NEW YORK DEAF-BLIND COLLABORATIVE

# CHILD COUNT FORM

| CHILD ID#: | |
|---|---|
| SCHOOL ID#: | |



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

| 1.*First Name: | | Last Name: | | Middle Initial: | |
|---|---|---|---|---|---|
| 2.*Gender: | ___ Male | ___ 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.)*

**HEREDITARY/CHROMOSAL SYNDROMES AND DISORDERS**

101 Alcardi Syndrome
102 Alport Syndrome
103 Altrom Syndrome
104 Apert Syndrome (Acrocephalosyndactyly, Type I)
105 Bardet-Biedi Syndrome (Laurence Moon-Biedi)
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 Dysotosis)
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
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 Neurofibromastosis
137 Norrie Disease
138 Optico-Cochleo-Dentate Degeneration
139 Pfieffer 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-Hirschorn Syndrome (Trisomy 4p)
199 Other: ___________________________
**(Indicate the numeric code in the box above and specify in this space)**

**PRE-NATAL/CONGENITAL COMPLICATIONS**

201 Congenital Rubella
202 Congenital Syphilis
203 Congenital Toxoplasmosis
204 Cytomeglovirus (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)**

**POST-NATAL/NON CONGENITAL COMPLICATIONS**

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)

**RELATED TO PREMATURITY**

401 Complications to Prematurity

**UNDIAGNOSED**

501 No determination of Etiology

| 7. Ethnicity | | 1.American Indian or Alaskan Native | | 2.Asian | | 3.Black/African American | | 4.Hispanic | | 5.White | | 6. Native Hawaiian/ Pacific Islander | | 7. Two or more races |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

## 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.

| | 1.Low Vision | | 2.Legally Blind | | 3.Light Perception Only |
|---|---|---|---|---|---|
| | 4.Totally Blind | | 6.Diagnosed Progressive Loss | | 7.Further Testing Needed |
| | 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.

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

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| 3. Does the child have any of the following: | Yes | No | Unknown | 4. Indicate all other documented impairments, in addition to vision and hearing impairments: | 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]***

| | | | | | |
|---|---|---|---|---|---|
| | At-risk for developmental delay | | Developmentally Delayed | | Not reported under Part C |

**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]***

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

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

| | | | | | |
|---|---|---|---|---|---|
| | 1.Home | | 2.Community-Based Setting | | Other [please specify]: ___________________ |

**4. Educational setting 3-5 years of age.** ***Please choose the one which best describes which type of program the child attends.***

| | | | | | |
|---|---|---|---|---|---|
| | 1.Attending a regular early childhood program at least 80% of the time. | | | | |
| | 2.Attending a regular early childhood program 40% to 79% of the time. | | | | |
| | 3.Attending a regular early childhood program less than 40% of the time. | | | | |
| | 4.Attending a separate class. | | 5.Attending a separate school. | | 6.Attending a residential facility. |
| | 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.***

| | | | |
|---|---|---|---|
| | 9.Inside the regular class 80% or more of the day | | 10.Inside the regular class 40% to 79% of the day |
| | 11.Inside the regular class less than 40% of the day | | 12.Separate school |
| | 13.Residential Facility | | 14.Homebound/Hospital |
| | 15.Correctional Facilities | | 16.Parentally placed in private school |

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

| | |
|---|---|
| | 1.Regular grade-level State assessment. |
| | 2.Regular grade-level State assessment with accommodations. |
| | 4.Alternate assessments (NYSAA) based on alternate achievement standards. |
| | 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.***

| | | | |
|---|---|---|---|
| | 0.In a Part C early intervention program. | | 1.Completion of IFSP prior to reaching maximum age for Part C. |
| | 2.Eligible for IDEA, Part B | | 3.Not eligible for Part B, referral t other program. |
| | 4.Not eligible for Part B, exit without referrals. | | 5.Part B eligibility not determined. |
| | 6.Deceased. | | 7.Moved out of state. |
| | 8.Withdrawal by parent/guardian. | | 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.***

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

**9. Current living status:**

| | | | | | |
|---|---|---|---|---|---|
| | 1. Home: Parents | | 2. Home: Extended Family | | 3. Home: Foster Parents |
| | 4. State residential facility | | 5. Private residential facility | | 6. Group home (less than 6 residents) |
| | 7. Group home (6 or more residents) | | 8. Apartment (with non family) | | 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 | | | |
| Assistive Listening Devices (i.e. hearing aids or FM system) | | | |
| Additional Assistive Technology (other than corrective lenses or assistive listening devices) | | | |

**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?**

| | | | |
|---|---|---|---|
| | Yes | | No |

Please return this form and the appropriate Release Form to:

NYDBC – Queens College
Powdermaker 200
65-30 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.