Prior to bringing the following screening application to the Preschool Office you must complete the GPS Online Registration. This is required to process paperwork for screening. A screening appointment cannot be set up until this is completed.

Please go to the link below to complete this portion of the registration process. Any preschooler you are considering having tested or enrolling as a tuition student must be listed as "Enrolling Student" on this registration. Do NOT use "non school age sibling". For grade you will choose "Amanecer Preschool" and for campus you will choose "GPS Holding"

http://gilbertschools.net/enroll

Let us put a face with a name!

Along with the screening application, original birth certificate, and utility bill, please attach a current picture of your child to the paperwork that is brought to the preschool district office. This will only be used internally while your child participates in this process.

Thank you!

Gilbert Public Schools 140 S. Gilbert Road Gilbert, AZ 85296	Office Use Only	Screening Application Received: _____ OLR Number: _____ Screening Date: _____ Screening Time: _____ Student Number: _____

For Special Needs Screening/Placement please complete the following pages.

Gilbert Public School's Amanecer Developmental Preschool was established in 1985 in response to State and Federal legislation that requires public schools to provide special education services for 3 to 5 years olds with handicapping conditions "or" significant developmental delays. Public schools, at this time, are not required to offer preschool to all children. Gilbert District, however, chooses to offer, on a tuition basis, four placements in each integrated class to "typically-developing three and four year olds" living in the community.

What are the major cross streets closest to your home?

Child's Name (Last, First, Middle Initial)		Address of Residence Street:_____ City: State: Zip:
Date of Birth (month/day/year)	Sex ❑ Male ❑ Female	Public Elementary School attended by children in your neighborhood:
Mother's Name (Last, First)		Best Phone #
Mother's email Mother's Occupation		Mom's Address:
Father's Name (Last, First)		Best Phone #
Father's email Father's Occupation		Dad's Address:

With whom does child live?

❑ Dad ❑ Both Together

❑ Mom ❑ Each Separately** ❑ Other** _____

Child's relationship to parents in home: (check any that apply)

❑ Biological ❑ Step ❑ Adopted ❑ Foster**

Length of time in this family setting _____

****COURT DOCUMENTS REGARDING EDUCATIONAL DECISIONS MUST BE PROVIDED**

Brother(s):	Age	Lives in home? Y/N	Sister(s):	Age	Lives in home? Y/N

Home Language Survey

Is **English** the only language your child has been exposed to?

☐Yes - skip to page 3, Social Developmental History.

☐No - continue with Home Language Screening on page 2.

Office Use Only
Language:
Spanish _____
Other _____

Interpreter Request _____
Emailed Spanish_____

Gilbert Schools Amanecer Developmental Preschool Program 480-497-3461

HOME LANGUAGE SCREENING

1. What is/are the languages(s) spoken most often in the child's home? _____
2. What language was the child exposed to first? _____
3. What language is used at the daycare or in-home childcare setting? _____
4. Does the child have problems communicating at home? Yes/No _____ If yes, explain how your child communicates _ with you? _____
5. What language is used with the child?_____
   a. Language used by the mother with the child: _____
   b. Language used by the father with the child: _____
   c. Language used by the child with sibling(s): _____
   d. Language used by the child with his/her peers: _____
6. Does the child have difficulties following spoken directions? Yes/No_____ Describe:_____

   _____
7. In what country, and when was the child first introduced to English? _____ Age: _____
8. Describe the setting in which the child first learned English. _____

   _____
9. Has the child been taught in his/her native language? Yes/No_____ If yes, explain: _____

   _____
10. Is the child frustrated about communicating in English? Yes/No_____ Describe: _____

    _____
11. Does the child watch television in a language other than English? Yes/No____ If yes, in which language? _____
12. Does the child listen to the radio in a language other than English? Yes/No____ If yes, in which language? _____
13. Does the child read or is read books, magazines, etc., in a language other than English at home? Y/N _____

    If yes, in which language? _____

    Types of Material: _____

SOCIAL DEVELOPMENTAL HISTORY

1. What is your primary concern about your child's development?

2. Do you think that this child has a language, speech, or hearing problem? Yes ____ No ____
   If yes, describe the problem.

   a. When was the problem first noticed?

   b. What, if anything has been done about the problem? Has this helped?

3. Has anyone outside the immediate family ever suggested that this child be seen for special testing?
   If yes, describe the circumstances. Yes ____ No ____

4. Does this child exhibit what you consider to be any unusual behaviors? Yes ____ No ____
   If yes, please describe.

5. Does this child prefer to play alone or with others?

6. Any diagnosed medical condition that is or has been followed by a physician:_____

_____

In comparison with other children of the same age, is this child's activity level:

❑ Under active ❑ Over active ❑ About as active

EDUCATIONAL / INTERVENTION HISTORY

Has this child ever attended preschool or day care?

