

Appendix B. Data Collection Forms Developed for PRISM Project

PROJECT PRISM: A National Collaborative Study on the Early Development of Children with Visual Impairments

Division of Special Education, University of Northern Colorado, Greeley, CO 80639
303-351-1653 FAX 303-351-1061

Dear Parents:

The University of Northern Colorado, in collaboration with the agencies listed above, has received a five-year grant from the United States Department of Education, Office of Special Education Programs, to study young children with visual handicaps. We want to learn more about how infants and preschoolers with visual handicaps grow and develop and how their families and educational programs help them in the process. The program your child attends has agreed to help us with this study. With your permission, we would like your child to take part, too.

Your permission would mean four things:

- (1) Your child would be tested by someone from the agency who has been specially trained by us (we call them “project evaluators”). The tests include both developmental tests (that measure a child’s developmental progress) and a test of visual functioning (that looks at how your child uses his or her vision). There is no risk to your child in this testing; the tests are very similar to those which your agency already uses.
- (2) You would be interviewed by the project evaluator from your agency about what your child does at home.
- (3) You would complete a packet of questionnaires in private that would be returned directly to us. These questionnaires try to get a handle on how families deal with daily life. One of the questionnaires also asks you how satisfied you are with the services you receive from your early intervention program. These questionnaires, because they are so personal, will only be seen by project staff at the University of Northern Colorado. Your responses are confidential, and your child’s program will never know how you or anyone else in the study responded.
- (4) The agency would share information with us about your child’s medical history and the type and amount of services you receive.

This information would be collected at several different points (but no more than three times a year), depending on your child’s age when entering the study. As each assessment is completed, we will send you \$25.00 to thank you for your time.

The study is funded for 5 years, and we hope that you will be able to work with us for the entire time. However, you have the right to withdraw from the study at any time. Your decision about participation, either now or in the future, will not affect any of the services your family receives from the early childhood program. Your participation is completely voluntary. We want to assure you again that the information we receive is confidential, and that your family will never be referred to by name.

Thank your for your time and interest. If you are willing to help us, please complete the attached permission form and return it to your program. If you have any questions, please call me at 970-351-1653; I would be happy to talk with you and to tell you why I think this study is so important.

Thanks again,

Sincerely,

Kay Alicyn Ferrell, Ph.D.

Associate Professor

Division of Special Education

Principal Investigator, Project PRISM

Attachment

PROJECT PRISM: A National Collaborative Study on the Early Development of Children with Visual Impairments

Division of Special Education, University of Northern Colorado, Greeley, CO 80639
303-351-1653 FAX 303-351-1061

Permission Form

I have read the attached letter and agree to participate in Project PRISM. I understand that, no more than 3 times a year:

- (a) My child will be assessed by staff members from our early childhood program;
- (b) I will be interviewed by staff members from our early childhood program;
- (c) I will complete a packet of questionnaires and send them to Project PRISM staff;
- (d) The early childhood program will share medical and other information with Project PRISM staff; and
- (e) I will be paid \$25.00 for each completed set of questionnaires.

I further understand that all information about my child and my family is completely confidential. I know that I may stop participating in this project at any time, and that whether or not I participate will not affect my family's services.

Child's Name *(please print)*

Parent's Name *(please print)*

Name of Early Childhood Program

Address

Parent's Signature

Parent's Social Security Number *(needed for payment)*

Date

PROYECTO PRISMA: Un Estudio Colaborativo Nacional sobre el Desarrollo Temprano de Niños con Impedimentos Visuales

Division of Special Education, University of Northern Colorado, Greeley, CO 80639
1-800- 395-2693 303-351-1653 Fax 303-351-1061

Estimado padres:

La Universidad del Norte de Colorado, en colaboración con los organismos anteriormente citados, ha recibido de la Oficina de Programas de Educación Especial del Departamento de Educación de los Estados Unidos una donación, con una duración de cinco años, para estudiar a niños pequeños con impedimentos visuales. Es nuestro deseo conocer más acerca de cómo los bebés y los niños de edad preescolar con impedimentos visuales crecen y se desarrollan y cómo sus familias y los programas educativos pueden ayudarles en este proceso. El programa en que participa su niño ha acordado ayudarnos en este estudio. Con su permiso, quisiéramos que su niño también participara en el mismo.

