

PRESCHOOL SCREENING PACKETS

PLEASE RETURN THE FOLLOWING 3 FORMS TO
REGISTER YOUR CHILD FOR PRESCHOOL SCREENING

Child's Name _____

_____ **Preschool Screening Form**

_____ **Birth Certificate**

_____ **Copy of Your Child's Immunization Records**

What is your school preference?

_____ PT Higgins

_____ Houghtaling

_____ Fawn Mountain

_____ Fawn Mountain Indian Education PS

_____ Tongass School

_____ Pioneer Home Indian Ed Preschool

School Staff- Only

Date returned _____ Time _____ am/pm

Preschool Screening is only for children age(s) 3 years of age, through 5 years of age. If your child is younger or older than this, they are not eligible to be screened.

EARLY CHILDHOOD SCREENING INTERVIEW

Please fill as much of this form out as possible and return to:

The school you would like your child to attend

Houghtaling, Fawn Mountain, Tongass School or Point Higgins.

For questions phone 907-247-2115, fax 907-225-2269

Today's Date: _____ Date of Birth _____
Child's Name _____ Gender _____ Ethnicity _____
Parent's Name _____ Home Phone _____
Mailing Add _____ Work Phone _____
Physical Add _____ Cell Phone _____

Doctor _____ Date of Last Exam _____

AK Native students, which Tribe, Band or Group does your child belong to? _____

Brothers and Sisters

Name	DOB	Age	Gender

PAST MEDICAL HISTORY (check all that apply to your child)

<input type="checkbox"/> difficult birth	<input type="checkbox"/> had mumps
<input type="checkbox"/> was premature	<input type="checkbox"/> had rheumatic fever
<input type="checkbox"/> had meningitis	<input type="checkbox"/> had measles (red or German)
<input type="checkbox"/> had pneumonia	<input type="checkbox"/> had strep throat
<input type="checkbox"/> had scarlet fever	<input type="checkbox"/> has asthma
<input type="checkbox"/> has allergies (please list)	<input type="checkbox"/> has diabetes

Takes the following medications: _____

Describe any serious accidents: _____

Has had problems with vision _____ yes _____ no
if yes, does your child wear glasses? _____ yes _____ no

Has had problems with hearing _____ yes _____ no
if yes, does your child have tubes? _____ yes _____ no

List any other health issue that is pertinent _____

(Over)

IMMUNIZATION RECORD (check which immunizations are up-to-date)

diphtheria tetanus whooping cough (pertussis)
 polio measles mumps

Please list your child's age when s(he) could first do the following:

sits alone walks alone says single words
 says sentences was toilet trained

Please circle the appropriate responses:

- 1. yes no Plays well with other children
- 2. yes no Follows directions to stay where s(he) is told
- 3. yes no Cooperates with adults
- 4. yes no Wipes nose without reminders
- 5. yes no Dresses and undresses alone
- 6. yes no Fastens and unfastens buttons
- 7. yes no Fastens and unfastens snaps
- 8. yes no Zips and unzips zippers
- 9. yes no Can feed self with spoon
- 10. yes no Can feed self with fork
- 11. yes no Is aware of dangerous situations
- 12. Is able to wash hands and face with help without help
- 13. Is able to brush teeth with help without help

Does your child attend preschool? yes no
If yes, where? _____

Does your child attend Head start? yes no
If yes, where? _____RurALCAP _____Saxman

What concerns do you have about your child? _____

Bus Pick up _____ Bus Drop off _____

(Both pick up and drop off must be within boundaries of school your child is attending)

CONSENT FOR SCREENING

I give consent for my child, _____ to participate in
the Early Childhood Screening.

Parent Signature

Date

