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| **AREA DE PLAN LOCAL DE EDUCACIÓN ESPECIAL DESERT/MOUNTAIN**  **AREA DE PLAN LOCAL DE EDUCACIÓN ESPECIAL CHARTER DESERT/MOUNTAIN**  17800 HIGHWAY 18 • APPLE VALLEY, CA 92307  (760) 552-6700 • (760) 242-5363 FAX  **Remisión de Evaluación de Tecnología Asistencial** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **información del estudiante** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nombre del Estudiante: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | Fecha de Nacimiento: | | | | | | | | | |  | | | | | | | | | |
| Nro. Medi-Cal: | | | | | | |  | | | | | | | | | | | | | | | | | | Grado: | | | | | | |  | | | | | Género: | | | | | Masculino | | | | | | Femenino | | |
| Discapacidad: | | | | | |  | | | | | | | | | | | | | | | | | | | | Diagnóstico Médico: | | | | | | | | | |  | | | | | | | | | | | | | | |
| Plantel Escolar: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | Nombre del Maestro: | | | | | | |  | | | | | | | | | | | | | | |
| Distrito de Asistencia: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | Distrito de Residencia: | | | | | | | |  | | | | | | | | | | | | | | |
| Padre/Tutor: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Teléfono del Hogar: | | | | | | | | | | | |  | | | | | Teléfono de la Oficina : | | | | | |  | | | | | | | | | | | | Otro Teléfono: | | | | | | | | |  | | | | | | |
| Dirección: | | | |  | | | | | | | | | | | | | | | Ciudad: | | | |  | | | | | | | | | | | Estado: | | | |  | | | | | | | | Código Postal: | | |  | |
| Dirección Correo: | | | | | | | | | |  | | | | | | | | | Ciudad: | | | |  | | | | | | | | | | | Estado: | | | |  | | | | | | | | Código Postal: | | |  | |
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| Servicios/Ubicación de educación especial actual: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Hora/día en que el estudiante puede ser observado realizando la habilidad/actividad de inquietud: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Persona de Contacto: | | | | | | | | | | | | |  | | | | | | | | Teléfono de Contacto: | | | | | | | | | | | |  | | | | | | | | | Fax: | | | | |  | | | |
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| **SOLICITUD DE iNFORMACIÓN ADICIONAL** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. **Describa las siguientes áreas de inquietud:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  | | --- | | 1. *Acceso al Interruptor:* | |  | | 1. *Acceso al Computador:* | |  | | 1. *Comunicación Aumentativa:* | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **2. ¿Qué pregunta(a) se intenta responder en la Evaluación de Tecnología Asistencial?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **3. Por favor señale el equipo de adaptación usado actualmente:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Silla de Ruedas | Aparatos Ortopédicos | Stander | | Dispositivo de Comunicación | | Muletas | Computador | Férulas de Reposo | | Chaqueta | | Silla de Salón Especializada | Interruptores | Otra: |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Comentarios Adicionales:** *(Por ejemplo: inquietudes emocionales/comportamiento; problemas médicos; déficits de escucha o visión, etc.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Remitido por: | | | | | | | | |  | | | | | | | | | | | | | | | Título: | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Teléfono de Contacto: | | | | | | | | | | | | | | | |  | | | | Email: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Firma del Director de Educación Especial: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | Fecha: | | | |  | | | | | | | |
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| **Adjunte una copia del último informe pscicológico del estudiante e iep actual e incluya cualquier información adicional tales como informes médicos, informes de habla/lenguaje, informes previos ot/o pt, etc.**  **Por favor tenga en cuenta: las remisiones incompletas se devolverán para su diligenciamento y para volver a enviarlas.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |