

CENSUS FORM

CHILD ID#:		P.1
SCHOOL ID#:		

I. Information About the Individual (Child/Young Adult)

1.*First Name:		Last Name:		Middle Initial:		
2.*Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	3.*Child's Date of Birth:	__ month	__ day	___ year
4. Child's County of Residence:						
5. Parent/Guardian Name:						
Address:				City/Town:	Zip Code:	
Phone:		Fax:		Email:		

6. Primary Identified Etiology (Enter one numeric code in the box from the list below.)

<p>HEREDITARY/CHROMOSOMAL SYNDROMES AND DISORDERS</p> <p>101 Alcardi Syndrome 102 Alport Syndrome 103 Altrom Syndrome 104 Apert Syndrome (Acrocephalosyndactyly, Type I) 105 Bardet-Biedl Syndrome (Laurence Moon-Biedl) 106 Betten Disease 107 CHARGE Syndrome 108 Chromosome 18, ring 18 109 Cockayne Syndrome 110 Cogan Syndrome 111 Cornelia de Lange Syndrome 112 Cri du chat Syndrome (Chromosome 5p Syndrome) 113 Crigler-Najjar Syndrome 114 Crouzan Syndrome (Craniofacial Dysostosis) 115 Dandy Walker Syndrome 116 Down Syndrome (Trisomy 21 Syndrome) 117 Goldenhar Syndrome 118 Hand-Schuller-Christian 119 Hallgren Syndrome 120 Herpes-Zoster (or Hunt) 121 Hunter Syndrome (MPS II) 122 Hurler Syndrome (MPS I-H) 123 Kearns-Sayre Syndrome 124 Klippel-Fell Sequence 125 Klippel-Trenaunay-Weber Syndrome 126 Kniest Dysplasia 127 Leber Congenital Amaurosis 128 Leigh Disease 129 Marfan Syndrome</p>	<p>130 Marshall Syndrome 131 Maroteaux-Larry Syndrome (MPS VI) 132 Moebius Syndrome 133 Monosomy 10p 134 Morquio Syndrome (MPS IV-B) 135 NF1-Neurofibromatosis (von Recklinghausen disease) 136 NF2-Bilateral Acoustic Neurofibromatosis 137 Norrie Disease 138 Optico-Cochleo-Dentate Degeneration 139 Pfeiffer Syndrome 140 Prader-Willi 141 Pierre-Robbin Syndrome 142 Refsum Syndrome 143 Scheie Syndrome (MPS I-S) 144 Smith-Lemli-Optiz (SLO) Syndrome 145 Stickler Syndrome 146 Sturge-Weber Syndrome 147 Treacher Collins Syndrome 148 Trisomy 13 (Trisomy 13-15, Patau Syndrome) 149 Trisomy 18 (Edwards Syndrome) 150 Turner Syndrome 151 Usher Syndrome, Type I 152 Usher Syndrome, Type II 153 Usher Syndrome, Type III 154 Vogt-Koyanagi-Harada Syndrome 155 Waardenburg Syndrome 156 Wildervanck Syndrome 157 Wolf-Hirschhorn Syndrome (Trisomy 4p) 199 Other: _____ (Indicate the numeric code in the box above and specify in this space)</p>	<p>PRE-NATAL/CONGENITAL COMPLICATIONS</p> <p>201 Congenital Rubella 202 Congenital Syphilis 203 Congenital Toxoplasmosis 204 Cytomegalovirus (CMV) 205 Fetal Alcohol Syndrome 206 Hydrocephaly 207 Maternal Drug Use 208 Microcephaly 209 Neonatal Herpes Simplex (HSV) 299 Other: _____ (Indicate the numeric code in the box above and specify in this space)</p> <p>POST-NATAL/NON CONGENITAL COMPLICATIONS</p> <p>301 Asphyxia 302 Direct Trauma to the eye and/or ear 303 Encephalitis 304 Infections 305 Meningitis 306 Severe Head Injury 307 Stroke 308 Tumors 309 Chemically Induced 399 Other: _____ (Indicate the numeric code in the box above and specify in this space)</p> <p>RELATED TO PREMATUREITY</p> <p>401 Complications to Prematurity</p> <p>UNDIAGNOSED</p> <p>501 No determination of Etiology</p>
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7. Ethnicity (select one)	<input type="checkbox"/> 1.American Indian or Alaskan Native	<input type="checkbox"/> 2.Asian or Pacific Islander	<input type="checkbox"/> 3.Black (not Hispanic)	<input type="checkbox"/> 4.Hispanic	<input type="checkbox"/> 5.White (not Hispanic)
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II. Information about Vision, Hearing, and Other Impairments

1.* Documented Vision Loss Select ONE that best describes the individual's:

A. Documented degree of vision loss with correction, or
B. Indicate that further testing is needed (testing must be complete prior to the next census submission) or
C. Indicate that the student has a documented functional vision loss.

<input type="checkbox"/> 1.Low Vision	<input type="checkbox"/> 2.Legally Blind	<input type="checkbox"/> 3.Light Perception Only
<input type="checkbox"/> 4.Totally Blind	<input type="checkbox"/> 6.Diagnosed Progressive Loss	<input type="checkbox"/> 7.Further Testing Needed
<input type="checkbox"/> 9.Documented Functional Vision Loss		

2.* Documented HEARING LOSS Select ONE that best describes the individual's:

A. Documented degree of hearing loss with correction, or
B. Indicate that further testing is needed (testing must be complete prior to the next census submission) or
C. Indicate that the student has a documented functional hearing loss.

<input type="checkbox"/> 1.Mild (26-40 dB loss)	<input type="checkbox"/> 2.Moderate (41-55 dB loss)	<input type="checkbox"/> 3.Moderately Severe (56-70 dB loss)
<input type="checkbox"/> 4.Severe (71-90 dB loss)	<input type="checkbox"/> 5.Profound (91+ dB loss)	<input type="checkbox"/> 6.Diagnosed Progressive Loss
<input type="checkbox"/> 7.Further Testing Needed		
<input type="checkbox"/> 9.Documented Functional Hearing Loss		

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3. Does the child have any of the following:				4. Indicate all other documented impairments, in addition to vision and hearing impairments:			
	Yes	No	Unknown		Yes	No	Unknown
Auditory Neuropathy				Physical Impairments			
Central Auditory Processing Disorder (CAPD)				Cognitive Impairments			
Cochlear Implant				Behavior Disorder			
Cortical Visual Impairment				Complex Health Care Needs			
Other:				Speech and Language			
Other:				Other:			

III. Reporting, Funding and Placement Information

1. Part C Reporting Category. *If the child is 0-2 years of age please enter the category under which the child was reported within the Early Intervention program (Department of Health). [Select one]*

<input type="checkbox"/>	At-risk for developmental delay	<input type="checkbox"/>	Developmentally Delayed	<input type="checkbox"/>	Not reported under Part C
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2. Part B Reporting Category Code. *If the child is 3-21 years of age indicate the primary category code under which the individual was reported on Part B, IDEA Child Count. [Select one]*

<input type="checkbox"/>	1.Mental Retardation	<input type="checkbox"/>	6.Orthopedic Impairment	<input type="checkbox"/>	10.Multiple Disabilities
<input type="checkbox"/>	2.Hearing Impairment (includes deafness)	<input type="checkbox"/>	7.Other Health Impairment	<input type="checkbox"/>	11.Autism
<input type="checkbox"/>	3.Speech or Language Impairment	<input type="checkbox"/>	8.Specific Learning Disability	<input type="checkbox"/>	12.Traumatic Brain Injury
<input type="checkbox"/>	4.Visual Impairment (includes blindness)	<input type="checkbox"/>	9.Deaf-Blindness	<input type="checkbox"/>	14.Non-Categorical
<input type="checkbox"/>	5.Emotional Disturbance	<input type="checkbox"/>	13.Developmentally Delayed (ages 3 through 9)	<input type="checkbox"/>	888 Not reported under Part B of IDEA

3. Early Intervention Setting (0-2). *Please specify where the child receives services.*

<input type="checkbox"/>	1.Home	<input type="checkbox"/>	2.Community-Based Setting	<input type="checkbox"/>	Other [please specify]: _____
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4. Educational setting 3-5 years of age. *Please choose the one which best describes which type of program the child attends.*