When and where?_____ Phone_____

Has this child ever received private or AzEIP testing/services for:

		DATES	FREQUENCY	WHERE
Speech and Language Therapy	❑ No ❑ Yes If yes, describe:			
Physical Therapy	❑ No ❑ Yes			
Occupational Therapy	❑ No ❑ Yes			
Counseling/ Therapy	❑ No ❑ Yes			
Other	❑ No ❑ Yes			

_____

_____

_____

HEALTH AND MEDICAL HISTORY

Child's birth weight _____
Child's length at birth _____
Mother's age at birth of child _____
Father's age at birth of child _____
Length of pregnancy (weeks) _____
Was labor spontaneous or induced _____
Total hours in labor _____
Caesarian? _____
Anesthetics or drugs used _____
Instruments used? _____
Single birth? _____
Other significant factors regarding the pregnancy:
_____

Presentation: ❑ Normal ❑ Breech ❑Baby was turned
Did baby breathe immediately? _____
Did baby cry immediately? _____
Was incubator used? _____ How long? _____
Oxygen given to the baby? _____
Transfusion given? _____
How long after birth did baby go home? _____
Other significant information regarding birth: _____
_____
_____
_____
_____
_____

During the **first month** of life, did this child have any of these conditions?

❑ Cyanosis (blue)
❑ Physical deformity
❑ Infection
❑ Vomiting
❑ Excessive crying/colic
❑ Jaundice (yellow)
❑ Paralysis
❑ Skin rash
❑ Diarrhea
❑ Injury/bruises
❑ Seizures
❑ Feeding difficulty
❑ Constipation
❑ Listless behavior

Hospitalizations for illness or surgery:

Hospital	Location	Age	Length of Stay	Reason

Medications:
If this child is now on medication, list the name, dosage, and purpose._____
_____
Has medication been prescribed in the past to help the child's behavior or mood?_____
What was the medication and what was its effect? _____

Check box if this child has had any of these illnesses/conditions:

❑ Allergy
❑ Asthma
❑ Bronchitis
❑ Chicken Pox
❑ Croup
❑ Diarrhea
❑ Eczema / skin rash
❑ Encephalitis
❑ Fainting
❑ Foot / leg problems
❑ Food Allergies
❑ Frequent colds
❑ Frequent vomiting
❑ Food sensitivities
❑ Headaches
❑ Head injury
❑ Heart defect
❑ Hepatitis
❑ Hernia
❑ High Fever
❑ Hives
❑ Influenza
❑ Kidney infections
❑ Measles
❑ Meningitis
❑ Mumps
❑ Nosebleeds
❑ Overweight
❑ Underweight
❑ Neuromuscular disorder
❑ Pneumonia
❑ Rheumatic fever
❑ Rickets
❑ Scarlet fever
❑ Seizures
❑ Severe stomachaches
❑ Tonsillitis
❑ Other_____
_____
_____

DEVELOPMENTAL MILESTONES

Did you find this child's early development (walking, talking, toilet training, etc.) to be:

❑ Early ❑ Average ❑ Late

Sat alone	_____	months	Said "mama" or "dada"	_____	months
Crawled	_____	months	Said other single words	_____	months
Walked without holding	_____	months	Used 2-3 word phrases	_____	months
Rode tricycle	_____	months	Used sentences	_____	months
Ran with good control	_____	months	Toilet training started	_____	months

COMMUNICATION

Do you have difficulty understanding child's speech? _____ Yes _____ No

Do other people have difficulty understanding child's speech? _____ Yes _____ No

Does this child understand what you say as well as you think he/she should? _____ Yes _____ No

Does this child make sounds incorrectly? _____ Yes _____ No

If so, which ones? _____

Does this child's speech consist mainly of:

❑ Complete Sentences ❑ Phrases ❑ One or two words ❑ Sounds

Did this child ever start talking and then stop? _____ Yes _____ No If yes, please explain: _____

_____

Additional Comments: _____

HEARING HISTORY

Does this child have a hearing problem? _____ Yes _____ No

Did this child have ear problems before the age of 2? _____ Yes _____ No
(ear infections, ear aches, draining ear, medications taken for ears, fluid behind eardrum, hole in eardrum, etc.)

