

# Preschool for All Screening Form

# Sample Form 1

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

**The Following Will be Worth 5 points:**

- Child will be 4 years old by Sept. 1 ..... \_\_\_\_\_
- Motor Skills – potential concern..... \_\_\_\_\_
- Concepts – potential concern ..... \_\_\_\_\_
- Social-Emotional Observations – potential concern ..... \_\_\_\_\_
- Speech & Language – potential concern..... \_\_\_\_\_
- Economic Status: low income, Public Aid, Free/Red. Lunch..... \_\_\_\_\_
- Physical/Health concerns ..... \_\_\_\_\_
- Prenatal/Birth concerns ..... \_\_\_\_\_
- Family situation: abuse/alcohol/drugs/prison involvement/  
Family member in special ed/developmental  
or mental disability/chronic illness of parent/  
divorce/lived in shelter, domestic violence, etc..... \_\_\_\_\_
- Child lives with adult other than birth parent..... \_\_\_\_\_
- Family lives with child's grandparents, friends, or homeless ..... \_\_\_\_\_
- Family has required services of DOVE, DCFS ..... \_\_\_\_\_

**The Following Will be Worth 4 points:**

- Parent did not graduate from high school ..... \_\_\_\_\_
- Mother is 21 years old or younger ..... \_\_\_\_\_
- Family is associated with, or receives support services from  
one or more social service agencies..... \_\_\_\_\_
- Parenting Skills – lack of effective or positive interaction,  
non-nurturing, other ..... \_\_\_\_\_

**The Following Will be Worth 3 points:**

- Serious behavior concerns..... \_\_\_\_\_
- English as a second language ..... \_\_\_\_\_
- Short attention span ..... \_\_\_\_\_
- Difficulty communicating/separating ..... \_\_\_\_\_
- Sibling in program..... \_\_\_\_\_

Comments: \_\_\_\_\_

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- \_\_\_\_\_ Child meets eligibility requirements for at-risk criteria
- \_\_\_\_\_ Child does not meet eligibility requirement for at-risk criteria

## Screening Eligibility Sample

## Sample Form 2

1. Children are eligible if they show a delay in any two areas measured by the screening instrument. (ASQ and BHASED screening tool)
2. Children are eligible if they show a delay in any one area and score 5 or more on risk factors. (ASQ and BHASED screening tool)
3. Children are eligible if they are questionable in an area and score above 8 on the risk factors. (ASQ and BHASED screening tool)
4. Children are eligible if they score a 12 or above on the risk factors.
5. Children are eligible if they receive a score of PKF on the BHASED screening tool. (This indicates that the child is eligible for prekindergarten services.)
6. Children are eligible if they receive a score of Refer on the BHASED screening tool. (This indicates that the child is eligible for Special Education services.)
7. Children are eligible if they attended the prekindergarten program during the previous year.

### Risk Factors

3 Pts	Attends no program (No child care or other prekindergarten)	3 Pts	Multiple employment/struggling to meet basic needs
2 Pts	Attends one day per week or less	3 Pts	Child or family receiving counseling
0 Pts	Attends two or more days per week	3 Pts	Living in multiple households
3 Pts	Homeless/foster child	2 Pts	Receiving additional services (i.e., speech, mental health)
3 Pts	DCFS involved with family	2 Pts	Vision/Hearing referrals
2 Pts	Low birth weight/Failure to thrive/Premature	2 Pts	Teacher referrals
3 Pts	Fetal alcohol/drug exposure	2 Pts	Parent balancing work and school
3 Pts	Congenital or chronic illness of child	3 Pts	Chronic or terminal illness of household family member
3 Pts	Disability of child/early intervention eligibility	3 Pts	Disability of household family member
3 Pts	Social security (SSI) disability funded	3 Pts	Excessive mobility (more than three times since birth)
3 Pts	Poverty/TANF eligibility	3 Pts	Single-parent household
3 Pts	Public housing eligibility	3 Pts	Grandparent(s) raising child
3 Pts	Federal lunch program eligible	2 Pts	Large family size (4 or more children)
3 Pts	Age of mother at birth of this child 18 years or younger	3 Pts	Language other than English in the home
2 Pts	Low education of parent	3 Pts	Siblings who are older are experiencing academic difficulties
3 Pts	Parent deceased/incarcerated		
3 Pts	Victim of abuse/domestic violence		
3 Pts	Drug/alcohol abuse of parent		

*Sample form provided by Rock Island County Regional Office of Education #49*

# Eligibility Checklist

# Sample Form 3

\_\_\_\_\_ Eligible  
\_\_\_\_\_ Ineligible  
\_\_\_\_\_ Other

Child's Name \_\_\_\_\_

### PLEASE CHECK ALL THAT APPLY

- 5 \_\_\_\_\_ History of abuse in family
- 5 \_\_\_\_\_ One parent incarcerated or past history of incarceration
- 5 \_\_\_\_\_ Two or more screeners indicate concern
- 5 \_\_\_\_\_ Referral from other agency Explain \_\_\_\_\_
- 5 \_\_\_\_\_ Summer birthday
- 5 \_\_\_\_\_ Primary caregivers are not the child's parents
- 5 \_\_\_\_\_ Speech/Language pathologist indicates need for intervention
- 5 \_\_\_\_\_ Socially isolated
- 4 \_\_\_\_\_ Child has been served by another at-risk program
- 4 \_\_\_\_\_ Teen parent at birth of first child
- 4 \_\_\_\_\_ History of alcohol or drug abuse in family
- 4 \_\_\_\_\_ Would not separate from parents
- 4 \_\_\_\_\_ Health concern Explain \_\_\_\_\_
- 4 \_\_\_\_\_ Other siblings or parents in special program
- 4 \_\_\_\_\_ Siblings had been enrolled in Pre-Kindergarten program
- 4 \_\_\_\_\_ Receive community resources Identify \_\_\_\_\_
- 4 \_\_\_\_\_ Low income/parents unemployed
- 3 \_\_\_\_\_ Behavioral concerns
- 3 \_\_\_\_\_ Listening skills and attention a concern
- 3 \_\_\_\_\_ Single parent family/blended family
- 3 \_\_\_\_\_ Wide sibling gap
- 3 \_\_\_\_\_ Concern on the hearing and/or vision screening
- 3 \_\_\_\_\_ Parent(s) not high school graduates
- 2 \_\_\_\_\_ Family history of transience
- 2 \_\_\_\_\_ Environmental factors

\_\_\_\_\_ RED FLAG CONCERNS \_\_\_\_\_

\_\_\_\_\_ = TOTAL SCORE

\_\_\_\_\_ Speech/Language rescreen                      \_\_\_\_\_ Hearing/Vision Referral  
\_\_\_\_\_ Speech/Language evaluation                      \_\_\_\_\_ Special Education referral



# Parent Information Form

# Sample Form 5

Today's Date \_\_\_\_\_ Form Completed By: \_\_\_\_\_

The information you provide on this form is strictly confidential. This information is important because it helps us to have a picture of the whole child when we are considering referral or placement options. Thank you for your cooperation.

Child's FULL Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_

Date of birth \_\_\_\_\_ Boy \_\_\_\_\_ Girl \_\_\_\_\_

Phone \_\_\_\_\_

If no phone, please give name and number for emergency: \_\_\_\_\_

Are both parents living in the home with this child? Yes \_\_\_\_\_ No \_\_\_\_\_ Homeless \_\_\_\_\_