Su decisión de otorgar su permiso implicará lo siguiente:

- (1) Su niño sería evaluado por una persona de su organización que ha sido capacitado especialmente por nuestro personal (nosotros les llamamos "evaluadores del proyecto"). Las pruebas incluyen tanto pruebas del desarrollo (que miden el progreso logrado por el niño en su desarrollo) como una prueba del funcionamiento visual (que evalúa la forma en que su niño utiliza su visión). Las pruebas no implican riesgo alguno para su niño; son muy similares a las que ya utiliza su organización.
- (2) El evaluador del proyecto que trabaja en su organización les entrevistaría acerca de las actividades realizadas por su niño en el hogar.
- (3) Ustedes completarían una serie de cuestionarios, en la privacidad de su hogar, los cuales serían devueltos directamente a nosotros. Estos cuestionarios procuran ayudarnos a conocer la manera en que las familias enfrentan la vida cotidiana. Uno de los cuestionarios también pregunta sobre qué tan satisfechos se encuentran con los servicios que reciben de su programa de intervención temprana. Estos cuestionarios, debido a que tratan sobre asuntos tan personales, sólo serán vistos por el personal del proyecto en la Universidad del Norte de Colorado. Sus respuestas se mantendrán confidenciales, y nadie del programa de su niño sabrá jamás las respuestas dadas por ustedes ni las dadas por ningún otro padre que haya participado en el estudio.
- (4) Su organización compartiría con nosotros información acerca del historial médico de su niño y del tipo y cantidad de servicios que recibe.

La información sería recogida en varias diferentes fechas (pero no más de tres veces al año), dependiendo de la edad de su niño cuando se incorpore al estudio. Cuando se haya finalizado cada evaluación, les enviaremos un cheque por la cantidad de \$25.00 como muestra de nuestro agradecimiento por su tiempo.

El estudio ha recibido financiamiento para un período de cinco años y esperamos que podrán trabajar con nosotros durante todo ese período. No obstante, tienen el derecho de retirarse del estudio en

cualquier momento. Su decisión acerca de la participación de su niño, sea ahora o en el futuro, de ninguna manera afectará los servicios que recibe su familia del programa de intervención temprana. Su participación es totalmente voluntaria. Queremos asegurarles nuevamente que la información que nos proporcione será tratada confidencialmente y que nunca se hará referencia directa a los nombres o apellidos de miembros de su familia.

Gracias por su tiempo y por el interés que ha mostrado en este proyecto. Si están de acuerdo en ayudarnos, agradeceremos llenen el formulario de autorización adjunto y lo devuelvan a su programa. Si tienen preguntas, rogamos me llamen al teléfono 303-351-1653; tendré mucho placer en hablar con ustedes para explicarles por qué considero tan importante este estudio.

Con muestras de mi agradecimiento, soy de ustedes

Atentamente,

Kay Alicyn Ferrell, Ph.D.
Profesora Adjunta
División de Educación Especial
Investigadora Principal, Proyecto PRISMA

Adjunto

PROYECTO PRISMA: Un Estudio Colaborativo Nacional sobre el Desarrollo Temprano de Niños con Impedimentos Visuales

Division of Special Education, University of Northern Colorado, Greeley, CO 80639
1-800- 395-2693 303-351-1653 Fax 303-351-1061

FORMULARIO DE AUTORIZACION

He leído la carta adjunta y acepto participar en el Proyecto PRISMA. Entiendo que, con una frecuencia no mayor de tres veces al año:

- (a) Mi niño será evaluado por miembros del personal de nuestro programa de intervención temprana;
- (b) Seré entrevistado por miembros del personal de nuestro programa de intervención temprana;
- (c) Completaré una serie de cuestionarios y los enviaré al personal del Proyecto PRISMA;
- (d) El programa de intervención temprana compartirá información médica y de otro tipo con el personal del Proyecto PRISMA; y
- (e) Recibiré la suma de \$25.00 por cada juego de cuestionarios completados.

Entiendo además que toda información referente a mi niño y a mi familia se mantendrá estrictamente confidencial. Reconozco que puedo dejar de participar en este proyecto en cualquier momento y que mi decisión de participar o no participar no afectará de manera alguna los servicios que recibe mi familia.

Nombre del Niño
(favor usar letra de imprente)

Nombre del Padre o de la Madre
(favor usar letra de imprente)

Nombre del Programa de Intervención
Temprana

Dirección

Firma del Padre o de la Madre

Número de Seguro Social del Padre o de la Madre
(se requiere para poder efectuar los pagos)

Fecha

PROJECT PRISM: A National Collaborative Study on the Early Development of Children with Visual Impairments

Division of Special Education, University of Northern Colorado, Greeley, CO 80639
303-351-1653 FAX 303-351-1061

Dear Parents:

The enclosed questionnaires are for you to fill out in your free time and in privacy. Please complete them within one week and mail them to us at Project PRISM at the University of Northern Colorado in the envelope provided. All this information is confidential. All of your questionnaires will only be seen by Project PRISM staff, and no information that is personally identifiable will be given at any time to your child's agency or to any other source.

These questionnaires are part of our effort to observe the course of your child's and your family's experiences throughout these early years of growth. Your honest and thoughtful responses are helpful to us in learning how to better serve families and children. Please understand that many of these questionnaires were designed for children without visual impairments, so some of the question may not apply to your family situation. Other questions may assume that your child has normal vision. When you find questions that do not apply, just mark them "N/A" for "not applicable."

When we receive these forms, we will send you a check for \$25.00. Thank you very much for your time. We appreciate your contribution to the project.

Sincerely yours,

Kay Alicyn Ferrell, Ph.D.
Principal Investigator
University of Northern Colorado

Sally J. Deitz, Ph.D.
Project Director

**PROYECTO PRISMA: Un Estudio Colaborativo Nacional sobre el
Desarrollo Temprano de Niños con
Impedimentos Visuales**

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1-800- 395-2693 303-351-1653 Fax 303-351-1061

Estimados Padres:

Adjunto encontrarán unos cuestionarios los cuales agradeceremos se sirvan llenar en su tiempo libre y en la privacidad de su hogar. Favor completarlos dentro de una semana y devolverlos a vuelta de correo en el sobre adjunto al Proyecto Prisma en la Universidad de Colorado del Norte. Toda esta información es confidencial. Todos los cuestionarios serán vistos únicamente por el personal del Proyecto Prisma, y en ningún momento se divulgará a fuentes externas información que pudiera servir para identificarlos personalmente.

Estos cuestionarios forman parte de nuestro esfuerzo por observar el curso de las experiencias de su hijo y de su familia durante estos años iniciales de crecimiento. Sus respuestas honestas y razonadas nos ayudarán a aprender cómo podemos servir mejor a las familias y a sus hijos. Sírvanse tomar en cuenta que muchos de estos cuestionarios fueron diseñados para recoger información sobre niños que no tienen impedimentos visuales, de modo que algunas de las preguntas pueden no ser aplicables a la situación particular de su familia. Otras preguntas pueden suponer que su hijo tiene visión normal. Cuando usted encuentre preguntas que no sean aplicables a su situación, sencillamente escriba "N/A" para indicar "no aplicable".

Cuando recibamos estos formularios, les enviaremos un cheque por \$25.00. Muchas gracias por su tiempo. Agradecemos su contribución al proyecto.

Atentamente,

Kay Alicyn Ferrell, Ph.D.
Investigadora Principal
Universidad de Colorado del Norte

Sally J. Deitz, Ph.D.
Directora del Proyecto

PROJECT PRISM: A National Collaborative Study on the Early Development of Children with Visual Impairments

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303-351-1653 1-800-395-2693 FAX 303-351-1061

Payment to Participants Form

Name of Parent Completing Forms: _____

Parent's Social Security Number: _____

Parent's Address: _____

Type of participation: Completion of parent data collection forms

Amount: \$25.00

Account: 4-80607-3110

Requested by: _____ Date: _____
(Parent's Signature)

Approved by: _____ Date: _____
(UNC Project Signature)

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FORMULARIO PARA EFECTUAR PAGOS A PARTICIPANTES

Nombre del Participante: _____

No. de Seguro Social: _____

Dirección del participante: _____

Typo del participación: Llenado de formularios de recolección de datos por los padres

Monto:\$25.00

Cuenta: 4-80607-3110

Solicitado por: _____
(Parent's Signature)

Fecha: _____

Aprobado por: _____
(UNC Project Signature)

Fecha: _____

Child Health Status

Child's Name _____ Date: _____

Your Child's Health

1. In general, would you say your child's health is excellent, good, fair or poor?

(Circle one)

- | | |
|-----------------|---|
| Excellent | 1 |
| Good..... | 2 |
| Fair | 3 |
| Poor..... | 4 |

2. In general, would you say your child's health is excellent, good, fair or poor?

(Circle one)

- | | |
|--------------------|---|
| A great deal | 1 |
| Somewhat | 2 |
| A little..... | 3 |
| Not at all | 4 |

3. In general, would you say your child's health is excellent, good, fair or poor?

(Circle one)

- | | |
|--------------------|---|
| A great deal | 1 |
| Some | 2 |
| A little..... | 3 |
| Not at all | 4 |

4. Please read each of the following statements, and then circle one of the numbers on each line to indicate whether the statement is true or false for this child. There are no right or wrong answers. Some of the statements may look or seem like others. But each statement is different and should be rated by itself.

	Definitely True	Mostly true	Don't know	Mostly false	Definitely false
A. This child's health is excellent.	5	4	3	2	1
B. This child seems to resist illness very well.	5	4	3	2	1
C. This child seems to be less healthy than other children I know.	5	4	3	2	1
D. When there is something going around, this child usually catches it.	5	4	3	2	1

Additional Comments (Use back of sheet if you want):

*Adapted from Lewis, C.C., Pantell, R.H., & Kieckhefer, G.M. (1989). Assessment of children's health status: Field test of new approaches. *Medical Care*, 27(Suppl. 3), S54-S64.

