USE THIS FORM
IF YOU ARE HANDWRITING
ON TO A HARD COPY
APPLICATION.

CALIFORNIA DEPARTMENT OF EDUCATION
Diagnostic Center, Southern California

4339 State University Drive • Los Angeles, CA 90032 • Phone: (323) 222-8090 • Fax: (323) 222-3018
Website: www.dcs-cde.ca.gov

APPLICATION FOR ASSESSMENT
PARENT INFORMATION FORM

(To Be Completed by the Parent or Guardian)

Instructions: Your child is being referred to the Diagnostic Center for assessment services. This form must be completed by you and submitted with your district's application. Please complete, print, sign, and return this form to your child's school district. Feel free to put it in a sealed envelope to ensure confidentiality. If you have any questions regarding this form, please feel free to contact the Family Services Coordinator at the Diagnostic Center at (323) 222-8090.

Name of person completing this form: **Date:**

Child's Name *(Last, First, M.I.):*	Date of Birth:	Sex: ☐ M ☐ F

	Mother/Legal Guardian's Contact Information		*Father/Legal Guardian's Contact Information*	
Name		Age		Age
Cell Phone	( ) -		( ) -	
Home Phone	( ) -		( ) -	
Work Phone	( ) - ext.		( ) - ext.	
Email				
Address				
City/Zip Code				
Mailing Address *(If different than above)*				
City/Zip Code				
Occupation				
Employed by				
	☐ Living with child ☐ Divorced ☐ Separated ☐ Deceased ☐ Other _____		☐ Living with child ☐ Divorced ☐ Separated ☐ Deceased ☐ Other _____	

	Stepmother's Contact Information		*Stepfather's Contact Information*	
Name		Age		Age
Occupation				
Employed by				
Phone	( ) -		( ) -	
	☐ Living with child ☐ Divorced ☐ Separated ☐ Deceased ☐ Other _____		☐ Living with child ☐ Divorced ☐ Separated ☐ Deceased ☐ Other _____	

Child lives with:	☐ Parent(s)	☐ Guardian(s)	☐ Step Parent	☐ Group Home / Foster Care	☐ Other

Names of adults with rights to make educational decisions for child:			
Mail Correspondence to: (Please check all that apply)			
☐ Mother	☐ Father	☐ Step Parent	☐ Guardian(s)

If living with Guardian or Conservator, provide court date:		
If living in a group home or foster care, provide Name of Guardian:		
Address:	City/Zip Code:	Phone: ( ) -
Is child adopted? ☐ Yes ☐ No	Date of adoption:	

Child's Ethnicity:		
Child's Primary Language:		Other Languages spoken in the Home:
Will you need an interpreter to participate in the assessment? ☐ Yes ☐ No		
If yes, what language?		
School Student Attends:		
Address:		Principal's Name:
City:		Teacher's Name:
Zip Code:	County:	District:
Phone: ( ) -		Grade:

CONSENT

I authorize the Diagnostic Center, Southern California to conduct an observation of my child in his/her school. If accepted, information from the observation may be included in the assessment report.	
_____ *Signature of Parent/Guardian*	Date:
Relationship to child:	

_____ ***Student signature required if 18 years or older**	Date:

If your child is accepted, you will be sent an acceptance letter detailing the components of the assessment.

CHILD'S INFORMATION

Describe your child's strengths and interests:

What concerns you most about your child?

What is the reason the school district is requesting a Diagnostic Center assessment?

What do you hope will be the outcome(s) of this assessment?

FAMILY IDENTIFICATION / HISTORY

Besides parents, please list immediate family members. (Please also list siblings living out of the household.)

Name	*Relationship to Child*	*Age*	*Check if out of home*
			☐
			☐
			☐
			☐
			☐
			☐

Did anyone in the child's family ever have any of the conditions below? ☐ Yes ☐ No

	Father	Mother	Siblings	Grandparents	Aunts, Uncles, Cousins
Alcoholism	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐
Neurologic Disorder	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐
Emotional/ Mental Illness:					
Anxiety Disorder	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Obsessive Compulsive Disorder	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Other:	_____	_____	_____	_____	_____
Other:	_____	_____	_____	_____	_____
Other:	_____	_____	_____	_____	_____

Please comment further on any conditions indicated:

CHILD'S PHOTOGRAPHS

Please insert a recent photo of your child and each member of his/her immediate family. It is not necessary that all members of the family be in the same picture. Please identify each member by writing their name(s) directly below their picture.

