appointment be made?
Participants: Educational Diagnostician, Project Supervisor

SCREENING

Assessment Activities: (1) Observation of the child with parents, other adults, peers, and at play, (2) Administration of formal screening instruments.
Decisions Reached: (1) Should the child be placed in the program on a diagnostic basis?, (2) Should the child be referred to another program or agency?
Participants: Educational Diagnostician, Project Supervisor, Therapists

PROGRAM DEFINITION (DIAGNOSTIC PLACEMENT)

Assessment Activities: Formal and informal assessment of the child by all members of the assessment team; formal ARD staffing on the findings and the assessment results.
Decisions Reached: (1) Should the child be officially placed in AECSE or be referred to another program? (2) Should the child's classroom be changed if the child remains in AECSE?
Participants: Educational Diagnostician, Project Supervisor, Speech Pathologist, Occupational Therapist, Classroom Teacher

PROGRAM IMPLEMENTATION

Assessment Activities: (1) Continuous monitoring of the child's progress on individual goals, (2) Further formal or informal assessment is performed as needed.

Decisions Reached: (1) Should the established educational plan be modified? (2) Should the child be referred for exit from AECSE due to progress or age?

Participants: Educational Diagnostician, Project Supervisor, Speech Pathologist, Occupational Therapist, Classroom Teacher.

PROGRAM EVALUATION

Assessment Activities: (1) Evaluation of progress made on educational goals and objectives, (2) Indepth, formal and informal assessment by assessment team, (3) Formal ARD staffing on findings.

Decisions Reached: (1) Should child be referred out of AECSE to another agency or program? (2) Where should placement be recommended if child is to leave AECSE?

Participants: Educational Diagnostician, Project Supervisor, Speech Pathologist, Occupational Therapist, Classroom Teacher.

Appendix A

AUSTIN INDEPENDENT SCHOOL DISTRICT
Department of Special Education
ADMISSION, REVIEW, AND DISMISSAL COMMITTEE

_____
School

_____ _____
Name Birthdate

Recommendation: _____

_____

_____

_____

Transportation: Needed_____ Not needed_____

Committee:

Name	Position
	Administration
	Appraisal
	Instruction
	Sp.Ed.Supervisor

_____
Meeting Date.

REFERRAL FORM - EARLY CHILDHOOD

Taken by: _____ Referred by: _____ Date: Year ___ Mo. ___ Day ___

Child's Name: _____ Sex: ____ DOB: ___ ___ ___
Last First Mid.

CA: ___ ___ ___

Type of disability and reason for referral: _____

_____

_____

Child's daytime location: _____

Parent/Guardian's Name:

Male: _____ Relationship to Child: _____

Female: _____ Relationship to Child: _____

Home Address: _____ Phone: _____
Street city zip

Work Address: (FA) _____ Phone: _____

(MA) _____ Phone: _____

What is the major language spoken in the home? _____

In what language is the child most fluent? _____

What services (medical, S.T.,O.T.,P.T.,educational) has the child previously received?

What and Where	When	By Whom

Parent aware of referral: Yes: ____ No: ____ Registration packet sent: (date) _____

Date seen for screening: _____ Status: Accepted _____ Rejected _____

If rejected, why? _____

Parents notified: Yes: ____ No: ____ By Phone ____ Letter ___ in person ____

General Comments: _____

Screening Information

Description of the child: _____

Comments by parents: (M or F) _____

Demonstrated Language Ability of the child: _____

Demonstrated Cognitive Ability of the child: _____

Demonstrated Motor Ability: _____

Social/Emotional behavior demonstrated: _____

Estimated teaching level: _____

Comments and Status: _____

AUSTIN INDEPENDENT SCHOOL DISTRICT
Department of Special Education

MEDICAL-PROFESSIONAL RELEASE

Many times it is necessary for us to contact doctors, clinics, schools, or other persons for information concerning your child that might be of assistance in evaluating and planning for him. Sometimes we find after working with your child that a communication with your physician or other professional persons who have worked with him/her in the past will help us to understand the child's problem and approach to learning. This in turn will be reflected in a better learning situation. Your signature on the following release form will give us your permission to ask for this information.

Thank you.

T. R. Hinojosa, Director
Department of Special Education

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RELEASE:

I, _____, do hereby give my consent for the release of any diagnostic and prognostic information to the Director of Special Education of the Austin Independent School District concerning _____.
Child's Name

_____ _____
Date Relationship to child

AUSTIN INDEPENDENT SCHOOL DISTRICT
EARLY CHILDHOOD SPECIAL EDUCATION
Parent Information and Registration Form

Confidential Information

PLEASE NOTE: The information requested below is considered to be essential for planning a program which will best meet the needs of your child. Care should be taken to ensure that all questions are answered as accurately as possible.

This information will be kept confidential and is subject to all laws concerning the privacy of the individual and the confidentiality of information. The following persons will have access to this information: All persons working directly with your child (i.e., teachers, administrators, appraisal personnel). Except for your name, address, and phone number, all persons not working for Austin Independent School District must have your consent before any other information on this form will be released.

Child's Name _____ Birthdate _____

Ethnic Background _____ Male ____ Female _____ Age _____

Mailing Address _____ Telephone _____
(street)

_____
(city) (county) (state) (zip)

Lives with (name) _____ Relationship _____

Address if different from above _____

Father's Occupation _____ Mother's Occupation _____

Work Address _____ Work Address _____

Work Phone _____ Work Phone _____

Who referred you to our program? _____

Is the child adopted? ____Yes ____ No Adopted at what age? _____

List all those living in the home by name, including the parents:

Name	Age	Relationship	School	Grade	Occupation

THE CHILD'S PROBLEM

What is the child's problem or handicap as you understand it?_____

_____

_____

When did you first feel that something was different about your child?

_____

Who diagnosed the problem of handicap? Date_____

Name _____ Position or relationship _____

Address _____ Telephone _____

What was the medical diagnosis?_____

Is the child on medication NOW? ____ Yes ____ No If so, what type?_____

_____ To be administered during school? ____Yes ____No

Has the child been on medication in the past? ___Yes ____No If so, what type?_____

Have people outside the family noted the problem?_____

Is he teased or ridiculed because of his problem?_____

If he has any food allergies, please list food(s): _____

_____ AND describe reaction:_____

Is there any reason whatsoever that your child's physical activity should be limited? Yes____ No____. Please explain if yes:_____

Please indicate any medical reasons or health reasons that may cause absences from school or may interfere with your child's progress in class:

_____

_____

DEVELOPMENTAL HISTORY

1. Pre-natal: What was the mother's condition during the time she carried the child?_____ If any difficulties occurred, please note:_____

_____

Length of Pregnancy: Full term ____ Premature ____

Months _____

2. Delivery: Normal ____ Prolonged ____ Hold back delivery _____

"Pop" delivery ____ Weight of child ___ Length ____

3. Post-delivery: Did the mother have any unusual post-delivery surgery?_____

Did the child receive any unusual medical attention?

_____

Attending physician_____

Hospital _____

4. Post-Natal: If you kept records or can recall, please put the age at which child developed. If not, circle normal, slow, fast compared with other children in family.

Sat alone_____	Normal Slow Fast	compared with other children
Crawled _____	Normal Slow Fast	compared with other children
Walked alone _____	Normal Slow Fast	compared with other children
Said single words _____	Normal Slow Fast	compared with other children
Made sentences_____	Normal Slow Fast	compared with other children
or phrases_____	Normal Slow Fast	compared with other children
Got first tooth_____	Normal Slow Fast	compared with other children
Toilet trained_____	Normal Slow Fast	compared with other children
Bowel_____	Normal Slow Fast	compared with other children
Bladder_____	Normal Slow Fast	compared with other children
Night_____	Normal Slow Fast	compared with other children

How much does the child talk now?_____

How much of this speech can mother understand?

All_____ Most _____ Some_____ None _____

How much can other adults understand?

All_____ Most_____ Some_____ None_____

How much does the child use gestures to help others understand?

_____

Has the child learned to say nursery rhymes?_____ Sing songs?_____

Have the parents done anything to help the child with his speech?_____ If so, what?_____

Did the child have any difficulty with sucking? _____

Swallowing? _____ Chewing?_____. Does the child drool?_____

Was the child very quiet as a baby (did not babble and coo as much as most babies)? _____

Is he toilet trained? Totally _____ Partially____ Not at all_____

Is he on a schedule? _____ If so, what _____

Which of the following behavior were or are frequent problems:

Column # 1	Past Concern	Present Concern	Column # 2	Past Concern	Present Concern
Whining			Shyness		
Fighting, hitting			Sensitiveness		
Excessive crying			Irritability		
Quarreling with siblings			Listlessness, inaction		
Hair pulling			Competitiveness		
Thumb sucking			Aggressiveness		
Undue demand for attention			Fearfulness		
Masturbation			Day dreaming		
Nose Picking			Awkwardness		

Nail Biting			Phobia (fear of certain persons, places, things)		
Head banging					
Spitting					
Bites self			Destructiveness		
Bites others			Excitable		
Screams			Nervousness		
Destroys or damages toys and household items			Other (explain details)		
Running in the house					
Playing in the street					
Throwing tantrums					
Rocking back and forth					
Other (give details)					

Which three problems ~~in column #1~~ concern you the most?

1. _____ Why? _____
2. _____ Why? _____
3. _____ Why? _____

Which three problems in column #2 concern you the most?

1. _____ Why? _____
2. _____ Why? _____
3. _____ Why? _____

Family

Is any other language than English spoken in the home? _____ If so, What? _____

Has anyone else in the family had a disability or handicap? (Physical, or mental handicap, learning problem, hearing loss, heart murmur, psychological problem, etc.)

_____

_____

_____

Has the child ever been separated for periods of time (long or short) from his mother?_____ father?_____ Give details:_____

How did he adjust? Comments:_____

Do you feel that this child takes more time than most children?_____

When it is time to discipline him, who usually is responsible?_____

What methods do you use to correct the child?_____

In general, do mother and father agree on child rearing process?

Yes_____ No_____ Please explain:_____

Siblings and playmates

Does the child show any signs of jealousy of any siblings? Yes____ No____

Please explain:_____

With whom does he prefer to play? Brother___ Sister ___ Playmate ___
What age?_____

What activities, toys do they prefer when they are together?_____

When your child is alone, what does he prefer to play with?_____

In what ways do you feel that this preschool placement may help your child?_____

_____

_____

Is there anything else you feel we should know about the child?_____

_____

_____

_____ _____

Date (Signature of parent or guardian)

AUSTIN INDEPENDENT SCHOOL DISTRICT
Department of Special Education

MEDICAL REPORT FOR SPECIAL EDUCATION PROGRAM

NAME_____ SEX_____ BIRTHDATE_____

PARENT'S NAME_____ STUDENT'S SCHOOL_____

ADDRESS_____ PHONE_____

MEDICAL HISTORY (TO BE OBTAINED FROM PHYSICIAN)

I. PRENATAL AND BIRTH (Information supplied by attending physician, not from mother)

A. Length of pregnancy _____

B. Complications of pregnancy _____

C. Length of labor _____

D. Type of delivery _____

E. Complications of delivery _____

F. Condition at birth _____ Wt. _____ Length _____

G. Other _____

II. DEVELOPMENTAL HISTORY (Approximate age at which each item was well established)

A. Rolled over _____

B. Sat without support _____

C. Walked without support _____

D. Used single words _____

E. Used full sentences _____

F. Bowel and bladder control _____

III. HISTORY OF IMMUNIZATIONS AND TESTS (Enter dates received)

A. Small pox _____ Results _____

B. DPT _____ Booster _____

C. DT _____ Booster _____

D. Polio Sabin _____ Booster _____

E. Measles (Live) _____

F. Mumps _____

G. Tuberculosis Test _____ Results _____

H. Other _____

IV. PAST MEDICAL HISTORY (Enter age and any complications)

A. Diphtheria _____ H. Convulsive Disorder _____

B. Whooping Cough _____ I. Operations _____

C. German Measles _____ J. Any high persistent fever _____

D. Measles _____ K. Congenital defects _____

E. Chickenpox _____ L. Asthma _____

F. Rheumatic fever _____ M. Other _____

G. Mumps _____

V. PREVIOUS HOSPITAL ADMISSIONS? _____

_____

VI. PREVIOUS DIAGNOSTIC EVALUATION? _____

_____

VII. IS THE CHILD ON ANY MEDICATION AT THE PRESENT TIME? Yes ____ No ____

If yes, please give name of drug and dosage _____

_____

PHYSICAL EXAMINATION

1. GENERAL

Height _____ Weight _____ Temperature _____ Pulse _____

Blood pressure _____

II. EYES

Visual acuity: Right_____ Left_____

Is an ophthalmological examination needed?_____

Please describe any condition of the eyes that would affect this child's capacity to learn_____

_____

Other_____

III. MOUTH AND THROAT

Condition of teeth_____

Abnormality of tongue or palate?_____

Other_____

Please describe any anomaly of mouth, etc,, which would affect his ability to speak normally _____

IV. EAR

Evidence in middle ear of mastoid disease?_____

Please describe any condition of the ears which could affect his ability to learn _____

Is an audiogram indicated?_____

V. ABDOMEN

Scars_____

Masses_____

VI. CIRCULATORY SYSTEM

Heart: Normal _____ Abnormal _____ Describe_____

_____

Limitations on activities?_____

VII. URINARY TRACT & BOWEL FUNCTION

Please describe any abnormality which would affect bladder and/or bowel control.

_____

VIII. MUSCULOSKELETAL SYSTEM

Essentially normal _____ Abnormal _____ Please describe any abnormalities: _____

_____

IX. NERVOUS SYSTEM

Cranial Nerves _____

Motor Abnormalities:

Gait _____
Station _____
Involuntary movement _____
Tremor _____
Spasticity _____
Rigidity _____
Muscle Tone or atrophy _____
Coordination _____
Articulation _____

Sensory _____
Reflexes: Right _____ Left _____

Aphasia _____

Apraxia _____
Brain Damage ( ) Definitely present ( ) Possibly present
( ) Not present ( ) No physical evidence but psychometrics testing suggest brain damage.

X. DIAGNOSIS: _____

_____

XI. RECOMMENDATIONS:

Classes for Mentally Retarded: ( ) Educable ( ) Trainable

Classes for Physically Handicapped: ( ) Vision ( ) Orthopedic ( ) Hearing ( ) Brain Inj.

( ) Classes for Emotionally Distrubed: _____

( ) Referred to following physicians: _____

XII. COMMENTS: _____

_____

XIII. IS OCCUPATIONAL THERAPY INDICATED FOR ANY ONE OF ALL OF THE FOLLOWING CATEGORIES?

( ) Self help ( ) Fine motor coordination ( ) Gross motor development ( ) Perceptual motor testing and remediation

_____
Physician's Signature

_____
Date

Please return to:

Department of Special Education
Casis - Early Childhood
2710 Exposition Blvd.
Austin, TX 78703

Austin Independent School District
Early Childhood Special Education

Community Service Record

The Early Childhood Program needs detailed information on services you have obtained for your child. Please list names and addresses for all services your child has received in each one of the following categories:

A. General Pediatric Care
B. Care and Evaluation from medical specialists: (eye, ear, nose, throat, dental, neurologist, orthopedist)
C. Therapy (physical, speech, occupational)
D. Counseling and psychological evaluation
E. Educational or Day Care Programs
F. Financial Assistance (Commission for the Blind, Crippled Children, Medicaid, etc.)
G. Other:

Type of Service	Name/Address of Agency or Individual	Comments/dates, results

TESTING RELEASE

Austin Independent School District
Department of Special Education
Early Childhood

In order to determine eligibility for the Early Childhood Program, it is necessary for a psychological evaluation to be performed on all the children. In attempting to deliver the best educational opportunities for all the children, language and speech training and occupational therapy may need to be provided. Therefore, we ask you to sign the following release.

I, _____, do hereby give my consent for the performance of psychological evaluation, language and speech training, and occupational therapy to the Department of Special Education concerning _____.
(child's name)

_____ DATE

_____ RELATIONSHIP TO CHILD

Austin Independent School District
Early Childhood Special Education

We, the parents of _____ give our consent to the preparation and showing of video tapes and still photographs in which our child will appear. We understand that the tapes and pictures are for instructional purposes only, and will be shown only to the staff and within the Austin Independent School District. We hereby release the Austin Independent School District and its employees, and the University of Texas and its employees from any responsibility in showing or permitting the use of the tapes.

Date _____

Signed _____

AUSTIN INDEPENDENT SCHOOL DISTRICT
Austin, Texas

RULES AND REGULATIONS FOR PUPILS WHILE RIDING SCHOOL DISTRICT BUSES

I. GENERAL STATEMENT

The Austin Independent School District provides transportation to Eligible Pupils under a program which is jointly financed from State Funds and Local Funds. This transportation program is a permissive program in that there is no State Law that requires the district to provide transportation to any Eligible or Ineligible pupils. State Laws Texas Education Agency Rules and Regulations require that a school district electing to participate in the program must operate its school buses in an economical and safe manner. Therefore the Austin Independent School District has adopted the following rules and regulations for the safety of pupils and for efficient operation of the transportation program.

All pupils riding buses are considered to be "in the classroom" and subject to District supervision upon entering the bus on the morning run to school and until they leave the bus on the afternoon run which returns the pupils to their bus pick-up points.

II. BEFORE LOADING: (At the bus stops and at school)

1. A bus pupil must have on file in the bus he rides or in his possession an official Bus Permit card and be able to show this card when required by the bus driver or any school official.

2. Pupil must be on time at the designated school bus stop and school loading area. Promptness helps keep the bus on schedule.

3. Bus riders should conduct themselves in a safe manner while waiting for the bus. Stay off the road or driveway. Be careful while the bus is approaching.

4. Do not move toward the bus or start loading until the bus has come to a complete stop. Pupils can get on the bus much quicker if they will line up and move in a single line.

5. A bus pupil is not allowed to carry any equipment on the bus which would have to be placed in the passageway or entrance, or which would interfere with the driver or the movement of any passenger in any emergency. In this respect, safety is the prime factor.

III. WHILE ON THE BUS

1. Upon entering the bus, move to the back and be seated. Pupils are not permitted to move around on the bus while it is in motion. Be seated and remain seated throughout the trip.

2. Pupils will not be permitted to stand unless every seat in the bus is occupied to its capacity of three pupils to a seat.

3. Pupils must keep hands and head inside the bus. Do not throw, hand, or dangle anything out the windows on the bus. Such action may cause injury to pedestrians, passing vehicles, or to the pupil.

4. Help keep the bus clean by not throwing things on the floor. Check before leaving to see that you have your books, clothing, lunches, etc.

5. Rowdiness, loud talking, pushing, shoving, bad language, smoking, destruction of property, and general discourtesies toward fellow riders or the bus driver will not be tolerated and will result in strict disciplinary action.

6. The bus driver is required to report to the principal any serious misbehavior on the part of any pupil or group of pupils while riding the bus. The principal must then take such corrective or disciplinary action as is necessary to assure the safety of all pupils riding the bus. The principal's action will include temporary or permanent suspension of permits for the rider or riders involved. Bus service for the entire group will be terminated when circumstances warrant such action.

7. Pupils and parents will be required to pay for any damage to the bus or other property resulting from misbehavior on the bus.

