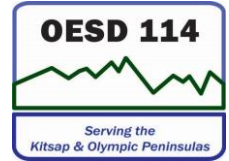




Olympic Educational Service District 114
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Disabilities Parent Questionnaire Head Start/ECEAP

Questionnaire for parents whose Head Start/ECEAP child is currently receiving services or in the process of being evaluated by the School District and not referred by Head Start/ECEAP.

Child's Name _____ Date _____

Area of Disability _____

Parent's Name _____ Phone Number _____

Staff's Name _____

_____ I need more information about my child's special need
My child's special need is _____
Specific information needed: _____

_____ I need more information about the school districts process
_____ Evaluation
_____ Individual Education Plan
_____ Other: _____

I need more information about:
_____ Supplemental Security Income
_____ Division of Developmental Disabilities
_____ Health Information
Specific need: _____

_____ Support Groups for Parents

For children receiving school district special services:

_____ I know the name of my child's special education teacher and/or therapist

_____ I know how to get in touch with my child's special education teacher and/or therapists

Other information needed: _____