BEHAVIOR AND EMOTIONAL ISSUES

How is your child's interaction with peers?	☐ Poor	☐ Good	☐ Excellent
Provide examples of activities your child engages in with peers:			

How is your child's interaction with adults?	☐ Poor	☐ Good	☐ Excellent
Provide examples of ways your child engages with adults:			

Is your child's behavior at school a problem? ☐ Yes ☐ No
Has your child been suspended or expelled? ☐ Yes ☐ No
Please describe:

How is your child's behavior at home and in the community?	☐ Poor	☐ Good	☐ Excellent
Please describe:			

PREGNANCY AND BIRTH HISTORY

Pregnancy complications:		
Labor and Delivery	Length of Gestation: weeks	Birthweight: lbs ozs
APGAR score:		
Labor / Birth complications:		

DEVELOPMENTAL HISTORY

Sat unsupported at	__ months	Used two or three words other than mama or dada at	__ months
Walked unsupported at	__ months	Spoke two or three-word sentences at	__ months
Toilet trained (bladder) at	__ months	Tricycle riding at	__ years __ months
Toilet trained (bowel) at	__ months	Bicycle riding without training wheels at	__ years __ months

How old was your child when you first began to have a concern that perhaps he/she was not developing the way you thought he/she should?
What area(s) of development did your child seem to have the most trouble with?

Emotional/Behavioral symptoms during first three years of life:					
Not cuddly	☐ Yes	☐ No	Excessive rocking	☐ Yes	☐ No
Seemed deaf	☐ Yes	☐ No	Hyperactive	☐ Yes	☐ No
Feeding difficulty	☐ Yes	☐ No	Excessive fearfulness	☐ Yes	☐ No
Frequent crying	☐ Yes	☐ No	Sleep disturbance	☐ Yes	☐ No
Discipline problems	☐ Yes	☐ No	Tantrums	☐ Yes	☐ No
Head banging	☐ Yes	☐ No			
Other:					

Which of these were of most concern to you?
Please add any other behavior that was a problem early on:

CHILD'S MEDICAL HISTORY

Has your child experienced any of the following:					
Major Illness	☐ Yes	☐ No	Major accidents or Trauma	☐ Yes	☐ No
Surgery	☐ Yes	☐ No	CT/MRI	☐ Yes	☐ No
Hospitalization	☐ Yes	☐ No	Genetic evaluation	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	EEG	☐ Yes	☐ No
Seizure Type:			EEG date:		

If yes, please describe, giving dates/child's age at the time of first and last experience, and frequency of occurrences:

Please check any that apply to your child:		
☐ Headaches	☐ Bed wetting	☐ Daytime wetting
☐ Attentional difficulties	☐ Hyperactivity	☐ Coordination problems
☐ Has entered puberty	☐ Has a hearing loss*	☐ Wears glasses*
** During assessment, please make sure your child brings glasses or hearing aids (if applicable).*		
☐ Special Diet/Allergies (Food/Medications):		

Does your child have any chronic illness, medical or physical problems? ☐ Yes ☐ No
If yes, please describe:

What medical and/or psychiatric diagnoses have been given to your child and by whom?

MEDICATION HISTORY

Does your child currently take medication? ☐ Yes ☐ No			
If yes, list medication and dosage below:			
Current Medication	*Dosage*	*Who Prescribed*	*Date Started*

Previous Medication	*Reason Discontinued or Side Effects*

EVALUATIONS AND SERVICES

In order for us to conduct a complete assessment, we would like to review records concerning evaluation and services that have been provided to your child. These services may include Doctors, Mental Health Specialists, agencies such as Regional Center or California Children's Services (CCS), and/or private specialists such as Occupational Therapists, Physical Therapists, and/or Education Therapists.

Depending on the issues, we may need to request reports from agencies you list below. **Please complete an Authorization for Use and/or Disclosure of Information form for each name listed below. Be sure to include addresses, phone, and fax numbers on the authorization form(s).**

Current Physicians:

Agency/Specialist	*Reason for Services*	*Area Code/Phone Number*
		Phone: ( ) -
		Phone: ( ) -
		Phone: ( ) -
		Phone: ( ) -
		Phone: ( ) -

Mental Health Services/Private Counseling:

Agency/Specialist	*Reason for Services*	*Dates*

Regional Center/California Children's Services (CCS), Private OT/PT:

Agency/Specialist	*Reason for Services*	*Dates*

Other Professionals/Agencies that have Provided Services:

Agency/Specialist	*Reason for Services*	*Dates*

Thank you for completing this application.
You will receive written notification regarding acceptance for Diagnostic Center assessment service.

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Child's Name:	Date of Birth:	Sex: ☐ M ☐ F
Mother's Name:	Father's Name:	
Address:	City/State/Zip:	

Individual and/or Organization disclosing information:	
Phone: ( ) - ext.	Fax: ( ) -
Address:	City/State/Zip:

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☐ Regional Center / California Children's Services		☐ Other Professional Services:
☐ Psychiatric / Mental Health: _____ *Signature of Parent, Legal Guardian, or Child if 18 years or older*		Date:
Dates of Service requested:		Restrictions if any:

The information requested will only be used for the following purposes:
Assessment and Evaluation / Educational Planning

Duration	This request shall become effective immediately and shall remain in effect for 12 months or until the completion of the Diagnostic Center evaluation.
Revocation	I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.
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