<input type="checkbox"/>	1.Attending a regular early childhood program at least 80% of the time.				
<input type="checkbox"/>	2.Attending a regular early childhood program 40% to 79% of the time.				
<input type="checkbox"/>	3.Attending a regular early childhood program less than 40% of the time.				
<input type="checkbox"/>	4.Attending a separate class.		<input type="checkbox"/>	5.Attending a separate school.	
<input type="checkbox"/>	6.Attending a residential facility.				<input type="checkbox"/>
<input type="checkbox"/>	7.Service provider location.			8.Home	

5. Educational setting 6-21 years of age. *Please choose the one which best describes the type of program the child attends.*

<input type="checkbox"/>	9.Inside the regular class 80% or more of the day.		<input type="checkbox"/>	10.Inside the regular class 40% to 79% of the day.	
<input type="checkbox"/>	11.Inside the regular class less than 40% of the day.		<input type="checkbox"/>	12.Separate school.	
<input type="checkbox"/>	13.Residential Facility.		<input type="checkbox"/>	14.Homebound/Hospital.	
<input type="checkbox"/>	15.Correctional Facilities.		<input type="checkbox"/>	16.Parentally placed in private schools.	

6.Participation in Statewide Assessments: *Please indicate what assessment system the child participates in.*

<input type="checkbox"/>	1.Regular grade-level State assessment.				
<input type="checkbox"/>	2.Regular grade-level State assessment with accommodations.				
<input type="checkbox"/>	4.Alternate assessments (NYSAA) based on alternate achievement standards.				
<input type="checkbox"/>	6.Not required at age or grade level.				

7. Special Education Status/Part C (0-2) Exiting. *Please indicate the ONE code that best describes the individual's special education program status.*

<input type="checkbox"/>	0.In a Part C early intervention program.		<input type="checkbox"/>	1.Completion of IFSP prior to reaching maximum age for Part C.	
<input type="checkbox"/>	2.Eligible for IDEA, Part B		<input type="checkbox"/>	3.Not eligible for Part B, referral to other program.	
<input type="checkbox"/>	4.Not eligible for Part B, exit without referrals.		<input type="checkbox"/>	5.Part B eligibility not determined.	
<input type="checkbox"/>	6.Deceased.		<input type="checkbox"/>	7.Moved out of state.	
<input type="checkbox"/>	8.Withdrawal by parent/guardian.		<input type="checkbox"/>	9.Could not contact parent.	

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8. Special Education Status/Part B Exiting. Please indicate the ONE code that best describes the individual's special education program status on December first of the current year.

<input type="checkbox"/>	0. In early childhood or school-age special education.	<input type="checkbox"/>	1. Transferred to regular education.
<input type="checkbox"/>	2. Graduated with regular high school diploma.	<input type="checkbox"/>	3. Received a certificate.
<input type="checkbox"/>	4. Reached maximum age.	<input type="checkbox"/>	5. Died.
<input type="checkbox"/>	6. Moved, Know to be Continuing.	<input type="checkbox"/>	8. Dropped Out

9. Current living status:

<input type="checkbox"/>	1. Home: Parents	<input type="checkbox"/>	2. Home: Extended Family	<input type="checkbox"/>	3. Home: Foster Parents
<input type="checkbox"/>	4. State residential facility	<input type="checkbox"/>	5. Private residential facility	<input type="checkbox"/>	6. Group home (less than 6 residents)
<input type="checkbox"/>	7. Group home (6 or more residents)	<input type="checkbox"/>	8. Apartment (with non family)	<input type="checkbox"/>	9. Pediatric nursing home
					555. Other

10. Does this individual use any of the following adaptive equipment?

	0. Yes	1. No	2. Unknown
Corrective Lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assistive Listening Devices (i.e. hearing aids or FM system)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Assistive Technology (other than corrective lenses or assistive listening devices)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. School Information

Agency/School Name:			
Street Address:			
City:		State:	Zip Code:
Telephone Number:		Fax Number:	
Teacher Name:		Teacher's Email:	

12. Is this individual receiving services from the New York Deaf-Blind Collaborative?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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Please return this form and the appropriate Release Form to:

NYDBC – Queens College
 Powerdermaker 200
 Kissena Blvd.
 Flushing, NY 11367

If you have any questions or need assistance in completing this form please contact us at: 718-997-4856 or email us at NYDBC@qc.cuny.edu.