Office Use Only
Date Received: _____
Enrollment Phase: _____

2021-2022
3-5 Enrollment Packet
Poudre School District Early Childhood Education Program

220 North Grant Avenue, Fort Collins, CO 80521
Phone: (970) 490-3204 Fax: (970)490-3134 Email: psdece@psdschools.org bit.ly/PSDpreschool

INFORMATION VERIFICATION

By my signature below, I am verifying that the information provided to the Poudre School District Early Childhood Education Program in this enrollment packet is, to the best of my knowledge, complete and truthful.

_____ _____ _____

Parent/Guardian Signature **Print Name** **Date**

Who completed this application: ☐Mother ☐ Father ☐Guardian

Child's Name:_____ Child's Date of Birth:_____

Please complete all information in black or blue ink

Phases	Communication about Placement
I. Early Application * **January 5, 2021 - February 28, 2021**	Mailed by April 9, 2021
II. Application* **March 1, 2021 - Last day of School (May 20, 2021)**	Mailed by June 10, 2021
III. Delayed Application* **May 21, 2021 - August 1, 2021**	Mailed prior to the first day of school
IV. Ongoing Year-Round Application* **Anything after August 2, 2021**	Varies based by Volume & Site Requested. (10-15 business days to process application, placement date unknown based on request)

*This applies to COMPLETE original applications, classroom change requests, data changes/address changes.

*Eligibility and Placements within certain funded sources are limited.

2021-2022 3-5 Enrollment Packet

Child's Name:_____ Child's Date of Birth: _____

Please complete the following boxes with Parent/Guardian's current contact information and employer information. This information is necessary so that we can contact you in the case of an emergency. Primary and Secondary Guardians will be contacted first. Additional emergency contacts may be added on the following page.

Primary Guardian:	
Street Address: **City, State, Zip:**	
Primary's Phone(s):	**( ) ☐Home ☐ Cell** **( ) ☐Home ☐ Cell Texting Ok? ☐ Yes ☐ No**
Email Address:	
Employer:	
Street Address: **City, State, Zip:**	
Work Phone:	**( )**

Secondary Guardian:	
Street Address: **City, State, Zip:**	
Secondary's Phone(s):	**( ) ☐Home ☐ Cell** **( ) ☐Home ☐ Cell Texting Ok? ☐ Yes ☐ No**
Email Address:	
Employer:	
Street Address: **City, State, Zip:**	
Work Phone:	**( )**

Emergency Contact Information
(In-State Contacts Only)

Child's Name:______________________________Child's Date of Birth: ___________

Emergency Contact (other than Primary & Secondary Guardian)		**Relationship to child:**	
Street Address: **City, State, Zip:**			
Phone #'s:	**( )** ☐ **Home** ☐ **Cell** **( )** ☐ **Home** ☐ **Cell**	**Check all that apply** ☐ **Emergency contact** ☐ **Release child to** **Is this person at least 16 years old with a valid ID?** ☐ **Yes** ☐ **NO**	

Emergency Contact (other than Primary & Secondary Guardian)		**Relationship to child:**	
Street Address: **City, State, Zip:**			
Phone #'s:	**( )** ☐ **Home** ☐ **Cell** **( )** ☐ **Home** ☐ **Cell**	**Check all that apply** ☐ **Emergency contact** ☐ **Release child to** **Is this person at least 16 years old with a valid ID?** ☐ **Yes** ☐ **NO**	

Emergency Contact (other than Primary & Secondary Guardian)		**Relationship to child:**	
Street Address: **City, State, Zip:**			
Phone #'s:	**( )** ☐ **Home** ☐ **Cell** **( )** ☐ **Home** ☐ **Cell**	**Check all that apply** ☐ **Emergency contact** ☐ **Release child to** **Is this person at least 16 years old with a valid ID?** ☐ **Yes** ☐ **NO**	

Emergency Contact (other than Primary & Secondary Guardian)		**Relationship to child:**	
Street Address: **City, State, Zip:**			
Phone #'s:	**( )** ☐ **Home** ☐ **Cell** **( )** ☐ **Home** ☐ **Cell**	**Check all that apply** ☐ **Emergency contact** ☐ **Release child to** **Is this person at least 16 years old with a valid ID?** ☐ **Yes** ☐ **NO**	