SITUACION DE SALUD DEL NIÑO¹

La Salud de Su Niño

1. En términos generales, ¿diría usted que la salud de este niño es excelente, buena, regular o delicada?

(Marcar uno con círculo)

Excelente	1
Buena	2
Regular	3
Delicada.....	4

2. Durante los últimos 3 meses, ¿qué tanto se ha preocupado usted por la salud del niño?

(Marcar uno con círculo)

Mucho	1
Bastante	2
Un poco	3
En nada.....	4

3. Durante los últimos tres meses, ¿qué cantidad de dolor o aflicción le ha causado a este niño su situación de salud?

(Marcar uno con círculo)

Mucho	1
Bastante	2
Un poco	3
Ninguno.....	4

4. Rogamos se sirva leer cada una de las siguientes declaraciones y luego encerrar en círculo uno de los números en cada renglón para indicar si la declaración es verdadera o falsa para este niño. No hay respuestas acertadas o incorrectas. Algunas de las declaraciones pueden lucir o parecer como otras. No obstante, cada declaración es diferente y debe calificarse individualmente.

	Definitivamente verdadera	Verdadera en su mayor parte	No sé	Falsa en su mayor parte	Definitivamente falsa
A. La salud de este niño es excelente	1	2	3	4	5
B. Este niño parece resistir muy bien las enfermedades	1	2	3	4	5
C. Este niño parece ser menos saludable que otros niños que yo conozco	1	2	3	4	5
D. Cuando hay alguna enfermedad rondando, este niño normalmente se enferma	1	2	3	4	5

¹ Adaptado de Lewis, C. C., Pantell, R. H., y Kiefckhefer, G. M. (1989). Assessment of children's health status: Field test of new approaches. *Medical Care*, 27(Suppl. 3), S54-S64.

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Division of Special Education, University of Northern Colorado, Greeley, CO 80639
303-351-1653 FAX 303-351-1061

Child's name:		ID#:
Date:	Project Evaluator:	Site:

CHILD MEDICAL QUESTIONNAIRE

Health Status and History

Visual diagnosis or diagnoses: _____

Diagnosis received from (check all that apply):
 Ophthalmologist Pediatrician Nurse Neurologist
 General Practitioner, M.D. Optometrist
 Other (identify):

Date of diagnosis of visual impairment: _____

During last 3 months:

_____ Number of hospitalizations/surgeries
_____ Days in hospitable (in-patient) last 3 months
_____ Number of injuries/illnesses requiring medical attention, including outpatient services,
but not hospitalization in last 3 months

Type and length of different illnesses in last 3 months _____

_____ Visits to pediatrician for standard check-ups
_____ Visits to pediatrician for illness or injury
_____ Visits to ophthalmologist for standard check-ups
_____ Visits to ophthalmologist for illness or injury

Additional Handicapping Conditions:

Autism Hearing impairment Learning disabilities

- Behavior disorder Developmental delay Mental retardation
- Cerebral palsy Emotional disturbance Microcephaly
- Deafness Hydrocephaly Physical anomalies

- Genetic syndrome (please specify):

- Neurological impairment (please specify):

- Other (please specify):

Diagnosis of additional handicapping condition received from (check all that apply):

- Ophthalmologist Pediatrician Nurse Neurologist
- General Practitioner, M.D.
- Other (identify):

Date additional handicapping condition diagnosed: _____

Additional Health/Medical Conditions:

- Asthma Failure to thrive HIV
- Attention deficit disorder Gastrostomy Tracheostomy
- Epilepsy or seizure disorder Heart disorder

- Prenatal infection (toxoplasmosis, rubella, cytomegalovirus, herpesvirus, etc.) (please indicate)
- Prenatal substance exposure (alcohol, drugs, tobacco) (please indicate)

- Other (please specify):

Diagnosis of additional health/medical condition received from (check all that apply):

- Ophthalmologist Pediatrician Nurse Neurologist
- General Practitioner, M.D.
- Other (identify):

Date additional health/medical condition diagnosed: _____

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303-351-1653 1-800-395-2693 FAX 303-351-1061

Child's name:		ID#:
Date:	Project Evaluator:	Site:

FAMILY DEMOGRAPHICS QUESTIONNAIRE

Mother's DOB: _____ Mother's years of education _____

Mother's ethnicity (please be as specific as possible): _____

Average hours per week mother employed during last 3 months _____

Father's DOB _____ Father's years of education _____

Father's ethnicity (please be as specific as possible): _____

Average hours per week father employed during last 3 months _____

Primary caregiver: _____

Relationship of primary caregiver to child: _____

Primary caregiver's DOB (if not parent) _____

Primary caregiver's years of education (if not parent) _____

Please indicate if this is a foster placement: Yes No

Does child have brothers and/or sisters? No

Yes, _____ number of brothers

Yes, _____ number of sisters

How many of these brothers and/or sisters are:

_____ half-siblings (who share a biological parent)

_____ step-siblings (child of a step-parent)

Primary language spoken in the home: _____

If not English, estimate % of English _____

Functional Status II-R*

How Well Has Your Child Been?

