PRESCHOOL- KINDERGARTEN SCREENING FORM

First Name Middle Initial Last Name

Birthdate: ___/___/___ Current Age: ____ Sex: Male Female Nickname _____

Address: _____ P. O. Box _____ City: _____ Zip Code: _____

Home Telephone: (____) _____-_____ **Social Security Number _____-_____-_____**
To be used on all State of Illinois Documents

Mother's Name: _____ Age: _____ Years of Education Completed _____

Employer: _____ Work Telephone: (_____) _____-_____

Father's Name: _____ Age: _____ Years of Education Completed _____

Employer: _____ Work Telephone: (_____) _____-_____

List Brothers and Sisters

Name: _____ Birthdate: ___/___/___ Name: _____ Birthdate: ___/___/___

Name: _____ Birthdate: ___/___/___ Name: _____ Birthdate: ___/___/___

Other People in the home: _____

Agencies involved with the family: **** Medicaid Number _____**

___ Mid Central Childfind
___ Easter Seals/UCP
___ WIC Program
___ Illinois Department of Mental Health
___ County Health Department
___ Public Aid (IDPA)
___ Department of Children & Family Services (DCFS)
___ Division of Services – Crippled Children
___ Holiday Center

South Pekin Grade School has permission to screen my child.

_____
Parent Signature Date

PRESCHOOL SCREENING FORM

First Name **Middle Initial** **Last Name**

School District you are a resident of: **Rankin Dist. 98** **So. Pekin Grade School Dist. 137** **Spring Lake District 606**

Preschool Experience: (daycare, nursery school, Sunday School, Head Start, etc.)

_____

I am concerned with my child's development for the following reasons:

___ Learns slowly
___ Is hard to control
___ Cannot get along with family or friends
___ Is over 3 and not toilet trained
___ Is very quiet
___ Seems to have speech/language problems
___ Seems to have vision problems
___ Is angry a lot
___ Does not like to color or draw
___ Seems sad
___ Has a short attention span
___ Is clumsy when walking or running
___ Does not like to color or draw
___ I have no concerns

If necessary describe concerns: _____

Has anything happened recently which may have influenced your child's development" (for example death, divorce, separation, relocation, new baby)? _____

If yes, please explain:

_____

PRESCHOOL SCREENING FORM

First Name Middle Initial Last Name

HEALTH HISTORY:

Child's Birth Weight _____ Mother's Age when child was born _____

Was there anything unusual about the pregnancy with this child _____ Explain _____

Did this child require any special medical care or hospitalization at birth or during the first month after birth? _____

Explain _____

Age child sat unsupported: _____ Age child walked: _____ Age child toilet trained _____

Has this child ever been in the hospital or been seriously ill at home: _____

Explain _____

Family Doctor: _____ Date last seen by Doctor _____/_____/_____

Is this child currently taking any medications? _____ Name of Medication: _____Dosage:_____

Does this child have a history of ear infections? _____ If so, how often? _____

Please check any health concerns you or your doctor have noticed:

___ Asthma
___ Indigestion
___ Constipation
___ Diarrhea
___ Headaches
___ Vomiting
___ Stomach Aches

___ Frequent Fevers
___ Sinus Trouble
___ Bed Wetting
___ Allergies
___ Serious Blows to the Head

___ Overtired or Lacking Pep
___ Nightmares
___ Thumb Sucking
___ Nail Biting
___ Diabetes

___ Lack of Consciousness
___ Chronic Ear Infections (more than 2 per year)
___ Heart Trouble

___ Hyperactivity
___ Sleeping Problems
___ Eating Problems
___ Epilepsy (seizures)
___ Nose Bleeding
___ Other physical Problems

Explain: _____

PRESCHOOL SCREENING FORM

First Name **Middle Initial** **Last Name**

LANGUAGE DEVELOPMENT:

At what age did this child first begin to speak? **First Words _____** **2-3 Words Together _____** **Sentences _____**

Does your child:

Stutter	**YES**	**NO**
Have difficulty expressing ideas and concepts	**YES**	**NO**
Speak so that other adults understand him/her	**YES**	**NO**
Speak so that other children understand him/her	**YES**	**NO**

HEARING ASSESSMENT:

Has this child ever had an ear/hearing examination or treatment? _____

If Yes: When: _____ By Whom: _____ Results: _____

Does your child:

1.	**Seem to have difficulty hearing**	**YES**	**NO**
2.	**Turn up the TV louder than other members of the family**	**YES**	**NO**
3.	**Seem to favor one ear over the other**	**YES**	**NO**
4.	**Jump or appear to be more startled than others if there is a sudden noise**	**YES**	**NO**
5.	**Seem to hear you if you talk in a whisper**	**YES**	**NO**
6.	**Make you talk loudly or repeat frequently**	**YES**	**NO**
7.	**Become confused in following more than two verbal directions at a time**	**YES**	**NO**
8.	**Have difficulty remembering things for a long time**	**YES**	**NO**
9.	**Have difficulty remembering things for a short time**	**YES**	**NO**

VISUAL ASSESSMENT:

Has this child ever had a vision examination or treatment: _____

If Yes: When: _____ By Whom: _____ Results: _____

Do you suspect any vision problems:		**YES**	**NO**
Does this child:			
1.	**Seem to have difficulty seeing small lines or pictures**	**YES**	**NO**
2.	**Seem to have a problem seeing things far away**	**YES**	**NO**
3.	**Squint**	**YES**	**NO**
4.	**Wear glasses**	**YES**	**NO**
5.	**Have eyes that turn in**	**YES**	**NO**
6.	**Have eyes that turn out**	**YES**	**NO**
7.	**Sit very close to the television**	**YES**	**NO**
8.	**Rub eyes a lot**	**YES**	**NO**
9.	**Turn head to use primarily one eye**	**YES**	**NO**
10.	**Lower one side of the head when looking at others**	**YES**	**NO**