If no, with whom does this child live? \_\_\_\_\_

Relationship to child \_\_\_\_\_

Father's name \_\_\_\_\_ Age \_\_\_\_\_

Presently employed? Yes \_\_\_\_\_ No \_\_\_\_\_

Education: (Indicate highest level completed) \_\_\_\_\_

Place of employment \_\_\_\_\_ Work phone \_\_\_\_\_

Address if different from child's \_\_\_\_\_

Phone if different from child's \_\_\_\_\_

Mother's name \_\_\_\_\_ Age \_\_\_\_\_

Presently employed? Yes \_\_\_\_\_ No \_\_\_\_\_

Education: (Indicate highest level completed) \_\_\_\_\_

Place of employment \_\_\_\_\_ Work phone \_\_\_\_\_

Address if different from child's \_\_\_\_\_

Phone if different from child's \_\_\_\_\_

Person to be contacted: Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_

If other than parents, fill in below:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Please check any of the agencies your family is/has been involved with:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Preschool for All (Pre-K) | <input type="checkbox"/> GED  | <input type="checkbox"/> Drug and/or Alcohol Rehabilitation |
| <input type="checkbox"/> Head Start                | <input type="checkbox"/> Public Aid (IDPA)                            | <input type="checkbox"/> County Health Dept.                |
| <input type="checkbox"/> Birth-3 Program           | <input type="checkbox"/> Dept. of Children and Family Services (DCFS) | <input type="checkbox"/> WIC                                |
| <input type="checkbox"/> Private Preschool         | <input type="checkbox"/> Shriners                                     | <input type="checkbox"/> Other _____                        |
| <input type="checkbox"/> Alternative Ed.           | <input type="checkbox"/> Department of Corrections                    | _____   |
| <input type="checkbox"/> Special Education         | <input type="checkbox"/> Social Security                              | _____   |

List names of all people living in household:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check appropriate yearly family income:

- |  |  |
|--|--|
| <input type="checkbox"/> \$0 - \$10,000      | <input type="checkbox"/> \$20,000 - \$30,000 |
| <input type="checkbox"/> \$10,000 - \$15,000 | <input type="checkbox"/> \$30,000 - above    |
| <input type="checkbox"/> \$15,000 - \$20,000 |  |

Has anything happened that may be influencing your child's development: (For example: divorce, separation, relocation, new baby, death, etc.) Yes \_\_\_ No \_\_\_

If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

### Developmental Background

Family Doctor \_\_\_\_\_

Was this child premature? Yes \_\_\_ No \_\_\_ If yes, how much? \_\_\_\_\_

Child's birth weight: \_\_\_\_\_

Were there any complications or difficulties during pregnancy and/or birth of this child?

Yes \_\_\_ No \_\_\_

If yes, please explain: \_\_\_\_\_

Was this child exposed to drugs or alcohol before birth? (Including prescription drugs taken by the Mother during pregnancy) Yes \_\_\_ No \_\_\_

Is this child on medication? Yes \_\_\_ No \_\_\_ If yes, why and what is the medication? \_\_\_\_\_

Is the child prone to ear infections? Yes \_\_\_ No \_\_\_ If yes, how often? \_\_\_\_\_

Has the child had an ear/hearing exam Yes \_\_\_ No \_\_\_ When \_\_\_\_\_

Where \_\_\_\_\_ Results \_\_\_\_\_

Has the child had a vision exam? Yes \_\_\_ No \_\_\_ When \_\_\_\_\_

Where \_\_\_\_\_ Results \_\_\_\_\_

Is there a history of any serious health problems in your family? Yes \_\_\_ No \_\_\_

Please explain \_\_\_\_\_

This child began walking at \_\_\_\_\_ months.

Do you notice or has a doctor reported any of the following in this child?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Nose bleeding         | <input type="checkbox"/> Stuttering            |
| <input type="checkbox"/> Chronic ear infection | <input type="checkbox"/> Indigestion           | <input type="checkbox"/> Bed wetting           |
| <input type="checkbox"/> Nail biting           | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Diarrhea              |
| <input type="checkbox"/> Epilepsy (seizures)   | <input type="checkbox"/> Heart trouble         | <input type="checkbox"/> Hyperactivity         |
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Lack of consciousness |
| <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Serious blows to head | <input type="checkbox"/> Frequent fevers       |
| <input type="checkbox"/> Lack of coordination  | <input type="checkbox"/> Stomach aches         | <input type="checkbox"/> Medical problems      |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Overtired/lacking pep | <input type="checkbox"/> Nightmares            |
| <input type="checkbox"/> Sinus                 | <input type="checkbox"/> Thumb sucking         |  |

Other physical problems? Please explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else you would like us to know? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