Here are some statements that mothers have made to describe their children. Please answer them thinking about this child during the last 2 weeks.

Please answer only those Part 2 items for which you chose an asterisked answer in Part 1.

Part 1. During the last 2 weeks, how often did this child:

Part 2. Was this due to illness?

1. Eat well.	*Never or rarely	*Some of the time	Almost always	Yes	Sometimes	No
2. Sleep well.	*Never or rarely	*Some of the time	Almost always	Yes	Sometimes	No
3. Seem contented and cheerful.	*Never or rarely	*Some of the time	Almost always	Yes	Sometimes	No
4. Act moody.	Never or rarely	*Some of the time	*Almost always	Yes	Sometimes	No
5. Communicate what he/she wanted.	*Never or rarely	*Some of the time	Almost always	Yes	Sometimes	No
6. Seem to feel sick and tired.	Never or rarely	*Some of the time	*Almost always	Yes	Sometimes	No
7. Occupy him/herself.	*Never or rarely	*Some of the time	Almost always	Yes	Sometimes	No
8. Seem lively and energetic.	*Never or rarely	*Some of the time	Almost always	Yes	Sometimes	No
9. Seem unusually irritable.	Never or rarely	*Some of the time	*Almost always	Yes	Sometimes	No
10. Sleep through the night.	*Never or rarely	*Some of the time	Almost always	Yes	Sometimes	No
11. Respond to your attention.	*Never or rarely	*Some of the time	Almost always	Yes	Sometimes	No
12. Seem unusually difficult.	Never or rarely	*Some of the time	*Almost always	Yes	Sometimes	No
13. Seem interested in what was going on around him/her.	*Never or rarely	*Some of the time	Almost always	Yes	Sometimes	No
14. React to things by crying.	Never or rarely	*Some of the time	*Almost always	Yes	Sometimes	No

* Adapted from Lewis, C. C., Pantell, R. H., & Kieckhefer, G. M. (1989). Assessment of children's health status: Field test of new approached. *Medical Care*, 27 (Suppl. 3), S54-S64.

SITUACION FUNCIONAL II-R

¿Cómo Ha Sido la Salud de Su Niño?

He aquí algunas declaraciones hechas por madres para describir a sus niños. Favor de dar sus respuestas en términos de la situación de este niño durante las últimas dos semanas.

Rogamos respondan únicamente a los puntos de la Parte II para los cuales haya seleccionado una respuesta señalada con asterisco en la Parte 1.

Parte 1: Durante las últimas dos semanas, con qué frecuencia hizo este niño lo siguiente:

Parte 2: ¿Era esto porque estaba enfermo?

1.	Comer bien	* Nunca o raras veces	* Una parte del tiempo	Casi siempre	Sí	A veces	No
2.	Dormir bien	* Nunca o raras veces	* Una parte del tiempo	Casi siempre	Sí	A veces	No
3.	Parecer contento y alegre	* Nunca o raras veces	* Una parte del tiempo	Casi siempre	Sí	A veces	No
4.	Mostrarse taciturno	Nunca o raras veces	* Una parte del tiempo	* Casi siempre	Sí	A veces	No
5.	Comunicar sus deseos	* Nunca o raras veces	* Una parte del tiempo	Casi siempre	Sí	A veces	No
6.	Parecer sentirse enfermo y cansado	Nunca o raras veces	* Una parte del tiempo	* Casi siempre	Sí	A veces	No
7.	Ocuparse en alguna actividad	* Nunca o raras veces	* Una parte del tiempo	Casi siempre	Sí	A veces	No
8.	Parecer animado y enérgico	* Nunca o raras veces	* Una parte del tiempo	Casi siempre	Sí	A veces	No
9.	Parecer inusualmente irritable	Nunca o raras veces	* Una parte del tiempo	* Casi siempre	Sí	A veces	No
10.	Dormir toda la noche	* Nunca o raras veces	* Una parte del tiempo	Casi siempre	Sí	A veces	No
11.	Responder a sus atenciones	* Nunca o raras veces	* Una parte del tiempo	Casi siempre	Sí	A veces	No
12.	Parecer inusualmente difícil	Nunca o raras veces	* Una parte del tiempo	* Casi siempre	Sí	A veces	No
13.	Parecer tener interés en las actividades en su alrededor	* Nunca o raras veces	* Una parte del tiempo	Casi siempre	Sí	A veces	No
14.	Reaccionar ante los eventos llorando	Nunca o raras veces	* Una parte del tiempo	* Casi siempre	Sí	A veces	No

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1-800-395-2693 303-351-1653 FAX 303-351-1061

Child's name:	Date:
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Project Evaluators have told Project PRISM that they feel uncomfortable asking parents questions about such personal matters as income. Yet, this information can be valuable to us when we group together all the information on all the children.

We would appreciate your answering these questions. This information will not be shared with anyone and will remain strictly confidential.

