

Preliminary Screening for _____ (Program Name)
Publically Funded Preschool Program

Initial contact: _____ Staff: _____ date: _____

Second contact: _____ Staff: _____ date: _____

Third contact: _____ Staff: _____ date: _____

Child's name _____ DOB _____ Age _____ Race/Ethnicity _____

Address _____

Phone _____
(home) (cell) (work)

Email _____ Verbal consent to share yes no

Parent's name _____ Race/ethnicity _____ Age _____

Highest level of education _____ Occupation _____

Parent's name _____ Race/ethnicity _____ Age _____

Highest level of education _____ Occupation _____

Languages spoken _____ Family income _____

Siblings Name	DOB/age	Special Needs	Current School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prenatal complications _____

Early developmental concerns, EI _____

Current Medical concerns _____

Speech/language, IEP _____

ECSE _____

Adopted _____ Foster child _____

Referral agency/or how did parent obtain knowledge of program _____

(Reason for referral)
Staff signature _____ date _____

Staff name _____ Recommended for screening ___ No ___ Yes ___

Screening date _____ Outcome of screening _____