



# Section D:

**SPECIAL EDUCATION PROGRAMS AND RELATED SERVICES**



Pre-Elementary Education Longitudinal Study

# Early Childhood Teacher Questionnaire

**Dear Early Childhood Professional:**

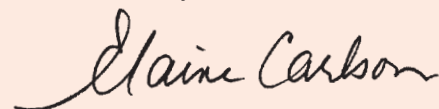
Your school district is participating in an important U.S. Department of Education study called the Pre-Elementary Education Longitudinal Study (PEELS). The child named on the label is one of more than 3,000 children nationwide who are taking part in PEELS. This questionnaire is the only source of information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

Please complete Section D 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](mailto:questions@peels.org), or visit the PEELS web site at [www.peels.org](http://www.peels.org).

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

Sincerely,



Elaine Carlson  
Project Director, PEELS

Questionnaire?

**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.

## Section D:

### SPECIAL EDUCATION PROGRAMS AND RELATED SERVICES

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

**D1.** What are this child’s disabilities?

PLEASE ✓CHECK ALL THAT APPLY IN COLUMN A.

PLEASE ✓CHECK ONE PRIMARY DISABILITY IN COLUMN B.

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

**D2.** 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

**D3.** 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: \_\_\_\_\_)

**D4.** 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. Early childhood classroom (regular education)
- 02  b. Early childhood special education classroom
- 03  c. Therapy site for special services outside the classroom
- 04  d. Outpatient medical service facility, clinic, or therapy site
- 05  e. Child's home
- 06  f. Someone else's home (e.g., a babysitter)
- 07  g. Other (Specify: \_\_\_\_\_)

**D5.** For this school year, what are the three most important IEP goals for this child? PLEASE ✓CHECK UP TO THREE.

- 01  a. Improve overall school readiness
- 02  b. Improve pre-academic performance in a specific area: \_\_\_\_\_
- 03  c. Improve social skills
- 04  d. Improve appropriateness of general behavior
- 05  e. Improve adaptive behavior or self-help skills
- 06  f. Improve speech/communication skills
- 07  g. Improve fine motor skills
- 08  h. Improve gross motor skills
- 09  i. Other (Specify: \_\_\_\_\_)
- 98  j. Don't know

**D6.** 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

- IF YOU COMPLETED SECTIONS A,B, and C, please go to the back cover.
- IF SOMEONE ELSE COMPLETED SECTIONS A,B, and C, please continue with Question D7.

**D7.** 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 this 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 para-educator assigned to work with this child
- 07  g. Other (Specify: \_\_\_\_\_)

**D8.** What are your main roles in this school or program?

PLEASE ✓ CHECK ALL THAT APPLY.

- 01  a. Early childhood teacher, not special education
- 02  b. Special education teacher
- 03  c. Related service provider (e.g., speech therapist)
- 04  d. Program specialist (e.g., full inclusion specialist)
- 05  e. Case manager/service coordinator
- 06  f. School psychologist
- 07  g. School counselor
- 08  h. Other (Specify: \_\_\_\_\_)

**D9.** 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.)*

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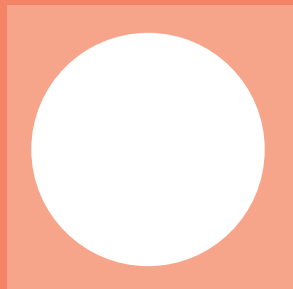
*Thank you for completing this questionnaire.*

|  |  |
|--|--|
| <b>Date Completed:</b> ___/___/___<br>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

**WESTAT**

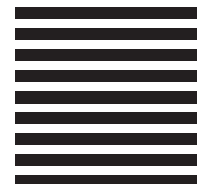
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