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: ____________________ 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)

___ 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. __ with help    ___ without help  Is able to wash hands and face
13. __ with help    ___ without help  Is able to brush teeth

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