8. Where the age span of the riders cover several grades, the older children are asked to look after the safety of the younger children.

9. The driver will not discharge riders at places other than the regular bus stops on the route or at the school unless by proper authorization from the principal.

10. In case of emergency, children are to remain in the bus unless otherwise directed by the driver.

IV. AFTER LEAVING THE BUS:

1. Be alert to the danger signals and instructions of the bus driver, especially when you need to cross the road in front of the bus.

2. Pupils not crossing the street must step back from the bus a safe distance so that the bus driver may proceed. Pupils must not run after or alongside the bus because of the danger of personal injury.

PLEASE COMPLETE THE FORM ON THE NEXT PAGE, SIGN, AND RETURN TO THE PRINCIPAL'S OFFICE OF THE SCHOOL YOUR CHILD ATTENDS.

APPLICATION FOR SCHOOL BUS PERMIT

I have read RULES AND REGULATIONS FOR PUPILS WHILE RIDING SCHOOL DISTRICT BUSES and will assist in every way possible to see that my child follows them. I hereby apply for a permit for my child to ride an Austin Independent School District School Bus.

Signature (Parent or Guardian) _____

(If the pupil is in the 4th grade or above the pupil should read the rules and sign below to indicate he or she understands them and will abide by them. For pupils in the 1st, 2nd, and 3rd grades the parent should sign both places indicating that the rules have been read to the pupil or discussed with the pupil and the pupil knows he or she must abide by them. KEEP THE RULES FOR FUTURE REFERENCE AND REVIEW.)

Signature of parent or pupil _____

Name of pupil to ride _____

Address _____

School _____ Grade _____

Home Phone Number _____ Date _____

PSYCHOLOGICAL REPORT FORMAT FOR EARLY CHILDHOOD SPECIAL EDUCATION

Below is given the psychological report format used by the Early Childhood Special Education Program and the type of information listed under each heading and subheading.

(Interum)
or Psychological Report of Individual Testing
(Summary)

CONFIDENTIAL: For Professional Use Only

Name: Date of Report: Year Month Day

Sex: Date of Birth:

Grade: Chronological Age:

Teacher: Examiners: all examiners who have worked with the child are listed by name and title.

School:

Parents:

Address:

Referral

Who referred the child and what the reasons for referral were.

Background

Social: Family data -- who lives in the home -- number of siblings, concerns of the parents about the child, child's developmental history -- any data that could clarify why the child behaves or functions at the level he/she does that could be attributed to family environment or modified by the home environment or detected by developmental history.

Medical: Results of most recent physical examination, date of exam, physician. Any pertinent medical history. Medication taken, the results of hearing, vision, and dental screening.

Previous Testing

Results and findings of any testing done by other agencies as well as diagnostic impressions, conclusions, or diagnoses.

Current Testing

A list of all tests administered at AECSE by the examiners listed on page one. Scores obtained by the subjects are included.

Test Behavior and Clinical Observations

Description of subject's behavior during testing, stressing any behavior that would lower scores obtained by subject. Reports of clinical findings -- hand dominance, method of attack on structured items (block patterns, manipulative tasks), language dominance, behaviors that may indicate problems (bending low over pictures--possible vision problem, giving vocabulary definitions for words which sound much like the cue word given (car vs. bar)--possible auditory discrimination problem, etc.)

**Classroom Teacher Report:

Professional observations on child's behavior in the classroom as reported by the teacher, which includes relative strengths and weaknesses in: social/emotional behavior, general classroom functioning, self-help skills, language skills, and academic skills.

Test Results and Implications

A written report of scores obtained on each test administered and the implications of the obtained scores for classroom and general school functioning.

**Speech Pathologists's Report:

Summary of the findings by the Speech Pathologist in Speech and Language testing; implications and recommendations.

**Occupational Therapist's Report:

Summary of the findings by the Occupational Therapist's evaluation; implications, recommendations.

**Physical Therapist"s Report:

Summary of findings by the Physical Therapist's evaluation; implications and recommendations.

Summary

Summary of all pertinent findings by all examiners mentioned in the body of the report. A statement about the child's eligibility for special education services and label.

Recommendations

Recommendations made from data given above, including placement, services needed, and educational plan.

**May not be included in an Interum Psychological Report; always in a summary report.

CHILD DIAGNOSTIC SUMMARY SHEET

School Year _____ to _____

Child's Name: _____ Date of Birth: _____

Ethnicity: _____ Language Dom: Eng. _____
Sp. _____
None _____

Date of Entrance: _____ Date of Exit: _____

ARD Classification: _____ Date of ARD Meeting: _____

Medical Diagnosis and/or comments: _____

_____

_____ Physician: _____ Date: _____

List any medication taken and reasons: _____

_____

Indicate Therapies needed: ST___ OT___ PT___ Behv. Mngt.___

Summary of Psychological Testing and/or Observations: Examiner: _____

If tests not approved, justify use of unapproved test.

Date: _____

Summary of Speech and Language Testing and/or Observations:

Examiner: _____ Date: _____

Summary of Occupational Therapy Testing and/or Observations:

Examiner: _____ Date: _____

Summary of Physical Therapy Testing and/or Observations:

Examiner: _____ Date: _____

Summary of Classroom Teacher Testing and/or Observations:

Teacher: _____ Date: _____

Relative Strengths:

Relative Weaknesses:

Summary of Behavior Management Program if needed:

AUSTIN INDEPENDENT SCHOOL DISTRICT
EARLY CHILDHOOD SPECIAL EDUCATION

EDUCATIONAL PLAN

Date

Student: _____ Birthdate: _____

Teacher: _____ School: _____

Planners: _____

1. Present Status and Description of the Child: (see page 2)
   A. Presenting Problem;
   B. Physical appearance and Outstanding Characteristics;
   C. Typical Classroom Behavior

2. Basic Instructional Level:

3. Estimated Rate of Learning:

4. Relative Strengths:

5. Relative Weaknesses:

6. Best Learning Modality:
   Input:

   Output:

Evaluation Key: Use dates to mark evaluation boxes on goals and objectives

A = Objective 100% completed -- spontaneously exhibited and generalized to other context

B = Objective 100% completed -- exhibited in structured situations only

C = Exhibits behavior 80% or more of the time

D = Exhibits behavior 50% or more of the time

E = Exhibits behavior 50% or less of the time; objectives not attempted (NA); objectives appear inappropriate (I); or objectives may be too advanced (please note which).

Present Status and Description of the Child

A. Presenting Problem:

B. Physical Appearance and Outstanding Characteristics:

C. Typical Classroom Behavior:

Language Goals and Intermediate Objectives

	Rating				
	A	B	C	D	E
1. Language Goal:					
Intermediate Objectives:					
1.					
2.					
3.					
4.					
2. Language Goal:					
Intermediate Objectives:					
1.					
2.					
3.					
4.					

COMMENTS:

Cognitive Goals and Intermediate Objectives

	A	B	C	D	E
1. Goal:					
Intermediate Objectives:					
1.					
2.					
3.					
4.					
2. Goal:					
Intermediate Objectives:					
1.					
2.					
3.					
4.					

COMMENTS:

Psychomotor-Perceptual Goals and Intermediate Objectives
(also includes Self-Help Skills)

	A	B	C	D	E
1. Goal:					
Intermediate Objectives:					
1.					
2.					
3.					
4.					
2. Goal:					
Intermediate Objectives:					
1.					
2.					
3.					
4.					

COMMENTS:

Social-Behavioral Goals and Intermediate Objectives

	A	B	C	D	E
1. Goal:					
Intermediate Objectives:					
1.					
2.					
3.					
4.					
2. Goal:					
Intermediate Objectives:					
1.					
2.					
3.					
4.					

COMMENTS:

Educational Services

Overview

The educational services component of the AECSE Program is based in the classroom and directed by the classroom teacher. Traditionally education for children is thought of as academic in nature. However, in the case of young handicapped children it is necessary that appropriate development and skill acquisition occur in all areas of their lives before academic instruction can be successfully introduced.

In programs for preschool age handicapped children the range of levels of functioning and the individual needs of children are tremendous. Younger children and older, more seriously disabled children may require a great deal of close supervision for toilet training, socialization and individual instruction. Less impaired children may not need as much close physical supervision in the classroom, but they still need much direction and guidance to aid their development to its highest potential. This guidance and direction may be for developing appropriate compensatory behavior, learning to cope with physical disabilities, learning to discriminate various sensorial stimuli or improving self-help skills.

In developing a delivery system for providing educational services, it is necessary that the needs of each child are met as efficiently as possible while maintaining as economical a utilization of adult and classroom time as possible. In designing a service delivery system

which incorporates an economical use of teacher time without sacrificing individual needs of children, it is necessary to prioritize children's needs according to a sequential pattern to development from which a system for grouping children and organizing classrooms can be developed.

The delivery system which the AECSE Program uses is based on children's levels of social functioning. The rationale for selecting social functioning levels as the criterion for classroom organization and placement is based on the belief that a child who is withdrawn and does not explore or interact appropriately with his physical and human environment cannot learn from it. Therefore, the sequential development of these skills is viewed as a basic need of handicapped children and fundamental to the development of other higher learning.

Goals and Objectives

The educational services component of the AECSE Program attempts to provide a realistic, successful learning experience for each child served. The needs of the children in the program are numerous and diverse, thus individualization becomes imperative. Specific objectives for the educational services component are:

1. To provide a classroom placement for the child which is suited to his developmental level.

2. To provide a classroom organization and schedule which is stimulating to the child and at the same time promotes relevant learning experiences.

3. To utilize a curriculum structure within the classroom which allows individualization and provides each child with experiences in a variety of curriculum areas.

4. To frequently review each child's progress and share relevant information with other staff members who work with the child in order to ensure an effectively integrated, comprehensive school program.

Classroom Placement

Classroom placement in the AECSE Program is organized according to developmental levels, of which the program recognizes four basic divisions. These classifications have been modified from a series of social functioning levels developed by Dr. Ernest A. Gotts, formerly of the University of Texas at Austin Early Childhood Special Education Program.

Division I: Self-Involved Child

This child can either be withdrawn or overly active. He demonstrates little or no planned exploration, appropriate initiation of activities, imitation abilities, or appropriate use of materials. He also does not approach or respond to adults or peers, and has little or no eye contact with others. He may frequently wander aimlessly, and often engages in repetitive activities or random behavior.

His self-help skills are usually poor. He can benefit from toilet training and self-feeding programs. Both his receptive and expressive language skills are very poor or may even be nonexistant. He is unable to attend to teacher selected tasks unless he is in a one-to-one situation with the teacher. He cannot benefit from peer modeling.

Division II: Annoying, Disruptive, or Clinging Child

This child may be overly active or overly passive. The passive type clings to adults, does not relate appropriately to adults or peers, is usually a non-verbal communicator, and does not imitate the actions of others.

The active type engages in frequent conflict with other children. Under adult direction he frequently refuses to appropriately explore, approach and respond to children or to follow directions. This child may

talk at people rather than with them.

This child's pre-academic skills are usually poor as are his fine and gross motor skills. Some minor problems with toilet training may still be present. He does not use language to communicate on a mutual basis, but only to express his needs, although his language skills may not be entirely adequate to express his needs and desires.

This child needs a great deal of one-to-one attention, but is capable of learning from a peer model in all areas.

Division III: Beginning Small Group Capability

This child requires much adult help to function in the classroom but he is able to explore, initiate activities, and imitate others. He is basically a verbal communicator. He is able to sit still for approximately 10 minutes if interested. He is beginning to accept limits and routines.

This child's self-help skills are fairly good. His pre-academic skills are capable of being developed. He is able to sit in a group of three to five children and benefit from the activity presented. With adult help he can take turns in activities. He will be able to express his needs and desires verbally in most cases. His fine and gross motor skills are relatively good.

Division IV: Beginning Large Group Capability

This child behaves in a socially appropriate manner in most classroom situations. He is able to attend to the task when in a group of eight or more children and can benefit from the activity. He can take turns and postpone gratification of desires for longer perids of time.

This child's pre-academic skills are close to the level of a beginning kindergarten student. Except for conditions created by his disability, his self-help skills are adequate in all situations and his fine and gross motor skills are good. He can be sent alone on short duties out of the classroom. His language skills are appropriate to those of a beginning kindergartener in most cases.

Within AECSE, developmentally young children (division I) who need much general supervision, individual instruction, and a low degree of stimulation, are placed into classrooms together. These classrooms have fewer children (eight or nine) and more adults (three or four) than other classrooms. Children who are developmentally more capable (division IV) are grouped together into larger classrooms (16 to 22) with a higher adult-child ratio (1:4 or 1:5). The remaining children (divisions II and III) are intermixed in classrooms of 14-16 children with four adults. These classrooms are carefully balanced between active and passive children, and between children with relatively higher and lower academic and social abilities.

There are some exceptions to the overall placement plan. Two major exceptions are the auditorially and visually handicapped children. These children require training from teachers who have specialized skills in dealing with these types of problems. Therefore, visually handicapped (or auditorially handicapped) children are usually grouped together in one classroom along with other children in the program. In this way, they can be under the supervision of a teacher who has special training in their area, and consultation by other experts can be provided to this teacher as necessary.

Other exceptions to the overall grouping theory are based on the individual needs of the child. As no child will meet all the criteria for each division, social skills usually take precedence over academic skills when determining placement. For example, a child who meets all the social skills necessary for placement in the division IV classification but is totally non-verbal due to his specific handicap, will probably be placed in the division IV classroom although his expressive language skills do not match the other children in the room. Although he cannot speak, his understanding of language is excellent, he socializes well with the other children on a non-verbal basis, and is capable of learning the material presented by the teachers. While his language expression is at the division I level, he would be grossly misplaced at that level.

Another example of deviation from the overall grouping theory would be an orthopedically impaired child whose self-help skills and gross and fine motor coordination are very poor. If he exhibits all the social skills for the division IV classification, but needs a great deal of individual attention from the teacher because of his orthopedic impairment, he would probably be placed in the division IV room. Again, he is capable of benefiting from the academic material presented as his social skills are good; he has a good attention span,

can take turns in a large group situation, can postpone gratification of desires, etc.

A child whose preacademic skills, language, self-help skills and gross and fine motor skills indicate he should be placed in a division IV classroom may not be placed in that type classroom. If his social skills are such that he cannot attend to and benefit from material presented in a large group situation, if he has difficulty accepting limits and routines, and if he frequently does not follow directions he will probably be placed in a classroom with division II and III children. In this setting, he can have more one-to-one attention, and an effective behavior management program can be more easily implemented. As his preacademic skills are probably more advanced than the other children in the room, the teacher will have to individualize his program to meet his needs in this area. When his social skills develop to the point that he will be able to progress in the division IV classroom, his classroom placement will be reconsidered and he will most likely be moved to that setting.

