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**Preschool Teacher Information Form**

**Parent Referral for Individual Evaluation**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date: |  | | | School: | | |  | | | | | |
| Student name: |  | | | ID#: | | |  | | | | | |
| Date of birth: |  | Referral source: | | | |  | | | | | | |
| Parent/guardian name: |  | | | | | | | | | | | |
| Address: |  | | | | | | | | | Apt/lot#: | |  |
| City: |  | | State | |  | | | Zip Code: | | |  | |
| Phone (home, cell, work): |  | |  | | | | | |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Enrollment, Attendance, and School Services/Supports** | | |
|  | Is attendance a concern? | | Yes  No |
|  | Does the child have behavior difficulties in the classroom? Explain if yes. | | Yes  No |
|  | What methods have been used to address these behaviors? | |  |
|  | Has the child moved frequently? | | Yes  No |
|  | **Child’s Strengths and Challenges** | | |
|  | What are the child’s strengths, talents, interests? | |  |
|  | What are the areas of challenge for him/her? | |  |
| Is the child able to meet pre-academic expectations in the classroom? Describe weak areas if any. | | Yes  No | |
| **Communication, Oral, Motor, Hearing** | | | |
| Does did the child have sucking, swallowing, drooling, or feeding difficulties? Explain if yes. | | | Yes  No |
| Does the child combine 2-5 words to form short sentences? | | | Yes  No |
| How does the child request/make needs known? Provide examples. | | |  |
| Does he/she name people and objects in the classroom environment? | | | Yes  No |
| When speaking, is the child easily understood by teachers and peers? | | | Most of the time  Sometimes  Never |
| What kinds of questions will the child answer appropriately?  Give examples: | | | Yes/No  What  Where  Who  Why |
| Can the child retell a story in his/her own words? | | | Yes  No |
| Can he/she follow directions you give? | | | Yes  No |
| Does the child follow a two (2) step direction independently? For example: “Get your coat, and take it to your room.” | | | Yes  No |
| How long will the child sit for structured activities such as circle time? | | |  |
| Does the child get frustrated when he/she is not understood and/or when he/she does not understand others? | | | Yes  No |
| Does the child echo what is said rather than giving an appropriate response? | | | Yes  No |
| Do you notice hearing difficulties in the classroom? | | | Yes  No |
| **Social Skills** | | | |
| Describe the student’s relationships with peers: | | |  |
| Describe the student’s relationship with teachers: | | |  |

Distribution:

Student Services

Parent

Confidential File