MONROE LOCAL SCHOOL DISTRICT

PRESCHOOL REQUEST FOR ASSISTANCE

Date Form Completed: _____ Date Form Received by District: _____

Identifying Data

Full Name: _____

Birth City/State: _____

Date of Birth: _____

Address: _____

_____

Building of Current Attendance: _____

_____

Present Teachers: _____

Father: _____

Address: _____

Home Phone: _____ Work Phone: _____

Father Cell: _____

Mother: _____

Address: _____

Home Phone: _____Work Phone: _____

Mother Cell: _____

Legal Guardian: _____

Address: _____

Phone: _____

Guardian Cell: _____

Parent Email: _____

Special accommodations needed for family or child: _____

Parent's native language (if not English): _____

Student's native language (if not English): _____

Reason for Request for Assistance: _____

_____

A. Family History

With whom does the child live? _____

Indicate siblings or any other individuals living with the child:

Names	**Ages**	**Relationship to Child**

With whom does the child stay during the day? _____

Describe any unique family circumstance that have a significant impact on this child's development: _____

_____

B. What is the child currently doing?

Checklist completed by: _____ Date: _____

Check method used: ❑ Observation ❑Structured Interview with: _____

EATING

- ❑ Needs to be fed
- ❑ Picks up food and eats with fingers
- ❑ Feeds self with spoon
- ❑Eats and drinks independently

DRESSING

- ❑ Needs to be dressed
- ❑ Removes small articles of clothing
- ❑ Puts on some clothes such as socks, shirt and/or pants
- ❑ Dresses self except for shoes

TOILETING

- ❑ Wears diapers
- ❑ Uses potty with help or reminders
- ❑ Independent

ATTENTION

- ❑ Needs constant attention/supervision
- ❑ Occupies self with toys for 10 or more minutes
- ❑ Attends to small group activity for 10 or more minutes

RECEPTIVE COMMUNICATION

- ❑ Does not appear to understand words
- ❑ Shows understanding of several words
- ❑ Can follow simple directions such as "Give Daddy the ball"

EXPRESSIVE COMMUNICATION

- ❑ Uses gestures or sounds
- ❑ Says at least 10 words you can understand
- ❑ Says 2 or 3 words together
- ❑ Can carry on a simple conversation
- ❑ Repeats easy jingles and rhymes
- ❑ Can be understood by people not familiar with his/her speech

HEARING

- ❑ Does not respond regularly to sounds
- ❑ Looks at or reacts correctly to sources of sounds (looks at phone when it rings)
- ❑ Responds to simple directions given when back is turned

COGNITIVE

- ❑ Looks for toy or person who is out of sight
- ❑ Shows understanding of how things work by turning on/off or activating a toy
- ❑ Sorts toys or objects by common features (color, size, shape)
- ❑ Counts to 4 and names 2 or 3 colors

FINE MOTOR

- ❑ Needs help to pick up small pieces of food or toys
- ❑ Independently picks up small toys and transfers from hand to hand
- ❑ Scribbles on paper
- ❑Draws some recognizable shapes/pictures

PLAY

- ❑Needs stimulation to be provided by another person
- ❑ Holds and manipulates toys (shakes, bangs)
- ❑ Uses toys and objects appropriately (brushes hair, pushes trucks)
- ❑ Uses imagination to play

GROSS MOTOR

- ❑ Needs to be carried/moved by another person
- ❑ Crawls
- ❑ Walks holding onto furniture
- ❑ Walks independently
- ❑ Demonstrates balance and coordination

VISION

- ❑ Does not show recognition of people/objects
- ❑Recognizes familiar people/objects/toys
- ❑ Points to and names people/things in pictures

SOCIAL

- ❑ Shows little response to other people
- ❑ Enjoys frolic play, peek-a-boo
- ❑ Plays alongside other children (parallel play)
- ❑ Sometimes share toys, cooperates in play
- ❑ Takes turn in simple games

C. What concerns do you have about this child?

Information supplied by: _____

Areas of Concern: ❑ Eating ❑ Dressing ❑ Toileting ❑ Attention ❑ Social/Emotional Behavior ❑ Hearing ❑ Vision

❑ Receptive Communication ❑ Play ❑ Adaptive Behavior

1. What is the child doing or not doing that you would like to see changed? _____

_____

_____

2. How long has this concern been observed? _____

_____

D. Medical/Developmental History

1. Who is the child's regular physician? _____
2. When was the child's last physical examination? _____
3. The child's birth followed a full-term pregnancy with no complications? YES _____ NO _____

   Baby's birth weight _____ Did the baby come home with you from hospital? YES _____ NO _____
4. Developmental Milestones: Sat unassisted: _____ Crawled: _____

   Walked: _____ First words: _____ Two or three word phrases: _____
5. Is there a history of significant health concerns, major illness? YES _____ NO _____

   Any hospitalizations? YES _____ NO_____ If yes, why? _____

   Any surgeries? YES _____ NO _____ If yes, why? _____

   Is your child under a "specialist" care? YES _____ NO _____ If so, who and why? _____

_____

   Frequent ear infections? YES _____ NO _____ How many? _____
6. Does the child take medication on a regular basis? YES _____ NO _____ If so, what and why? _____

_____
7. Does the child have food/environmental allergies? YES _____ NO _____ If so, what? _____
8. Does the child have medical or adaptive needs? YES _____ NO _____ If yes, please circle or list type: glasses, hearing aids, walkers, leg braces, wheelchair, specialized seating, feeding tube, dietary restrictions, catheter, shunt
9. Does the child have vision within normal limits? YES _____ NO _____

10. Does the child have hearing within normal limits? YES _____ NO _____

11. Is there a family history of educational concerns or medical conditions? YES _____ NO _____ If so, what? ___

_____

12. Any other significant health/nutrition issues not covered in the previous questions? YES _____ NO _____

_____

E. Intervention History

1. How have you tried to help your child? _____

2. Has your child received any formal testing? YES _____ NO _____

Please list what type, where and contact information: _____

_____

3. Has your child participated in any therapy (speech-language, occupational therapy, physical therapy, orientation and mobility)? YES _____ NO _____ Please list dates of therapy, type, contact person, address and phone number.

_____

_____

4. Has your child participated in Help Me Grow or Early Intervention? YES _____ NO _____

If yes, provide dates of service, contact information: _____

_____

5. Has your child attended childcare, preschool, or Head Start programs? YES _____ NO _____

If yes, please provide dates of attendance, contact information: _____

_____

_____ _____

Parent/Guardian Signature Initiating Request for Assistance Date

IF YOUR CONCERN IS THE WAY YOUR CHILD PRODUCES SPEECH SOUNDS, PLEASE COMPLETE THIS FORM. RETURN IT WITH THE REMAINING PACKET.

1. RATE YOUR CHILD'S OVERALL INTELLIGIBILITY (how he/she is understood when speaking):

   When he/she is talking about something that is present (talking about play while doing it, talking about an object while using it, talking about a food while eating it, etc.)

   Excellent Good Fair Poor

   When you don't know what he/she is talking about (such as describing something that happened yesterday or out of your sight):

   Excellent Good Fair Poor

2. Is your child aware of the speech difficulty? YES _____ NO _____ Describe your child's reaction(s) when not understood:

   _____Repeats self _____Tries new words _____Stops talking _____Uses gestures

   _____Becomes frustrated _____Becomes upset/angry

3. Has your child had a history of ear infections? YES _____ NO _____ PE Tubes? YES _____ NO _____

   Hearing tested? YES _____ NO _____

4. Please indicate sounds your child is having difficulty with: _____

   _____

   _____