A final factor which is considered in determining classroom placement is the number of children having physical problems which require a great deal of attention who are placed in a given class. Care must be taken to avoid overburdening teachers

with such children and thus detracting from the education of the other children in the class. While such individual exceptions do occur in classroom grouping, the overall divisions described above work very well for determining classroom placements.

Classroom Organization and Schedule

The organization of each classroom is planned by the classroom teacher or teaching team. Each classroom is designed with various learning centers around the room. These centers might include block or construction toys, manipulative, listening, library, art, language, fine motor or imaginative play centers. Each center is stocked with materials appropriate to the levels of children in the classroom.

Schedules in each classroom are planned according to children's needs and their levels of functioning. Most classroom schedules include time for large and small group activities, individual instruction, free play, structured play in learning centers, and outside play, as well as lunch, toileting and a short rest period.. The length of time allotted to the structure (individual, large or small group) and the type of activities is dependent on the children in each classroom -- their needs and abilities.

Children in the program attend classes from 8:30 a.m. until 1:00 p.m. Teachers and aides begin working at 7:45 a.m. and leave at 3:45 p.m. The time before children arrive is the mornings is used by the teachers to prepare the classroom for the day. The time after children leave is used for planning, staffings, parent conferences, home visits, and inservice training programs.

Curriculum

The AECSE classrooms utilize dual curricula. The first part of the classroom curricula is the individual educational plan for each child. The second part of the curricula is the overall framework around which planning for group and individual activities are made.

The individual educational plans or curricula are written by classroom teachers. These educational plans are developed from the data collected during the assessment process. This data forms the baseline of behavior and performance against which progress is evaluated.

Educational plans cover a three month period. Each consists of three or more long range goals in the combined areas of social-behavioral skills, language development, cognition, and perceptual-psychomotor (including self-help) skills. The long range goals are supported by sequential behavioral objectives which form the

task analysis of the goals. In turn these objectives are broken down further into subobjectives which are written on a weekly basis. The weekly objectives are the focus of daily classroom activities.

At the end of each week these objectives are evaluated and summaries of children's progress are written. Future planning is based on children's performance on past objectives. At the end of the three month period an evaluation and summary are written on the educational plan and the plan is revised for the next three months.

The general classroom curriculum is the framework within which all classroom activities are planned. These curricula may vary from classroom to classroom depending on the functioning levels of the children in each class. They will generally include story time, music activities, gross and fine motor activities, games and playtimes.

AECSE has selected two curriculum guides which teachers can use as resources from which to plan individual and classroom curricula. They are the Chapel Hill Training - Outreach Project Guide - A Planning Guide for Preschool Curriculum - The Child, The Process, the Day and Upper Peninsula Program, Delta School-craft ISD, Escanaba, Michigan.

Progress Review and Sharing Of Information

Providing an effectively integrated, comprehensive service program for handicapped children is dependent on communication of staff members who are involved in each of the service components and on the successful coordination of services children are receiving. Regular communication among staff members and coordination of services is provided for in a structured situation called staffing.

Staffings are held biweekly in each classroom. At these meetings teachers, educational diagnosticians, therapists and/or other staff members review children's progress, exchange new information, suggest measures to facilitate progress, and discuss problems and needs of children.

Staffings on particular children are initiated by classroom teachers. Teachers maintain a rotating schedule so every child is staffed periodically. Names of children who are to be staffed are posted by teachers in the program office so support staff members can begin preparation. Preparation for staffing involves observation of children in the classroom by support personnel and review of educational plans and weekly objectives.

During the staffing one teacher is designated as the meeting director. A second person is responsible for recording information

presented by staffing participants (see Staffing Form in Appendix B). Staff members who have had contact with the child report testing results, observations, and assessments of progress in the classroom and/or therapy. Specific recommendations may be made as to a child's needs, new techniques to be tried, or modification of a child's individual program.

All recommendations are reviewed at the next classroom staffings to assess their success. If necessary, recommendations may be modified. In addition, there may be specific problems requiring special observation. Results of staffing recommendations or, in some cases, the need for more information are routinely followed up at subsequent staffings.

Appendix B

Staffing Form

Child's Name _____ Date _____

Teachers _____ Recorder _____

Information covered at staffing.

____ Home visit or contact

____ assessment or testing

____ support staff information

____ Therapists

____ teacher information

____ classroom problems

____ .....

Purpose (State main focus of discussion)

Reports (List information provided by participant, i.e. source)

Recommendations (report verbatim)

Follow-up (Give date)

The project presented or reported herein was performed pursuant to a Grant from the United States Office of Education, Department of Health, Education and Welfare. However, the opinions expressed herein do not necessarily reflect the position or policy of the United States Office of Education; and no official endorsement by the United States Office of Education should be inferred.