Has this child had an ear problem in the last 6 months? _____ Yes _____ No

Approximately how many ear problems has this child had in his/her life? _____

Has this child ever had PE tubes placed in his/her ears? _____ Yes _____ No If yes, list date, age and results?

_____

Does this child have a diagnosed hearing loss? _____ Yes _____No If yes, please attach current audiogram.

Additional comments: _____

Please attach a copy of all hearing screenings / evaluations to this application.

VISION HISTORY

Does this child have vision problems? _____ Yes _____ No If yes, please explain: _____

_____

Does this child wear glasses? _____ Yes _____ No

Date of most recent vision testing: _____ (Attach copy of most recent exam, if available)

Additional comments: _____

Please attach a copy of all vision screenings / evaluations to this application.

FAMILY HISTORY

Is there anyone else in your family who has had a problem similar to your child's? _____

Have any members of the family {father (F), mother (M), brother (B), sister (S), aunt (A), uncle (U), grandparent (G), or cousins (C)} experienced any of the following?

__ Alcohol Abuse
__ Allergies / Asthma
__ Autism Spectrum
__ Blindness / vision problems
__ Cancer
__ Depression
__ Deafness / hearing problems
__ Diabetes
__ Drug Abuse
__ Epilepsy
__ Heart disease
__ Kidney problems
__ Learning problems
__ Mental illness
__ Mental retardation
__ Physical / motor handicap
__ Speech problems
__ Still birth or early childhood death
__ Suicide
__ Thyroid disease
__ Other _____

SOCIAL / EMOTIONAL

Please check any behavioral characteristics that apply to this child:

❑ Aggression
❑ Bedwetting
❑ Depression
❑ Excessive fantasies
❑ Frequent crying
❑ Impulsive
❑ Low self-esteem
❑ Manipulative
❑ Moodiness
❑ Nail biting
❑ Nightmares
❑ Noncompliant
❑ Perfectionist
❑ Poor motivation/apathy
❑ Short attention span
❑ Sleep problems
❑ Tantrums
❑ Tic/nervous gestures
❑ Toileting problems
❑ Unusual fears
❑ Other_____

Comments: _____

_____

_____

PARENT OBSERVATIONS

What things does your child like to do? _____

_____

_____

What are your child's strengths and special abilities? _____

_____

_____

What are the things your child finds hard to do? _____

_____

_____

How do you discipline your child? _____

_____

_____

How does your child play and get along with other children?_____

_____

_____

How would you describe your child? _____

_____

_____

Further comments or concerns: _____

_____

_____

_____

Completed by: _____Relationship to child _____ Date _____

Child Care Provider Questionnaire

*To be filled out by the teacher or primary childcare provider (**not parent**) at child care/preschool establishment **prior** to in-person screening/evaluation appointment.*

____ My child is cared for at home by a parent. (do not continue with form)

Child's Name_____

*Child Care Provider's:
Name_____
Name of person filling out form (if different than above)
_____
Address_____
Phone number_____

Parent Permission
I give my permission to the person listed above* to give Gilbert Public Schools input on my child's participation/behavior in their program.

_____date_____

Areas of success:

Areas of struggle/concern:

COMMUNICATION-
Please circle any of the following areas that you consider to be problematic for the child:
Expressing wants and needs difficult to understand answering questions following directions
talking in complete sentences labeling objects/pictures identifying objects/pictures responding to questions

Does the child have other language/communication difficulties not listed above? Please explain:

SOCIAL/EMOTIONAL FUNCTIONING-
Please circle any of the following areas that you consider to be problematic for the child:

Managing emotions Aggression (i.e., hits/kicks others) Defying caregivers

Joining group instruction Staying focused on an activity Transitioning between tasks

Peer interactions (i.e., sharing toys, parallel/cooperative play)

Does the child have other social skills difficulties not listed above? Please explain:

When do you typically see the behavior (Transitions , Circle time, Free play)?

Motor Development (fine/gross)
Please circle any of the following areas that you consider to be problematic for the child:

Climbing playground equipment climbing stairs jumping

Ball skills(throw, catch, kick) manipulating objects in hands

Scribble, draw, color pencil grasp scissor skills

Self-Help Skills
Please circle any of the following areas that you consider to be problematic for the child:

Self-care skills (i.e., eating, using utensils, drinking from a cup)

Dressing (i.e., pulling up/down pants, taking off jacket/backpack)

Handwashing

Toileting

Cognitive/Pre-academic SKills
Please circle any of the following areas that you consider to be problematic for the child:

Remembering material taught from day to day

Following the daily routine

Functional Play (i.e., playing appropriately with toys)

Other comments: