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!
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
---------|---------

Sex: Male Female | Public Elementary School attended by children in your neighborhood:

Mother’s Name (Last, First) | Best Phone #
-----------------------------|------------------

Mother’s email | Mom’s Address:

Mother’s Occupation

Father’s Name (Last, First) | Best Phone #
-----------------------------|------------------

Father’s email | Dad’s Address:

Father’s Occupation

With whom does child live?

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

❏ Dad     ❏ Both Together     ❏ Biological    ❏ Step    ❏ Adopted    ❏ Foster**

❏ Mom     ❏ Each Separately** ❏ Other** 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 ______
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: ______________________________________________________________________________
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?  
   Yes ____  No ____  
   If yes, describe the circumstances.

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:

<table>
<thead>
<tr>
<th>Service</th>
<th>Dates</th>
<th>Frequency</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech and Language Therapy</td>
<td>❏ No</td>
<td>❏ Yes</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>❏ No</td>
<td>❏ Yes</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>❏ No</td>
<td>❏ Yes</td>
<td></td>
</tr>
<tr>
<td>Counseling/ Therapy</td>
<td>❏ No</td>
<td>❏ Yes</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>❏ No</td>
<td>❏ Yes</td>
<td></td>
</tr>
</tbody>
</table>

---

3
# HEALTH AND MEDICAL HISTORY

<table>
<thead>
<tr>
<th>Child’s birth weight</th>
<th>Presentation: ☐ Normal ☐ Breech ☐ Baby was turned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s length at birth</td>
<td>Did baby breathe immediately? ____________________________</td>
</tr>
<tr>
<td>Mother’s age at birth of child</td>
<td>Did baby cry immediately? ____________________________</td>
</tr>
<tr>
<td>Father’s age at birth of child</td>
<td>Was incubator used? __________ How long? ______</td>
</tr>
<tr>
<td>Length of pregnancy (weeks)</td>
<td>Oxygen given to the baby? __________</td>
</tr>
<tr>
<td>Was labor spontaneous or induced</td>
<td>Transfusion given? __________</td>
</tr>
<tr>
<td>Total hours in labor</td>
<td>How long after birth did baby go home? ________________</td>
</tr>
<tr>
<td>Caesarian?</td>
<td>Other significant information regarding birth: __________</td>
</tr>
<tr>
<td>Anesthetics or drugs used</td>
<td>____________________________________________</td>
</tr>
<tr>
<td>Instruments used?</td>
<td>____________________________________________</td>
</tr>
<tr>
<td>Single birth?</td>
<td>____________________________________________</td>
</tr>
<tr>
<td>Other significant factors regarding the pregnancy:</td>
<td>____________________________________________</td>
</tr>
</tbody>
</table>

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

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

Hospitalizations for illness or surgery:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Location</th>
<th>Age</th>
<th>Length of Stay</th>
<th>Reason</th>
</tr>
</thead>
</table>

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

Did 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.
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.

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 _______________________

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: _______________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________
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: