2022/2023 Preschool Screening Student Background

*****INCOMPLETE DOCUMENTS WILL NOT BE ACCEPTED*****

Child's Full Name:

Date of Birth:

Age:

Gender:

City of Birth:

Legal Residence:

Father' Name:
Address:
Phone Number:
E-mail address:
Employer:

Mother's Name:
Address:
Phone Number:
E-mail address
Employer:

Preferred e-mail address to use for preschool communication:

Stepfather:

Stepmother:

Child lives with: ○ Mother ○ Father ○ Both
○ Other

Names and ages of other children living in the household:

List any previous schools / educational programs your child has attended:

Primary language spoken in the home:

PRESCHOOL SCREENING PERMISSION

During this screening, your child will have his / her vision, hearing, overall growth, and development checked. Results of this screening will be shared with you before you leave the screening. Upon written permission from a parent or legal guardian, the results of the screening maybe shared with another agency to which you may be referred to. Screening results may show a need for further testing of general health, speech, development, hearing, and/or vision.

I grant permission for my child to have a vision / speech / hearing / developmental check:

○ yes ○ no

CHILD'S BIRTH INFORMATION

Was the child premature? ○ Yes ○ No

Was oxygen required? ○ Yes ○ No

Did the child have any disabilities at birth? ○ Yes ○ No

Did the child have trouble sucking or crying? ○ Yes ○ No

Did the child dislike rocking or cuddling? ○ Yes ○ No

Did the child's mother experience any health problems during pregnancy? ○ Yes ○ No

Did the child experience and difficulties after birth? (if yes, please briefly explain)

Did the child's mother use alcohol / tobacco / drugs / medication during pregnancy? ○ Yes ○ No

Was there any thing unusual during the pregnancy , birth, or labor and delivery? (if yes, please briefly explain)

CHILD'S HEALTH / BEHAVIOR INFORMATION

Please select all that apply to your child:

- ☐ Serious illness / high fever
- ☐ Has allergies
- ☐ Has trouble hearing
- ☐ Has tubes in ears
- ☐ Sits close to TV
- ☐ Takes medication on a regular basis
- ☐ Dizzy spells
- ☐ Ingested poisons / medication accidentally
- ☐ Currently under doctors care for condition
- ☐ Had rheumatic fever
- ☐ Had red measles (10 day)
- ☐ Falls a lot
- ☐ Overweight
- ☐ Thumb sucking
- ☐ Cries easily
- ☐ Frequent nightmares
- ☐ Hits without cause
- ☐ Serious accident / injury
- ☐ History of ear / throat infections
- ☐ Prefers high volumes
- ☐ Has trouble seeing
- ☐ Brings items close to look at
- ☐ Fainting / blackout spells
- ☐ Drops things frequently
- ☐ Has asthma
- ☐ Had mumps
- ☐ Had German measles (3 day)
- ☐ Has whooping cough
- ☐ Stuttering
- ☐ Underweight
- ☐ Easily upsets
- ☐ Holds breath
- ☐ Starts fires / fascination with fire
- ☐ Too shy
- ☐ Serious head injury / loss of consciousness
- ☐ History of seizures / convulsions
- ☐ Ask "what" a lot
- ☐ Eyes cross
- ☐ Diagnosed with ADHD / ADD
- ☐ Frequent headaches
- ☐ Runs into objects frequently
- ☐ Been hospitalized
- ☐ Had tuberculosis
- ☐ Had pneumonia
- ☐ Has scarlet fever
- ☐ Drooling
- ☐ Bangs head
- ☐ Fight's with peers
- ☐ Trouble sleeping
- ☐ Breaks things on purpose
- ☐ Does not understand language

If selected any choices, please explain or elaborate. Also include any other information about your child's health / development that may assist in screening your child.

EARLY DEVELOPMENT

Check all task / skills that your child had difficulty with learning:

- ☐ sitting
- ☐ walking
- ☐ crawling
- ☐ standing
- ☐ using crayons
- ☐ using pencil
- ☐ using scissors
- ☐ toilet training
- ☐ speaking
- ☐ getting along with others

Other developmental delays that may be of concern:

GENERAL INFORMATION

Describe your child's temperament or personality:

Describe how your child interacts with family members and friends:

What does your child do for fun?

Describe your child's behavior at home:

What types of discipline strategies are effective with your child?

List several of your child's strengths:

List any special areas of concern you have for your child:

Describe your child's responsibilities and chores at home:

EATING

Does your child place the spoon / fork in their mouth with out turning the utensil upside down, with little or no spilling of food?

- ○ Most of the time
- ○ Sometimes
- ○ Rarely / No

Does your child use the side of the fork for cutting soft food, such as a piece of cake or baked potato?

- ○ Most of the time
- ○ Sometimes
- ○ Rarely / No

Does your child hold utensils in their fingers, not in fist?

- ○ Most of the time
- ○ Sometimes
- ○ Rarely / No

Does your child drink from a cup?

- ○ Yes - with no spill safety in place
- ○ Yes- with spill safety in place
- ○ No

DRESSING

Does your child put on their shoes and buckle or tie?
- Yes - correctly
- Yes - but wrong feet
- No

Does your child dress themselves unsupervised?
- Yes - completely independent
- Yes - with help
- Most of the time with help
- Rarely / No

Does your child put on their socks?
- Most of the time
- Sometimes
- Rarely / No

Does your child put on hat / coat independently?
- Yes
- No

TOILETING

Does your child get on the toilet by themselves (even if they need help with clothing)?
- Yes
- No

Does your child consistently use the toilet (no more than one accident a week)?

Bowel movements:
- Yes
- Sometimes
- Rarely / No

Urinating
- Rarely / No
- Sometimes
- Yes

Does your child attempt to wipe themselves if after toileting?
- Most of the time
- Sometimes
- Rarely / No

Does your child wipe themselves independently after toileting?
- Most of the time
- Sometimes
- Rarely / No

Does your child take care of flushing and hand washing after toileting?
- Most of the time
- Sometimes
- Rarely / No

Does your child go to the bathroom on their own without being asked or reminded?
- Most of the time
- Sometimes
- Rarely/ no

COMMUNICATION

Does your child:

Know his / her first name?	Yes	No
Use 3 to 4 word sentences?	Yes	No
Say most sounds?	Yes	No
Often repeats sounds or stammers?	Yes	No
Usually follows directions?	Yes	No
Started speaking later than peers?	Yes	No

GROSS MOTOR SKILLS

Can your child:

Hop on one foot	Yes	No	Occasionally
Climb	Yes	No	Occasionally
Kick a ball	Yes	No	Occasionally
Jump off of the ground	Yes	No	Occasionally
Catch a ball	Yes	No	Occasionally
Throw a ball	Yes	No	Occasionally
Ride a tricycle / bicycle	Yes	No	Occasionally
Does he/she trip or fall easily	Yes	No	Occasionally

FINE MOTOR SKILLS

Does your child:

Play successfully with puzzles / blocks	Yes	No	Has difficulty
Use scissors	Yes	No	Has difficulty
Grasp / hold pencil properly	Yes	No	Has difficulty
Write / draw rather than scribble	Yes	No	Has difficulty
Prefers which hand	Right	Left	Both hands
Uses buttons properly	Yes	No	Has difficulty
Uses snaps properly	Yes	No	Has difficulty
Ties shoes	Yes	No	Has difficulty
Uses zippers properly	Yes	No	Has difficulty

SOCIAL EMOTIONAL SKILLS / BEHAVIORS

Does your child:

Often have tantrums	Yes	No
Have a short attention span	Yes	No
Prefer to play alone more than with others	Yes	No
Seem overactive	Yes	No
Seem generally happy	Yes	No

Separate easily from parent / guardian	Yes	No	

RELATIONSHIPS WITH ADULTS

Does your child respond with feelings of pride and enthusiasm when they earn positive feedback?	Yes	No	Sometimes
Does your child look forward to sharing his / her feeling with you when he / she is happy?	Yes	No	Sometimes
Does your child enjoy sharing information with you about himself/ herself, such as things he/ she likes, names of his / her family members or pets, or what he/she did over the weekend?	Yes	No	Sometimes
Does your child share his / her thoughts and ideas with you?	Yes	No	Sometimes

PLAY AND RELATIONSHIPS WITH PEERS

Does your child have several friends but one who is special or best friend?	Yes	No	Sometimes
Does your child have a best friend with whom he/she is close and who reciprocates by coming over for play dates or extending an invitation to a party?	Yes	No	Sometimes
Does your child play cooperatively in large-group game, such as duck-duck-goose, tag, or kickball?	Yes	No	Sometimes
Does your child give verbal directions or incorporate verbal directions into play activities?	Yes	No	Sometimes

MOTIVATION AND SELF-CONFINDENCE

Does your child maintain interest when engaged in a small-group activity or project?	Yes	No	Sometimes
Does your child show that he/she likes to finish what he/she starts, perhaps by dawdling less than at an earlier age?	Yes	No	Sometimes
Does your child approach new tasks with confidence and a "can-do" attitude?	Yes	No	Sometimes
Does your child remain focused on what he/she has been asked to do even when there are minor distractions, such as a car making noise outside or someone tapping a pencil?	Yes	No	Sometimes

PROSOCIAL SKILLS AND BEHAVIORS

If supervised by an adult, does your child take turns without undue objection?	Yes	No	Sometimes
Does your child understand or accept the need to share and take turns, perhaps willingly taking turns even if he / she isn't asked to?	Yes	No	Sometimes
Does your child ask an adult for permission before using things that belong to others or before engaging in an activity that may be restricted, such as gong to the bathroom or leaving the classroom?	Yes	No	Sometimes
Does your child react to a disappointment or failure in an acceptable manner by being a good sport and refraining from shouting or getting upset?	Yes	No	Sometimes

---

Upon completion; save document and e-mail as an attachment to nogglea@waynetrace.org.