KINDERGARTEN school ELEMENTARY W4

Section B:

SPECIAL EDUCATION PROGRAMS AND RELATED SERVICES

PEELS

Pre-Elementary Education Longitudinal Study

Kindergarten 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

Elaine Carlson
Project Director, PEELS

Questions?

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

Section B:

SPECIAL EDUCATION PROGRAMS AND RELATED SERVICES

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

B1. What are this child's disabilities?
PLEASE ✓ CHECK **ALL** THAT APPLY IN COLUMN A.
PLEASE ✓ 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.

1 ○ Yes
2 ○ No

B3. For this school year, what are the three most important IEP goals for this child? PLEASE ✓ CHECK UP TO THREE.

01 ○ a. Not applicable—the child does not have an IEP. ➜ **Go to Question B6**
02 ○ b. Improve overall school readiness
03 ○ c. Improve academic performance in a specific area: _____
04 ○ d. Improve social skills
05 ○ e. Improve appropriateness of general behavior
06 ○ f. Improve adaptive behavior or self-help skills
07 ○ g. Improve speech/communication skills
08 ○ h. Improve fine motor skills
09 ○ i. Improve gross motor skills
10 ○ j. Other (Specify: _____)
98 ○ k. Don't know

B4. 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 ○ More progress than expected
3 ○ As much progress as expected
4 ○ Less progress than expected
5 ○ Much less progress than expected
8 ○ Don't know

B5. Were any of the following services provided to this child through the school system during the current school year? (*Include services the school contracted from other agencies.*) PLEASE ✓ CHECK ALL THAT APPLY.

01 ○ a. Adaptive physical education
02 ○ b. Assistive technology services/devices
03 ○ c. Audiology
04 ○ d. Augmentative or alternative communication system
05 ○ e. Behavior management program
06 ○ f. Health services (e.g., administering of medication, oxygen, tracheostomy care, tube feeding, catheterization)
07 ○ g. Instruction in American Sign Language
08 ○ h. Instruction in Manual English or Cued Speech
09 ○ i. Instruction in Braille
10 ○ j. Learning strategies/study skills assistance by a special educator
11 ○ k. Mental health services, personal/group counseling, therapy, or psychiatric care provided to this child
12 ○ l. Occupational therapy
13 ○ m. One-to-one para-educator/assistant (e.g., teacher aide, nurse's aide, full-inclusion assistant, behavioral assistant)
14 ○ n. Physical therapy
15 ○ o. Reader or interpreter
16 ○ p. Service coordination/case management
17 ○ q. Social work services
18 ○ r. Special transportation because of disability (e.g., help in travel or special equipment such as lifts, ramps)
19 ○ s. Specialized computer software or hardware
20 ○ t. Speech or language therapy
21 ○ u. Training, counseling, and other supports/services provided to this child's family
22 ○ v. Tutoring/remediation by a special education teacher
23 ○ w. Vision services
24 ○ x. Other (Specify: _____)

B6. Which of the following are provided to this child as part of his/her IEP or 504 plan?
PLEASE ✓ 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)

Learning aids

06 ❍ f. Books on tape
07 ❍ g. Communication aids (e.g., Touch Talker, manual printing board)
08 ❍ h. Use of spell checker
09 ❍ 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)**

- **IF YOU COMPLETED SECTION A, please go to the back cover.**
- **IF SOMEONE ELSE COMPLETED SECTION A, please continue with B7.**

B7. In what capacity (or capacities) are you involved with this child?
PLEASE ✓ CHECK **ALL** THAT APPLY.

01 ❍ a. Provide instruction directly to this child
02 ❍ b. Provide related services directly to this child
03 ❍ c. Provide consultation services to child's teacher(s)
04 ❍ d. Provide case management (e.g., program monitoring) for this child
05 ❍ e. Program administrator or supervisor
06 ❍ f. Supervise instructional assistant or paraeducator assigned to work with this child
07 ❍ g. Other (Specify: _____)

B8. We want to know what you think about special education for young children. In the space provided, please print any suggestions or concerns you have regarding the provision of special education services for young children. (*Be assured that your answers will be confidential.*)

_____
_____
_____
_____
_____
_____

Thank you for completing this questionnaire.

Date Completed: ____/____/____
mm dd yy

Please provide your name and contact information below, so that we can reach you if we have questions.

Your Name: _____

School/Program Name: _____

Address: _____

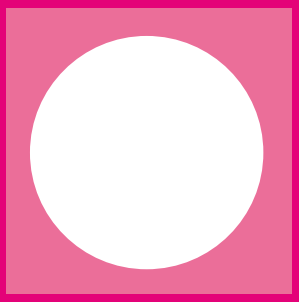
Phone: ( ) _____

Email: _____

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!

National Center for
Special Education Research

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