

Pection B:

SPECIAL EDUCATION PROGRAMS AND RELATED SERVICES



Pre-Elementary Education Longitudinal Study

Elementary School Teacher Questionnaire

Dear Education Professional:

Your school district is participating in an important U.S. Department of Education study called the Pre-Elementary Education Longitudinal Study (PEELS). The child named on the label is one of more than 3,000 children nationwide who are taking part in PEELS. This questionnaire is the only source of information about this child's special education and related services. Because of this, your participation is vitally important.

Please complete Section B of this questionnaire and return it in the self-mailer within 3 weeks. To use the self-mailer, simply fold the questionnaire in half, affix the seal to secure it, and drop it in your mailbox. Be assured that your answers will be confidential, and no information will be reported that identifies you, this child, or this school.

In completing this questionnaire, you may need to refer to the child's most recent Individualized Education Program (IEP). If you have any questions about the study or the questionnaire, please feel free to call the PEELS toll-free hot line at 1-888-534-8348, send an email to *questions@peels.org*, or visit the PEELS web site at *www.peels.org*.

Thank you in advance for your contribution to this very important study.

Sincerely

Elaine Carlson

Project Director, PEELS

Call the PEELS toll-free hot line: 1-888-534-8348

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1850-0809. The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. **If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:** U.S. Department of Education, Washington, D.C. 20202-4651. **If you have comments or concerns regarding the status of your individual submission of this form, write directly to:** National Center for Special Education Research, Institute of Education Sciences, U.S. Department of Education, 555 New Jersey Ave., NW, Washington, D.C. 20208.

OMB Control # 1850-0809, Expiration date: 1/31/08

Section B:

SPECIAL EDUCATION PROGRAMS AND RELATED SERVICES

REMINDER: "This child" refers to the child whose name appears on the label.

B1. \	What	are th	iis chil	d's d	lisabilities?
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PLEASE

CHECK ALL THAT APPLY IN COLUMN A.

PLEASE J CHECK ONE PRIMARY DISABILITY IN COLUMN B.

	A All disability categories applicable to this child Check all that apply	B This child's primary disability category Check one
a. Autism	01 🔾	01 🔾
b. Deaf/blindness	02 🔾	02 🔾
c. Deafness	03 🔾	03 🔾
d. Developmental delay	04 🔾	04 🔾
e. Emotional disturbance/behavior disorder	05 🔾	05 🔾
f. Hearing impairment	06 🔾	06 🔾
g. Learning disability	07 🔾	07 🔾
h. Mild mental retardation	08 🔾	08 🔾
i. Moderate/severe mental retardation	09 🔾	09 🔾
j. Multiple disabilities	10 🔾	10 🔾
k. Orthopedic impairment	11 🔾	11 🔾
l. Other health impairment	12 🔾	12 🔾
m. Speech or language impairment	13 🔾	13 🔾
n. Traumatic brain injury	14 🔾	14 🔾
o. Visual impairment/blindness	15 🔾	15 🔾
p. Other (Specify:)	16 🔾	16 🔾
q. Not sure	98 🔾	98 🔾

B2. Does this child use any medical devices that require school staff attention during any part of the school day? (Medical devices could include suctioning equipment, oxygen, catheters, etc. Do not include nonmedical devices such as communication devices, electronic equipment, etc.) PLEASE CHECK ONE.

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ВЗ.	Who participated in the most recent IEP or 504 plan development or review for this child? PLEASE CHECK ALL THAT APPLY.
	o1 O a. Regular education academic subject teacher(s)
	o2 O b. Regular education vocational teacher(s)
	os O c. Special education teacher(s)
	o4 O d. School administrator (e.g., principal, special education director, program coordinator)
	of O e. School counselor or psychologist
	of . Related services personnel (e.g., speech therapist, physical therapist, nutritionist)
	o7 O g. Parent/guardian(s)
	08 O h. Child
	09 O i. Staff of outside service agency or outside consultant
	10 O j. Advocate
	11 O k. Other (Specify:)
	98 O l. Don't know
B4 .	For this school year, what are the three most important IEP goals for this child? PLEASE CHECK UP TO THREE.
	on O a. Not applicable—the child does not have an IEP. \rightarrow Go to Question B7
	02 O b. Improve overall school readiness
	os O c. Improve academic performance in a specific area:
	04 O d. Improve social skills
	os O e. Improve appropriateness of general behavior
	of O f. Improve adaptive behavior or self-help skills
	of O g. Improve speech/communication skills
	08 O h. Improve fine motor skills
	09 O i. Improve gross motor skills
	10 O j. Other (Specify:)
	98 O k. Don't know
B5 .	Which of the following best describes the amount of progress this child has made in
	this school year with regard to the goals specified in the IEP? PLEASE CHECK ONE.
	This child has made:
	1 Much more progress than expected
	2 O More progress than expected
	3 As much progress as expected
	4 O Less progress than expected
	5 Much less progress than expected
	8 O Don't know

В6.	In which of the following settings does this child receive special education and related services? Please think about all the settings in which this child receives services. PLEASE CHECK ALL THAT APPLY.			
	01 🔾	a. Regular education classroom		
	02 🔾	b. Regular education program but outside the classroom		
	03 🔾	c. Special education classroom		
	04 🔾	d. Special education setting, but not a classroom		
	05 🔾	e. Therapy site for special services located at a regular elementary school		
	of O f. An outpatient medical service facility, clinic, or therapy site			
	07 O g. Child's home			
	08 🔾	h. Someone else's home (e.g., a babysitter)		
	09 🔾	i. Other (Specify:)		
В7.		of the following are provided to this child as part of his/her IEP or 504 plan? E CHECK ALL THAT APPLY.		
	Accommodations/modifications			
	01 🔾	a. Modified grading standards		
	02 🔾	b. Slower-paced instruction		
	03 🔾	c. Additional time to complete assignments		
	04 🔾	d. Modified assignments		
	05 🔾	e. Physical adaptations (e.g., preferential seating, special desks)		
	Learni	ng aids		
	06 🔾	f. Books on tape		
	07 🔾	g. Communication aids (e.g., Touch Talker, manual printing board)		
	\sim	h. Use of spell checker		
	\sim	i. Computer software designed for children with disabilities		
	10	j. Computer hardware adapted for child's unique needs (e.g., alternative keyboards, switch interface)		
	11 🔾	k. Other (Specify:)		
	95 🔾	No accommodations/modifications or learning aids provided (NOT ANY of items a. through k., above)		

Were any of the following services provided to this child through the school system during the current school year? (<i>Include services the school contracted from other agencies</i> .) PLEASE CHECK ALL THAT APPLY.	 IF YOU COMPLETED SECTION A, please go to the back cover. IF SOMEONE ELSE COMPLETED SECTION A, please continue with B9.
 a. Adaptive physical education b. Assistive technology services/devices c. Audiology d. Augmentative or alternative communication system e. Behavior management program f. Health services (e.g., administering of medication, oxygen, tracheostomy care, tube feeding, catheterization) g. Instruction in American Sign Language h. Instruction in Manual English or Cued Speech i. Instruction in Braille j. Learning strategies/study skills assistance by a special educator k. Mental health services, personal/group counseling, therapy, or psychiatric care provided to this child l. Occupational therapy m. One-to-one para-educator/assistant (e.g., teacher aide, nurse's aide, full-inclusion assistant, behavioral assistant) 	 B9. In what capacity (or capacities) are you involved with this child? PLEASE ✓ CHECK ALL THAT APPLY. ○1 ○ a. Provide instruction directly to this child ○2 ○ b. Provide related services directly to this child ○3 ○ c. Provide consultation services to child's teacher(s) ○4 ○ d. Provide case management (e.g., program monitoring) for this child ○5 ○ e. Serve as program administrator or supervisor ○6 ○ f. Supervise instructional assistant or para-educator assigned to work with this child ○7 ○ g. Other (Specify:
 14 O n. Physical therapy 15 O o. Reader or interpreter 	
p. Service coordination/case management	
17 O q. Social work services	
18 Tr. Special transportation because of disability (e.g., help in travel or special equipment such as lifts, ramps)	
19 Os. Specialized computer software or hardware	Thank you for completing
t. Speech or language therapy	
u. Training, counseling, and other supports/services provided to this child's family	this questionnaire.
v. Tutoring/remediation by a special education teacher	
w. Vision services	Date Completed:// Please provide your name and contact information below, so that we can reach you if we have questions.
24 O x. Other (Specify:)	mm dd yy
	Your Name:
	Caba al/Dan averas Nama
	School/Program Name:
	Address:
	Phone: ()

Email:

B8. Were any of the following services provided to this child through the school

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Please continue to the back cover.

Thank you for completing this questionnaire.

When you have completed this portion of the questionnaire, please seal it with the label below and place it in your local mailbox.



thank you!

Special Education Research

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