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| **PLAN DEL ÁREA LOCAL DE EDUCACIÓN ESPECIAL DE DESERT/MOUNTAIN**  **PLAN DEL ÁREA LOCAL DE EDUCACIÓN ESPECIAL AUTÓNOMA DE DESERT/MOUNTAIN**  17800 HIGHWAY 18 • APPLE VALLEY, CA 92307  (760) 552-6700 • (760) 242-5363 FAX  **Información Familiar** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **INFORMACIÓN DEL ESTUDIANTE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nombre del Estudiante: | | | | | | | | | | | |  | | | | | | | | | | Fecha de Nacimiento: | | | | | | | |  | | | | | | | | | | | Género: | | | Male  Female | | | | |
| Plantel Escolar: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | Profesor/a: | | | | | | | |  | | | | | | | | | |
| Distrito de Asistencia: | | | | | | | | | | |  | | | | | | | | | | | | | | | | Distrito de Residencia: | | | | | | | | | | | |  | | | | | | | | | |
| Padre/Tutor: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tel Casa: | | |  | | | | | | | | | | | | | | Tel. Trabajo: | | | | | |  | | | | | | | | | | | | Otro Teléfono: | | | | | | | |  | | | | | |
| Dirección: | | | | |  | | | | | | | | | | | | | Cuidad: | | | | |  | | | | | | | | | | Estado: | | | | | |  | | | | Código Postal: | | | | |  |
| Dirección de Correo: | | | | | | | | |  | | | | | | | | | Cuidad: | | | | |  | | | | | | | | | | Estado: | | | | | |  | | | | Código Postal: | | | | |  |
| Idioma hablado en casa: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **ListA DE HERMANOS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nombre** | | | | | | | | | | | | | | | | | | | | | | | |  | **Género** | | | | | | | | | | | | |  | | **Edad** | | | |  | | **¿En casa?** | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | Masc | | | | Femenino | | | | | | | | |  | |  | | | |  | | Sí  No | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | Masc | | | | Femenino | | | | | | | | |  | |  | | | |  | | Sí  No | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | Masc | | | | Femenino | | | | | | | | |  | |  | | | |  | | Sí  No | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | Masc | | | | Femenino | | | | | | | | |  | |  | | | |  | | Sí  No | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | Masc | | | | Femenino | | | | | | | | |  | |  | | | |  | | Sí  No | | |
| **ListA DE ESCUELAS A LAS QUE SU HIJO/A HA ASISTIDO** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Escuela** | | | | | | | | | | | | | | | | | | |  | | **Distrito** | | | | | | | | | |  | | | **Tipo de Programa** | | | | | | | | | | |  | | **Fecha** | |
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| **ListA DE HospitalEs, ClinicAs, O AgenciAs QUE HAN EXAMINADO A SU HIJO/A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Hospital/Clinica/Agencia** | | | | | | | | | | | | | | | | | | |  | | **Dirección** | | | | | | | | | | |  | | **Cuidad** | | | | | | | | | | |  | | **Estado** | |
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| **InfoRMACIÓN GENERAL** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. Describa brevemente la relación de su hijo/a con sus pares: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. Describa brevemente la relación de su hijo/a con sus hermanos, hermanas, y padres en casa: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. ¿Su hijo/a puede ser dejado sólo/a?  Sí  No Si no, por favor explique: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. ¿A qué tipo de disciplina su hijo/a responde mejor? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. ¿Qué intereses especiales tiene su hijo/a? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. ¿Cuáles son sus principales inquietudes con respecto a su hijo/a? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. ¿Su hijo/a ha sido reseñado dactilarmente? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **INFORMACIÓN FÍSICA** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. ¿Su hijo/a tiene alguna discapacidad?  Sí  No Si es así, por favor explique: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. ¿Su hijo/a ha estado recientemente o está bajo el cuidado de un médico?  Sí  No Si es así, por favor explique: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. ¿Su hijo/a toma algún medicamento(s) por alguno de los siguientes casos? Si es así, indique la frecuencia: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Ataque | | | | | | | Sí | | | | | | No | | Si es así, indique la frecuencia: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | Hiperactividad | | | | | | | Sí | | | | | | No | | Si es así, indique la frecuencia: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | Alergias | | | | | | | Sí | | | | | | No | | Si es así, indique la frecuencia: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | Diabetes | | | | | | | Sí | | | | | | No | | Si es así, indique la frecuencia: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | Tiroides | | | | | | | Sí | | | | | | No | | Si es así, indique la frecuencia: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | Asma | | | | | | | Sí | | | | | | No | | Si es así, indique la frecuencia: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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|  | | Otro: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. ¿Su hijo/a usa normalmente una de las siguientes ayudas? *(marque todas las que apliquen)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Gafas | | | | | | Correctores | | | | | | | | Audífonos | | | | | Zapatos correctores | | | | | | | | Otro: | | | | | | | |  | | | | | | | | | | | | |
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| 5. ¿Su hijo/a ha recibido ayuda especial en la escuela? Por favor describa: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Firma del Padre/Tutor: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | Fecha: | | | | |  | | | | | | |