Emergency Contact (other than Primary & Secondary Guardian)		**Relationship to child:**	
Street Address: **City, State, Zip:**			
Phone #'s:	**( )** ☐ **Home** ☐ **Cell** **( )** ☐ **Home** ☐ **Cell**	**Check all that apply** ☐ **Emergency contact** ☐ **Release child to** **Is this person at least 16 years old with a valid ID?** ☐ **Yes** ☐ **NO**	

Emergency Contact (other than Primary & Secondary Guardian)		**Relationship to child:**	
Street Address: **City, State, Zip:**			
Phone #'s:	**( )** ☐ **Home** ☐ **Cell** **( )** ☐ **Home** ☐ **Cell**	**Check all that apply** ☐ **Emergency contact** ☐ **Release child to** **Is this person at least 16 years old with a valid ID?** ☐ **Yes** ☐ **NO**	

Child's Name:_____ **Child's Date of Birth:** _____

Please read each box, initial and check Agree or Disagree

	Permission Contract	Check
Release of Information	I authorize the Poudre School District Early Childhood Education Program to release information to Partnering Community agencies/providers, contracted service providers, and to providers identified by the parent/guardian.	☐ **Agree** ☐ **Disagree**
Specific Information Shared	I understand that following PSD policy, I will need to complete a records release form every time I want to access copies of my child's records.	☐ **Agree** ☐ **Disagree**
Field Trips (3-5-year old only)	I understand that my child will ride a Poudre School District bus when they go on supervised field trips as part of the program. Permission slips must be signed for each trip for my child to be able to participate.	☐ **Agree** ☐ **Disagree**
Sunscreen/hand lotion	I understand that sunscreen and lotion may be used on my child and in classroom activities. Product information for classroom sunscreen is available in the classroom.	☐ **Agree** ☐ **Disagree**
Telephone Contact	I give my permission for the program staff to give my telephone number to another parent for the purpose of program/classroom events and parent involvement only.	☐ **Agree** ☐ **Disagree**
Media	I give permission to publish my student's photo, video and/or name in print and/or electronic media.	☐ **Agree** ☐ **Disagree**
Emergency Medical Care	In an emergency the Poudre School District Early Childhood Education Program will call 911 and access medical assistance for my child. I understand that all reasonable attempts will be made to contact myself and/or my emergency contacts. In the case that I cannot be reached, I give permission for Poudre School District Early Childhood Education Program to arrange emergency medical care for my child.	**Initial** _____
Data Collection	I understand that the Poudre School District Early Childhood Education Program collects non-identifiable statistical information to be used for documentation, Program Information Report, and funding purposes.	**Initial** _____
Home Visits and Conferences	I understand that there will be six home visits (**for Head Start funded families**) and Parent/Teacher Conferences **(for all families)** during the school year. Home visits and/or teacher conferences may include support from Teacher & Education, Health and Family Mentor staff. If I am unable to make a scheduled visit, I must reschedule. I understand that lack of attendance at home visits will lead to a review of my child's enrollment and may lead to disenrollment.	**Initial** _____
Quality Assurance	I understand that there may be a supervisor who comes into my home during a scheduled home visit with one of the staff members mentioned above for the purpose of quality assurance.	**Initial** _____
Screenings	I understand that my child will be screened throughout the school year for the purpose of assessment in vision, hearing, dental, speech, growth and developmental needs.	**Initial** _____
Poudre School District Cumulative File	I understand that if my child is enrolled in a Poudre School District Early Childhood Education Program my child's records will be transferred to his/her Poudre School District cumulative file.	**Initial** _____
Custody and Court Order	I understand that I must provide Custody and Court Orders that pertain to my child to the Early Childhood Education Program for the school to be aware of and follow special instructions.	**Initial** _____
Preschool Attendance Area	I understand that for my child to attend preschool in the Poudre School District our permanent home address must be in the Poudre School District boundaries. I verify that I have provided my child's actual home address.	**Initial** _____
Attendance Policy	I understand that if my child is enrolled in the Poudre School District Early Childhood Education Program my child will be subject to the program's attendance policy. I understand that attendance issues will lead to a review of my child's enrollment and possible disenrollment. I understand that this is not drop-in care.	**Initial** _____

This form is valid for the 2021-2022 school year.

_____

Parent/Guardian Signature **Print Name** **Date**

Department of Language, Culture & Equity
POUDRE SCHOOL DISTRICT

HOME LANGUAGE AND RESIDENCY (HOUSING) FORM

This box MUST be completed by school registrar before giving to site ELD and/or McKinney representative as appropriate.
Intake School:_____Intake Date: _____
Enrolling School:_____Date Enrolled: _____
Student ID #:_____Grade: _____

State and federal regulations require that schools determine eligibility for English Language Development, immigrant, migrant, refugee, or McKinney-Vento education services and supports. This information is used to ensure that the educational rights of each child are met. This **confidential information** is for school use only.

Student's Last Name	Student's First Name	Student's Middle Name
Date of Birth	Place of Birth	Address
Date Student Entered Colorado	Date Student Entered US (if applicable)	
Parent/Guardian Name(s)	Phone Numbers	

Home Language Survey

Does your child understand a language other than English? If yes, what other languages does your child know?	
What language did your child first learn?	
What language do you most frequently speak with your child?	
What language does your child most frequently **speak** with you?	
Is your child able to **read** and **write** in this language?	
List any other languages used in the home.	
Which language do you prefer for communication to and from school?	

Educational History

Please complete the following educational history as accurately as possible.

Grade and Date(s)	School Name	School Location	Language of Instruction

If you came to the US from another country, did your child attend school inthat country? Yes No
If yes, please complete the following:

How many total years did your child attend school in another country? Which country?	
Did your child receive any specialized instruction (Gifted/Talented, Special Education, Interventions)?	

Have you been given Refugee Status Paperwork? Yes No

Housing Information

The McKinney-Vento Assistance Act protects and supports the educational rights of students who do not have permanent housing. Your answers help to determine the support the student may be eligible for.
*This **confidential information** is for school use only.*

A. Please check which of the following situations the student resides in (you can choose more than one):

☐ Living with extended family members, non-family members, or friends
☐ Motel, car, campsite, or park
☐ Shelter (emergency, safehouse) or transitional housing program
☐ Inadequate housing (lacks proper kitchen, bathroom facilities, water or electricity, and/or infestations, mold, or other dangers)
☐ None of the above
☐ Other (Please Explain)

B. Please check all the following reasons that apply to the students living situation (you can choose more than one):

☐ Loss of housing
☐ Economic hardship
☐ Temporarily waiting for house or apartment
☐ Providing care for a family member
☐ Living with boyfriend/girlfriend/significant other/friend
☐ Loss of employment
☐ Parent/Guardian deployed
☐ None of the above
☐ Other (Please explain)

C. I am a student living apart from my parents or guardians. ☐ Yes ☐ No

For students **without** a fixed, regular and adequate nighttime residence the following rights apply:

Educational Rights

1. Go to school no matter where they live or how long they have lived there
2. Choose between the local school where they are living, the school they attended before they lost their housing, or the school where they were last enrolled
3. Enroll in school without proof of address, immunizations, school records, or other documents
4. Have access to extracurricular activities
5. Get transportation to their school of origin (if feasible and in their educational best interest)
6. Get all the school services they need (including free breakfast/lunch, fees waived)
7. Be free from harassment and isolation
8. Have disagreements with the schools settled quickly

Any questions about these rights can be directed to the local McKinney-Vento Program Specialist at 970-490-3242.

By signing below, I acknowledge that I have read and understand the above rights.

Signature of either parent, guardian, or unaccompanied youth Date

2021-2022 Health Conditions

Student Name:_____ Date of Birth:_____/_____/_____

Health Care Provider/Medical Clinic:_____ Last exam date: _____

Dentist/Dental Clinic:_____ Last exam date: _____

Are you enrolled in Supplemental Nutrition Assistance Program (SNAP) ☐ Yes ☐ No

Is your family currently on WIC ☐ Yes ☐ No

Medical Insurance:

☐ Medicaid/Health First ☐ Colorado Health Plan Plus (CHP+) ☐ None/Uninsured ☐ Other_____

Hospital Preference:

☐ Poudre Valley Hospital ☐ McKee Medical Center ☐ Medical Center of the Rockies ☐ Banner Health

Health Conditions:

Response		Health Condition	Response		Health Condition
YES	NO	Allergy- Environmental / Animal	YES	NO	Hearing Impairment- Devices worn? YES NO
YES	NO	Allergy – Food	YES	NO	Heart Condition
YES	NO	Allergy – Insect	YES	NO	Kidney /Urinary
YES	NO	Allergy - Medication	YES	NO	Mental Health
YES	NO	Asthma	YES	NO	Neurological
YES	NO	Autism Spectrum Disorder	YES	NO	Orthopedic
YES	NO	Brain / Head Injury	YES	NO	Physical limitation/restrictions
YES	NO	Cancer	YES	NO	Premature or significant birth history
YES	NO	Chewing or swallowing troubles	YES	NO	Seizures/ Epilepsy
YES	NO	Diabetes	YES	NO	Special Diet
YES	NO	G-Tube	Yes	NO	Vision Problem – Glasses worn? YES NO
YES	NO	Genetic Disorder	OTHER:		

Explain any health condition(s)above:_____

_____

_____

Does your child need medication at school? YES ☐ NO ☐

Name of Medication(s):_____

**Print or request an *Authorization to Administer Medication* form from your school or from the PSD health services website:

Please list any other daily medication(s) that your child is taking at home: _____

I voluntarily provide this information and understand I must provide the following health documents for my child's health file: Complete immunizations, current physical exam, dental exam, and lead blood test results

_____

Parent/Guardian Signature **Date**

Dental Screening – Early Childhood Permission Form

Children who are enrolled in the Poudre School District's Early Childhood Program have the opportunity to have their teeth examined by a local dentist from the community. This is a free service and is performed right in your child's classroom. This is a fun classroom activity that children really enjoy. With parent permission, a fluoride varnish will be applied to your child's teeth as well, in both the fall and spring of the 2021/2022 school year. This satisfies the program requirement for a dental exam. Written results of the exam will be sent home with each child. Parents will be informed if a child has cavities or needs further evaluation.

☐ **Yes** ☐ **No** **I give permission for a dental exam and evaluation.**

☐ **Yes** ☐ **No** **I give permission for fluoride varnish to be applied.**

For a copy of the Health District of Larimer County's Notice of Privacy Practices please visit their website at:
http://www.healthdistrict.org/sites/default/files/health-district-notice-of-privacy-practices-english-02-17.pdf

Parent/Guardian:_____ **Date:**_____
(Signature required for children age 17 or under)

(Please print your information)

Student's Last Name:	**Student's First Name:**	**Student's Gender:** ☐ **Male** ☐ **Female**
Student's Date of Birth:	**Parent/Guardian Name:**	**Relationship to Student:**
Address:	**City, State, Zip:**	**Phone:**

Type of dental insurance?
☐ **Medicaid / DentaQuest**
☐ **CHP+**
☐ **None**
☐ **Private Dental Insurance**
☐ **Other:** _____

Has your student seen a dentist before: ☐ No ☐ Yes: Date of child's last appointment:_____
Are your child's gums/teeth brushed at least once a day? ☐ No ☐ Yes
Does your child have any trouble with teeth, gums, or mouth that you know about? ☐ No ☐ Yes
Does your child have any cavities? ☐ No ☐ Yes
Does your child have trouble chewing or swallowing? ☐ No ☐ Yes

Child's dentist is at:

- ☐ **FoCo Kids**
- ☐ **Toothzone**
- ☐ **KidsFirst Dental**
- ☐ **Jennifer Hargleroad**
- ☐ **Keith Van Tassell (Ped. Dent. Of Rockies)**
- ☐ **Salud Dental Clinic**
- ☐ **Mountain Kids**
- ☐ **Big Grins**
- ☐ **Kindergrins**
- ☐ **Health District**
- ☐ **Drs. Gerken & Galm (Ped Dent. Of Loveland)**
- ☐ **Other (please specify):**_____

OFFICE USE ONLY:

Screening Date:_____/_____/_____

Number of cavities: _____

A____**B**____**C**____**D**____**E**____**F**____**G**____**H**____**I**____**J**_____

T____**S**____**R**____**Q**____**P**____**O**____**N**____**M**____**L**____**K**

Provider's Signature_____

Print Name_____

Provider Comments

FREE Vision Screening
Colorado Lions KidSight Program

The local Lions Club in your community, in conjunction with the Colorado Lions KidSight Program, will offer free vision screening to your child at his/her preschool or kindergarten. The screening uses state-of-the-art technology and is 85-90% effective in detecting the vision problems that could lead to lazy eye. No physical contact is made with your child and no eye drops or medications are used. ***WHY VISION SCREENING?*** 1 in 20 children has an undetected vision problem that could turn into lazy eye if left untreated. Early detection and treatment is essential to prevent lazy eye.

Parent/Guardian: Please fill out the following. All information is kept confidential and is not sold to third parties. PLEASE PRINT CLEARLY and ANSWER ALL QUESTIONS.

Child's full name:_____ Male_____ Female _____
First *Middle* *Last*

Child's date of birth: _____ Child's age: _____

Parent or Guardian: _____ Email: _____

Address:_____ City:_____ Zipcode: _____

Phone(INCLUDING areacode) _____

Is your child currently under the care of an eye doctor?
Yes☐ No☐ If yes, name of eye doctor: _____

I hereby give permission for my child to participate in the screening event. I have read and understood the following information regarding this program:

- The information obtained from this vision screening is preliminary only and does not constitute a diagnosis of vision problems.
- I may be communicated with by telephone or email if my child does not pass the vision screening.
- I understand that if my child does not pass the eye screening, I am responsible for arranging for an eye exam with an eye doctor of my choice. I understand that I am responsible for all costs of any eye exams.
- I will not hold the Lions organization, the Colorado Lions KidSight Program, their employees, agents, officers, and representatives liable for any injury which may accrue as a result of the vision screening, including but not limited to errors of commission, errors of omission, or other misdiagnosis.

Signature of Parent or Guardian_____ Date _____

RESULTS: **For Office Use Only**

_____Pass — We are unable to detect a vision problem at this time. The screening is not a substitute for a complete pediatric eye exam. Consult an eye care professional if a vision problem is suspected.

_____Unreadable — We were unable to get reliable vision screening results for this child. This can happen occasionally if the child looks away from the equipment during the screening. Consult an eye care professional if a vision problem is suspected.

_____Refer — Child should be examined by an eye care professional because he/she may have the following Condition:

____ Strabismus ____Anisometropia ____Astigmatism
____ High Farsightedness ____High Myopia
____ Other_____

Authorization for Disclosure of Protected Health Information

Doctor

PARENT TO COMPLETE

I authorize _____

(Provider/Clinic Name)

_____

(Provider/Clinic address and or Street)

to release the Health Information of the individual named below

Patient/Student Name_____DOB_____

Address_____

Phone Number_____Parent Name _____

PSD HEALTH STAFF TO COMPLETE

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Poudre School District Early Childhood Health Staff
220 North Grant, Fort Collins, CO 80521 Fax 970-490-3694

For the purpose of PSD Early Childhood Health Requirements

The type and amount of information to be disclosed is as follows: *(specify dates where appropriate):*

- Entire medical record, from date_____to date_____.
- Summary statement of diagnostic testing and treatmet plan, from date _____to date_____.
- Laboratory Result, from date_____to date_____.
- Immunizations records, from date_____to date_____.
- Well-child exam, from date_____to date_____.
- Dental exam, from date_____to date_____.
- Developmental reports and evaluations, from date_____to date_____.
- Other: _____
- (You must specifically indicate the release of records relating to drug or alcohol abuse, child abuse, HIV status, genetic testing, or mental health records. A separate authorization form is required for release of psychotherapy notes.)
- Verbal consultation as needed with _____

PARENT TO READ AND SIGN

I understand this authorization will expire, without my express revocation one year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that I have a right to a copy of this authorization. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on obtaining the individual's authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and once the information is disclosed, it may no longer be protected by federal HIPAA confidentiality rules.

_____ _____

Signature of Patient, Parent or Authorized Personal Representative **Date**

_____ _____

Printed Name of Patient, Parent or Authorized Personal Representative **Relationship** to Patient

This authorization reflects the requirements of HIPAA, 45 C.F.R.J 164.508.

Authorization for Disclosure of Protected Health Information

Dentist

PARENT TO COMPLETE

I authorize _____

(Provider/Clinic Name)

_____

(Provider/Clinic address and or Street)

to release the Health Information of the individual named below

Patient/Student Name_____DOB_____

Address_____

Phone Number_____Parent Name _____

PSD HEALTH STAFF TO COMPLETE

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Poudre School District Early Childhood Health Staff
220 North Grant, Fort Collins, CO 80521 Fax 970-490-3694

For the purpose of Early Childhood Health Requirements:

The type and amount of information to be disclosed is as follows: *(specify dates where appropriate):*

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- Laboratory Result, from date_____to date_____.
- Immunizations records, from date_____to date_____.
- Well-child exam, from date_____to date_____.
- Dental exam, from date_____to date_____.
- Developmental reports and evaluations, from date_____to date_____.
- Other: _____
- (You must specifically indicate the release of records relating to drug or alcohol abuse, child abuse, HIV status, genetic testing, or mental health records. A separate authorization form is required for release of psychotherapy notes.)
- Verbal consultation as neededwith _____

PARENT TO READ AND SIGN

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_____ _____

Signature of Patient, Parent or Authorized Personal Representative **Date**

_____ _____

Printed Name of Patient, Parent or Authorized Personal Representative **Relationship** to Patient

This authorization reflects the requirements of HIPAA, 45 C.F.R.J 164.508.

Please complete these last three pages only if you have concerns.

Child's Name:_____Child's Date of Birth: _____

Pregnancy & Birth		
Birth weight: _____lbs._____oz.	Child Born at:	☐ 40+ weeks ☐ Preterm at_____weeks due to _____

7. Please share any difficulties during pregnancy, labor, or delivery:

8. Did your baby experience any difficulties after delivery (ie: seizures, trouble breathing):

9. Any medications used during pregnancy: ☐Yes ☐No - List medications and reason:

10. Describe how your child was as a baby:

Health & Developmental History

Toileting	
☐ Training started	☐ Diapered during the day
☐ Needs help toileting	☐ Toilet trained
Soiling or wetting concerns:	

Sleeping Habits
Do you feel like your child gets enough sleep? ☐ Yes ☐ No
Is your child easily soothed? ☐ Yes ☐ No Concerns:

Family Considerations

Have there been any changes in the child's life such as a new sibling, divorce, marriage or death in the family?
Please describe the child's reaction, if any. _____

Current Child Development

Does your child have an: ☐ IEP ☐ IFSP ☐ Private Therapy: _____
If so, please provide us a copy or request to sign a Release of Information form so we can access a copy.

Do you have concerns about your child in any of the following areas?

☐ Yes	☐ No	MOTOR SKILLS (walking, drawing)	☐ Yes	☐ No	ADAPTIVE SKILLS (feeding and dressing self)
☐ Yes	☐ No	SOCIAL – EMOTIONAL (behavior, social skills)	☐ Yes	☐ No	EARLY LEARNING (engaging in play, early concepts)
☐ Yes	☐ No	COMMUNICATION (speech intelligibility, language comprehension)			

-- Developmental Inventory --

Thinking about the skills your child demonstrates consistently, does he or she:

Motor Skills

Does your child:	Yes	Not yet	N/A
Use crayons and/or markers to scribble, draw, or "write"			
Use scissors to snip the edge of a piece of paper			
Use one hand for most activities			
Run, walk, and jump			
Throw and kick a ball; try to catch a ball with both hands			

Social-Emotional

Does your child:	Yes	Not yet	N/A
Show an awareness of feeling, his/her own and those of others			
Want independence, but stills needs security of parents			
Enjoys playing with other children similar in age			
Verbally express what he/she wants or needs			
Show empathy toward familiar adults and friends			

Communication

Does your child:	Yes	Not yet	N/A
Listen and remember details of simple stories			
Understand simple 1-2 step directions			
Put 3-5 words together to speak in short sentences ("want more milk")			
Ask lots of questions			
Speak clearly so that most family members and friends understand him/her			

Adaptive Skills

Does your child:	Yes	Not yet	N/A
Feed himself/herself using a fork and/or spoon			
Wash and dry his/her own hands			
Help with dressing and undressing			
Drink from a cup			
Open doors and cupboards			

Early Learning

Does your child:	Yes	Not yet	N/A
Enjoy looking at books with an adult or independently			
Play with toys in expected way (drive and crash cars, take care of a doll)			
Name and match colors			
Sing along with familiar songs			
Ask for help with difficult activities			

Your specific concerns:

When did you first notice concerns in this area?

Have you pursued private services through your child's doctor?

Previous or Current Home-Based or Childcare/Preschool Provider

Name of Childcare or Preschool:	Month/Year Attending:
Street Address:	
City/State/ZIP:	Phone Number: ( )
Days/Hours:	☐ I agree to allow PSD to contact for further information
Your Child:	
Describe your child's personality:	
Share your child's favorite activities?	

Does your child have the opportunity to play with other children?	☐ Yes	☐ No	Explain (@ the park, with her cousins, etc.):	
My child attends to an engaging play activity (non-screen related) for:	☐ < 5 mins	☐ 5-10 mins	☐ 10-30 mins	☐ 30+ mins

How much time a day does your child spendwatching/using screens?_____hours _____minutes
Does this concern you? ☐ Yes ☐ No

Behavior

N/A	Yes	No	
			Do you have behavior concerns at home?
			Does your childcare provider have behavior concerns at childcare?
			Has anyone else (family or friend) expressed concerns about your child's behavior?
			Has your child ever been asked to leave a childcare setting due to behavior?

Anything else you would like us to know about your child?

What do you hope your child will learn from the PSD Early Childhood Education Program?