



Section B:

SPECIAL EDUCATION PROGRAMS AND RELATED SERVICES



Pre-Elementary Education Longitudinal Study Elementary School Teacher Questionnaire

Dear Education Professional:

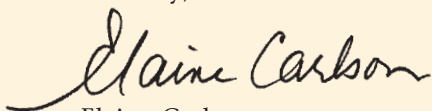
Your school district is participating in an important U.S. Department of Education study called the Pre-Elementary Education Longitudinal Study (PEELS). The child named on the label is one of more than 3,000 children nationwide who are taking part in PEELS. This questionnaire is the only source of information 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 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 <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"/>

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. Who participated in the most recent IEP or 504 plan development or review for this child? PLEASE ✓CHECK ALL THAT APPLY.

- 01 a. Regular education academic subject teacher(s)
- 02 b. Regular education vocational teacher(s)
- 03 c. Special education teacher(s)
- 04 d. School administrator (e.g., principal, special education director, program coordinator)
- 05 e. School counselor or psychologist
- 06 f. Related services personnel (e.g., speech therapist, physical therapist, nutritionist)
- 07 g. Parent/guardian(s)
- 08 h. Child
- 09 i. Staff of outside service agency or outside consultant
- 10 j. Advocate
- 11 k. Other (Specify: _____)
- 98 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.

- 01 a. Not applicable—the child does not have an IEP. → Go to Question B7
- 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

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 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

B6. 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
- 06 f. An outpatient medical service facility, clinic, or therapy site
- 07 g. Child's home
- 08 h. Someone else's home (e.g., a babysitter)
- 09 i. Other (Specify: _____)

B7. 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)

B8. 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: _____)

- IF YOU COMPLETED SECTION A, please go to the back cover.
- IF SOMEONE ELSE COMPLETED SECTION A, please continue with B9.

B9. 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. Serve as program administrator or supervisor
- 06 f. Supervise instructional assistant or para-educator assigned to work with this child
- 07 g. Other (Specify: _____)

B10. 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.)

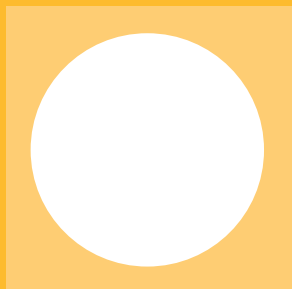
Thank you for completing this questionnaire.

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

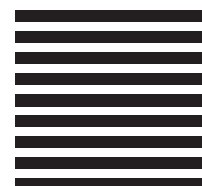
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