Family support from public assistance (check all that apply):

- AFDC
 - CIDC
 - Food Stamps
 - Other (please specify):
 - Medicaid
 - SSI
 - Title XIX
 - WIC
-
-

Please indicate approximate household income:

- Less than \$10,000 annually
- \$10,001 - \$20,000 annually
- \$20,001 - \$30,000 annually
- \$30,001 - \$40,000 annually
- \$40,001 - \$50,000 annually
- More than \$50,000 annually

PROYECTO PRISMA: Un Estudio Colaborativo Nacional sobre el Desarrollo Temprano de Niños con Impedimentos Visuales

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1-800- 395-2693 303-351-1653 Fax 303-351-1061

Nombre del niño:	Fecha:
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Los Evaluadores del Proyecto PRISMA han informado al personal del Proyecto que se sienten incómodos al solicitar a los padres información sobre asuntos personales, tales como el ingreso familiar. Sin embargo, tal información nos puede resultar de mucha utilidad cuando consolidemos toda la información relacionada con todos los niños.

Mucho agradeceríamos contestaran las siguientes preguntas. Esta información no sera compartida con otras personas y se mantendra estrictamente confidencial.

Susteno familiar proveniente de Fuentes de asistencia publica (favor marcar todas las respuestas aplicables):

- | | | |
|---|-----------------------------------|------------------------------------|
| <input type="checkbox"/> AFDC | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Title XIX |
| <input type="checkbox"/> CIDC | <input type="checkbox"/> SSI | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Estampillas (cupones) para alimentos | | |

Sirvanse indicar abajo el ingreso familiar aproximado:

- | | |
|---|---|
| <input type="checkbox"/> Menos de \$10,000 anuales | <input type="checkbox"/> De \$30,001 a \$40,000 anuales |
| <input type="checkbox"/> De \$10,001 a \$20,000 anuales | <input type="checkbox"/> De \$40,001 a \$50,000 anuales |
| <input type="checkbox"/> De \$20,001 a \$30,000 anuales | <input type="checkbox"/> Mas de \$50,000 anuales |

PROJECT PRISM: A National Collaborative Study on the Early Development of Children with Visual Impairments

Division of Special Education, University of Northern Colorado, Greeley, CO 80639
 303-351-1653 1-800-395-2693 FAX 303-351-1061

Child's name:		ID#:
Date:	Project Evaluator:	Site:

INTAKE BIRTH HISTORY

Date of Birth: _____ **Gender:** Female Male

Birthweight: _____ lbs. _____ oz. *or* _____ grams

Gestational age at birth: _____ weeks *or* _____ months

Date discharged from hospital following birth: _____
or number of days in hospital after birth: _____

Birth order: _____ [child] of _____ [total children]

Twin? Yes _____ No _____ Explain: _____

Perinatal history (obtain this information from your records or from family directly):

[] Apnea [] Hyaline membrane disease [] Neonatal hyperbilirubinemia

[] BPD (bronchopulmonary dysplasia) [] IVH (intracranial or intraventricular hemorrhage) [] Neonatal seizures

[] Bradycardia [] Meconium aspiration [] PDA (patent ductus arteriosus)

[] Failure to thrive [] Necrotizing enterocolitis

[] Other (please describe):

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Child's name:		ID#:
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PARENT EVALUATION OF SERVICES

This information is confidential and will only be seen by PRISM staff.

Please rate your satisfaction your child's services by circling the numbers on the scale below each question:

I feel that the overall actual services my child receives are

Very Poor 1 Poor 2 Average 3 Good 4 Excellent 5

I feel that the total amount of time my child receives services is

Very Poor 1 Poor 2 Average 3 Good 4 Excellent 5

I feel that the staff's availability to me to answer questions is

Very Poor 1 Poor 2 Average 3 Good 4 Excellent 5

I feel that my opportunity for contact with other parents is

Very Poor 1 Poor 2 Average 3 Good 4 Excellent 5

I feel that the availability of special services (such as physical therapy, occupational therapy or speech therapy) is

Very Poor 1 Poor 2 Average 3 Good 4 Excellent 5

I feel that the ease of getting to my child's services (in terms of distance, travel, transportation, parking) is

Very Poor	Poor	Average	Good	Excellent
1	2	3	4	5

I feel the availability of information about my child from the program is

Very Poor	Poor	Average	Good	Excellent
1	2	3	4	5

I feel my child's progress is

Very Poor	Poor	Average	Good	Excellent
1	2	3	4	5

I feel the parent education opportunities (such as meetings, seminars, workshops) are

Very Poor	Poor	Average	Good	Excellent
1	2	3	4	5

Comments:

Thank you very much for your time! Please mail this back to Project PRISM at the University of Northern Colorado in the envelope provided. THIS INFORMATION IS CONFIDENTIAL AND WILL ONLY BE SEEN BY PROJECT PRISM STAFF.

PROYECTO PRISMA: Un Estudio Colaborativo Nacional sobre el Desarrollo Temprano de Niños con Impedimentos Visuales

Division of Special Education, University of Northern Colorado, Greeley, CO 80639
1-800- 395-2693 303-351-1653 Fax 303-351-1061

Nombre del Niño:		No. Identificador:
Fecha:	Evaluador del Proyecto:	Agencia:

EVALUACION DE LOS SERVICIOS POR LOS PADRES

Esta información es confidencial y solamente será vista por el personal del Proyecto PRISMA.

Rogamos se sirva clasificar su satisfacción con los servicios recibidos por su niño encerrando en círculo el número apropiado en la siguiente escala:

Considero que, en conjunto, los servicios que efectivamente recibe mi niño son

Muy malo *Malo* *Regular* *Bueno* *Excelente*
1 2 3 4 5

Considero que la cantidad total de tiempo durante el cual mi niño recibe servicios es

Muy malo *Malo* *Regular* *Bueno* *Excelente*
1 2 3 4 5

Considero que el tiempo durante el cual el personal se hace disponible para contestar mis preguntas es

Muy malo *Malo* *Regular* *Bueno* *Excelente*
1 2 3 4 5

Considero que mis oportunidades para establecer contactos con otros padres son

Muy malo *Malo* *Regular* *Bueno* *Excelente*
1 2 3 4 5

Considero que la disponibilidad de servicios especiales (tales como los de terapia física, terapia vocacional o terapia de pronunciación) es

<i>Muy malo</i>	<i>Malo</i>	<i>Regular</i>	<i>Bueno</i>	<i>Excelente</i>
1	2	3	4	5

Considero que la facilidad con que puedo llegar al lugar donde se prestan los servicios a mi niño (en términos de distancia, tiempo de viaje, transporte, estacionamiento) es

<i>Muy malo</i>	<i>Malo</i>	<i>Regular</i>	<i>Bueno</i>	<i>Excelente</i>
1	2	3	4	5

Considero que la disponibilidad de información por parte del personal del programa acerca de mi niño es

<i>Muy malo</i>	<i>Malo</i>	<i>Regular</i>	<i>Bueno</i>	<i>Excelente</i>
1	2	3	4	5

Considero que la disponibilidad de información acerca del programa es

<i>Muy malo</i>	<i>Malo</i>	<i>Regular</i>	<i>Bueno</i>	<i>Excelente</i>
1	2	3	4	5

Considero que el avance logrado por mi niño es

<i>Muy malo</i>	<i>Malo</i>	<i>Regular</i>	<i>Bueno</i>	<i>Excelente</i>
1	2	3	4	5

Considero que las oportunidades educativas para padres (tales como reuniones, seminarios, talleres) son

<i>Muy malo</i>	<i>Malo</i>	<i>Regular</i>	<i>Bueno</i>	<i>Excelente</i>
1	2	3	4	5

Observaciones:

¡Muchas gracias por su tiempo! Sírvanse devolver este formulario por correo al Proyecto PRISMA, en la Universidad del Norte de Colorado, en el sobre adjunto. **ESTA INFORMACION ES CONFIDENCIAL Y SOLAMENTE SERA VISTA POR EL PERSONAL DEL PROYECTO PRISMA.**

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Child's name:		ID#:
Date:	Project Evaluator:	Site:

PRIMARY INTERVENTIONIST'S PERCEPTION OF SERVICES

Please rate your perceptions of the following items using the scale provided below:

Very poor **Poor** **Average** **Good** **Excellent**
 1 2 3 4 5

Family follow-through on recommendations and services:

1 2 3 4 5

Family knowledge of special education in general:

1 2 3 4 5

Family knowledge of program:

1 2 3 4 5

Family knowledge of child's progress:

1 2 3 4 5

Family knowledge of special education legislation:

1 2 3 4 5

Family support of program goals:

1 2 3 4 5

Family support of child goals:

1 2 3 4 5

(Over, please)

Please tell us a little bit about your training:

What is the highest degree you hold?

- B.A. M.A. M.Ed. Ph.D.
 B.S. M.S. Ed.D.

What certifications do you hold in your state:

- | | |
|--|--|
| <input type="checkbox"/> Blind and Visually Impaired | <input type="checkbox"/> Primary |
| <input type="checkbox"/> Deaf and Hearing Impaired | <input type="checkbox"/> Secondary |
| <input type="checkbox"/> Early Childhood | <input type="checkbox"/> Severe Disabilities |
| <input type="checkbox"/> Early Childhood Special Education | <input type="checkbox"/> Special Education |
| <input type="checkbox"/> Elementary | |

Other (please specify):

If you are not certified in blindness and visual impairment, have you had some training in the education of young children with visual disabilities?

