PRESCHOOL SCREENING PACKETS

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

Childs Name___________________________________

______**Preschool Screening Form**

______**Birth Certificate**

______**Copy of Your Childs 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: ____________________
Child's Name ____________________
Parent's Name ____________________
Mailing Add ____________________
Physical Add ____________________

Date of Birth ____________
Gender _____ Ethnicity _________
Home Phone ____________
Work Phone ____________
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)

___ difficult birth
___ was premature
___ had meningitis
___ had pneumonia
___ had scarlet fever
___ has allergies (please list)
___ had mumps
___ had rheumatic fever
___ had measles (red or German)
___ had strep throat
___ has asthma
___ 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)

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CONSENT FOR SCREENING

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

______________________________ ______________

Parent Signature Date