S.O.S. Program

Request for Support

early learning coalition of Osceola County

The Early Learning Coalition of Osceola County is available to provide on-site technical assistance for providers who serve children with learning difficulties. These services are available whether or not a child has been diagnosed with a specific special need. In addition to providing technical assistance, the Inclusion Specialist will observe the child to determine if the child may benefit from outside interventions.

Please fill out this packet, in its entirety, for the child you'd like assistance with.

Date of Request: _____
Name of Child Care Center: _____
School's Address: _____
Teacher(s): _____
Director: _____
Daytime Phone Number: _____
Email: _____

Please check any that apply:

☐ School Readiness Funded ☐ Private Pay ☐ Voluntary Prekindergarten Student

Type of Inclusion support requested (check all that apply):

- ☐ Community Referral Information for: **(circle all that apply)**
  Speech, Occupational, or Physical Therapy
- ☐ Classroom Observation and Technical Assistance for developmental progress of:
  (circle all that apply) Communication, Fine Motor, Gross Motor, Problem Solving
- ☐ Behavioral Observation and Technical Assistance
  (Must include Functional Behavior Assessment)
- ☐ Training on: **(circle all that apply)**
  Developmentally Appropriate Practice, Classroom Management, Social-Emotional Education, Literacy Development, Writing Development
- ☐ Other Assistance: _____

Submit to:

Attn: Inclusion Specialist
Early Learning Coalition of Osceola County
1631 E. Vine St. Suite E.,
Kissimmee, FL 34744
407-705-1926 FAX: 407-933-5012

Have you included?

(check all that you have included)

- ☐ Signed Parental Consent Form
- ☐ Functional Behavior Assessment(s)
- ☐ Most recent ASQ
  (non-School Readiness, only)
- ☐ Any additional documentation

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Parental Consent Form

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Child's Name: _____
Child's Date of Birth: _____
Parent/Guardian_____
Address: _____

Diagnosis (if known): _____
Is your child currently receiving Behavioral, Speech, Occupational, or Physical Therapy? (circle one) Yes No
If yes, which therapies?
_____

Please describe the concerns you have about your child:

Permission Statement:

As the parent/guardian of the child named above, I give permission for Early Learning Coalition Inclusion Specialist, or other appropriate staff, to complete an observation on my child to determine eligibility for services.

_____ _____
Parent/Guardian Signature Date

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Functional Behavior Assessment

early learning coalition of Osceola County

Child's Name: _____

Assessor's Name: _____

Date of Assessment: _____ Location of Assessment: _____

Be as specific as possible.

Antecedent

What happened right before the behavior occurred (i.e., specific playmates, schedule, etc.)

Behavior

What exactly did the child say/do and to whom or what?

Consequence

What happened right after the behavior? What did other children do? How did the teacher respond?

Strategies

What have you tried to attempt to curb the behavior? How effective have these strategies been? (i.e., time outs, sticker charts, behavior plans, parent conferences, etc.)