- _____ Yes
_____ No

IF YES:

- _____ Total university units/credits of VH-specific training
_____ In services only
_____ Workshops
_____ Continuing education credits
_____ Other: _____

Thank you very much for your time! Please return this to Project Prism at University of Northern Colorado in the envelope provided.

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Child's name:	ID#:
Date:	Project Evaluator:

SERVICE QUESTIONNAIRE

Is this child's major service provider a setting or program specializing in services for children or adults with visual disabilities?
(Please circle) Yes No

If not, does this child receive vision services as a support or related service? (Please circle) Yes
No

Complete the other side of this questionnaire by filling in the number of hours of actual/direct services received during the last month, according to what type of services were provided, who provided them, and whether they were provided to the child alone, to the child with his or her caregiver present, or to the caregiver alone.

	Provided to Child Alone		Provided to Child and Caregiver Together		Provided to Caregiver or Family Alone	
	Provided by PRISM collaborating agency or other specialized blindness/VI agency	Provided by some other generic agency	Provided by PRISM collaborating agency or other specialized blindness/VI agency	Provided by some other generic agency	Provided by PRISM collaborating agency or other specialized blindness/VI agency	Provided by some other generic agency
Services provided as part of the child's IFSP or IEP (i.e., part of the child's special education and early intervention program):						
Adapted physical education						
Counseling or social work						
Home visits, any age						
Infant program, group						
Infant program, individual						
Music therapy						
Nursing care						
Occupational therapy						
Orientation and mobility						
Physical therapy						
Preschool class						
Respite care						
Speech therapy						
Toddler class						
Other:						
Other:						
Other:						
TOTAL HOURS IN PAST MONTH:						

	Provided to Child Alone		Provided to Child and Caregiver Together		Provided to Caregiver or Family Alone	
	Provided by PRISM collaborating agency or other specialized blindness/VI agency	Provided by some other generic agency	Provided by PRISM collaborating agency or other specialized blindness/VI agency	Provided by some other generic agency	Provided by PRISM collaborating agency or other specialized blindness/VI agency	Provided by some other generic agency
Other activities child participates in, outside of special education:						
Day care						
Gymboree						
Mother's Day Out						
Preschool						
Sunday school						
Other:						
Other:						
Other:						
Other:						
TOTAL HOURS IN PAST MONTH:						

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Child's name:		ID#:
Date:	Project Evaluator:	Site:

Teller Acuity Card Score Sheet

Does child demonstrate a behavioral response to or awareness of light? Yes No
 Does child have light perception? Yes No

IF NO, and if both you and the family agree, the Teller Acuity Cards do not need to be administered.

cy/cm	Test #1			Test #2			Test #3		
	OU	OD	OS (circle 1)	OU	OD	OS	OU	OD	OS
	SC CC (circle 1)			SC CC			SC CC		
	Test distance:			Test Distance:			Test Distance:		
0.23									
0.32									
0.64									
1.3									
2.4									
4.8									
9.8									
19.0									
38.0									
Blank									

		5 (high)	4	3	2	1 (low)	too fussy to finish test	too sleepy to finish test	too inattentive to finish test
Confidence in estimates	OU:								
	OD:								
	OS:								

Procedures for Teller Acuity Card Administration

Before you begin, determine whether or not the child has a behavioral response to or awareness of light and/or light perception. Circle the answer to the two questions at the top of the score sheet.

Position yourself approximately 38 cm. from the child, who is either positioned correctly in an infant seat or being held by the parent. This is most likely the distance from your elbow to your longest outstretched finger. Test with both eyes (OU), but mark if the child is wearing corrective lenses (CC).

Begin with the blank card. Always proceed from the widest stripes (the coarsest grating) to the thinnest stripes (the finest grating).

1. Pick up card. Do not look at the front of the card to find out which side the stripes are on!
2. Observe the child's response through the card's peephole. *Guess* which side the stripes are on, based on the child's behavior (i.e., does the child look toward one side of the card?).
3. Reverse the card left-right without looking at the front of the card yet.
4. Observe the child's response through the card's peephole. *Guess* which side the stripes are on, based on the child's behavior (i.e., does the child look toward one side of the card?).
5. If child does look at the other side of card, check the front of the card to determine which side the stripes are on.
6. If you *correctly* guessed where the stripes were located both times, record a "+" for that card.

If you did *not* guess correctly where the stripes were located, record a "-" for that card.

If you guessed correctly once, but not when you reversed the card (or vice versa), record a "+/-" for that card.

7. Continue testing with the next finer grating (tinner-striped) card(s) until you reach two "-" in succession.
8. If you feel confident about your results, you can stop here and mark the confidence level at the bottom of the form.

If you want to repeat the procedures, start with the last card you used (the thinnest stripes) and work backwards (to the .23 card). Utilize the same procedures above to record your responses. *Remember, your goal is to find the finest grating the child will fixate consistently.* Follow the schematic diagram below to repeat your testing:

