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		School District of Residence					
5. Parent/Guardian 1 Name		Parent 2 Name					
Address		City/Town		Zip Code			
Phone (H)		Cell		Fax			
Email 1		Email 2					

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

HEREDITARY/CHROMOSOMAL 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 Batten 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, 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		5.Diagnosed Progressive Loss		6.Further Testing Needed
	7.Documented Functional Vision Loss	Right (w/C)		Left (w/C)	

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		8.Documented Functional Hearing Loss		
Right Ear			Left Ear		

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3. Does the child have any of the following:			
	Yes	No	Unknown
Auditory Neuropathy			
Central Auditory Processing Disorder (CAPD)			
Cochlear Implant			
Cortical Visual Impairment			
Other:			
Other:			

4. Indicate all other *documented* impairments, in addition to vision and hearing impairments:		
	Yes	No
Orthopedic/Physical Impairments		
Cognitive Impairments		
Behavior Disorder		
Complex Health Care Needs		
Communication, Speech/Language Impairment		
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.Intellectual Disability		6.Orthopedic Impairment		11.Autism
	2.Hearing Impairment (includes deafness)		7.Other Health Impairment		12.Traumatic Brain Injury
	3.Speech or Language Impairment		8.Specific Learning Disability		13.Developmentally Delayed (ages 3 through 9)
	4.Visual Impairment (includes blindness)		9.Deaf-Blindness		14.Non-Categorical
	5.Emotional Disturbance		10.Multiple Disabilities		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. In a regular early childhood program 10+ hours per week with services.				
	2. In a regular early childhood program 10+ hours per week – services elsewhere.				
	3. In a regular early childhood program less than 10 hours per week with services.				
	4. In a regular early childhood program less than 10 hours per week – services elsewhere.				
	5. Attending a separate class.		6. Attending a separate school.		7. Attending a residential facility.
	8. Service provider location.		9. Home		

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

	10. Inside the regular class 80% or more of the day		11. Inside the regular class 40% to 79% of the day
	12. Inside the regular class less than 40% of the day		13. Separate school
	14. Residential Facility		15. Homebound/Hospital
	16. Correctional Facilities		17. 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.	---	4. Not used
	2. Regular grade-level State assessment with accommodations.	---	5. Not used
	3. Alternate assessments (NYSAA) based on alternate achievement standards.		7. Parent Opt Out
	6. Not required current 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.		5. Part B eligibility not determined.
	1. Completion of IFSP prior to reaching maximum age for Part C.		6. Deceased.
	2. Eligible for IDEA, Part B		7. Moved out of state.
	3. Not eligible for Part B, exit with referrals to other program.		8. Withdrawal by parent/guardian.
	4. Not eligible for Part B, exit with no referrals.		9. Attempts to contact the parent and/or child were unsuccessful

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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.		4. Reached maximum age.
	1. Transferred to regular education.		5. Deceased.
	2. Graduated with regular high school diploma.		6. Moved; known to be continuing.
	3. Received a certificate.	---	7. Not used.
			8. Dropped out.

9. Deaf-Blind Project Exiting Status		0. Eligible to receive services from the deaf-blind project.		1. No longer eligible to receive services from the state deaf-blind project.

10. Current living status:		1. Home: With 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:

11. Does this individual use any of the following adaptive equipment?	
Corrective Lenses	____Yes ____ No ____ Unknown
Assistive Listening Devices (i.e. hearing aids or FM system)	____Yes ____ No ____ Unknown
Additional Assistive Technology (other than corrective lenses or assistive listening devices)	____Yes ____ No ____ Unknown
12. Does this individual receive Intervener Services?	____Yes ____ No ____ Unknown

13. School Information					
Agency/School Name					
Street Address					
City		State		Zip Code	
Telephone Number		Fax			
Teacher Name		Teacher's Email			
Intervener		Intervener's Email			

14. Please add me to SCIDB's email distribution list **(via Constant Contact).**		Yes		No

15. Would you like to have a referral made for a consultation or meeting with the SCIDB Project?			
	Yes		No

Signature: ____ Date: _______________________________

Please return this form to:

SCSDB: Deaf-Blind Project
Attn: Robert Hill, Director
101 Executive Center Drive, Suite 120
Columbia, SC 29210
or Fax: 803-896-4628

If you have any questions or need assistance in completing this form please contact us at: 1-800-984-4357 or email us at deafblind@scsdb.org.

Revised 06.21.18