educational excellence through leadership, partnership, and innovation

- **Transition from Infant and Toddler Early Intervention**
- **New Screening Referral**
- **Move In**

Child's Name: _____ Gender: _____

Birth Date:_____ SSN: _____

Child's Address:_____

School District Where Child Lives:_____

Mother's name :_____ Father's name:_____

Home Phone:_____ Home phone:_____

Mother's cell phone:_____ Father's cell phone:_____

Mother's work phone:_____ Father's work phone:_____

E-mail_____ E-mail:_____

Lives with child? _____Yes _____No Lives with child? _____Yes _____No

If No list address_____ If No list address_____

Primary language spoken in the home: _____	**Primary language spoken and understood by the child:** _____
Interpreter Needed for parents: ☐Yes ☐No	**Interpreter Needed for child:** ☐Yes ☐No

To be completed only if this child has a legal guardian/foster parents:

Legal Guardian/Foster Parent's name (s) :_____

Relationship: _____

Home Phone: _____

Guardian/Foster Parent's cell phone:_____

Guardian/Foster Parent's work phone:_____

Guardian/Foster Parent's E-mail_____

Who has education rights?_____

Please list any brothers and sisters below:

Name	Sex	Age	Live in the child's home?

Who should we call to schedule an Appointment?_____

What phone number (s) can we call between 8:30 AM and 4:00PM Monday-Friday?

_____

Revised 8/13/12

What concerns do you have about your child's development?_____

_____

How did you learn about the CAIU Preschool Program?_____

Does your child attend any of the following?

_____ Nursery School **_____ Day Care Center** **_____ Pre-K Counts**

_____Head Start **_____ Day Care in a home**

If you checked any of the above, please tell us: Where_____

What days_____ What time_____

DEVELOPMENTAL HISTORY

Did you have any difficulties: _____Before _____During _____ After the birth of this child?

Check any of the following that apply:
_____ Ventilator support **_____ Required Oxygen**
_____Intraventricular hemorrhage (Brain Bleed) **_____ PreEclampsia**
_____ Other:_____

Exposure to toxic substances: _____Drugs _____ Alcohol

Did your child require special medical care following birth? _____ Yes _____No
_____ NICU Treatment Number of days _____
Other:_____

Length of Pregnancy: _____ weeks Birth Weight: _____lbs. _____ oz (s)

GROSS MOTOR: How old was your child when he/she began: Sitting _____
Crawling _____
Walking _____

Child can: ____ walk ____ run _____ climb up steps/ stairs _____ go down steps/stairs
Alternates feet when climbing ___yes ___no

TOILETING: _____ Fully toilet trained _____ Partially toilet trained _____ Not toilet trained

EATING: Does your child feed himself/herself _____ NO _____YES WITH: _____Utensils _____ Hands
Does child usually drink from a: _____ bottle _____ cup with a spout _____ open cup
Does your child have any unusual eating habits (limited food preference, consistency, frequency, overeating, eating non-food items)? _____ Yes _____No If yes please describe:
_____
_____

DRESSING: Is the child able to _____dress independently _____requires some support
_____ does not dress independently

COMMUNICATION: How old was your child when he/she began : Using single words_____
Phrases _____
Sentences _____
My Child does not talk yet _____

If your child does not use words , or uses very few words , how does he/she let you know hat he/she wants?

_____ gestures/pointing _____ whining/crying _____ taking you to it _____ making sounds

Other:_____

How much of what your child says can you /family members understand?
_____100% (all) _____75% (most) _____50% (some) _____25% (little) _____ 0% (none)

How much of what your child says can others understand?
_____100% (all) _____75% (most) _____50% (some) _____25% (little) _____ 0% (none)

Once your child began using words did he/she ever stop talking? _____Yes _____ No

If yes please describe:_____

My child can: _____ follow 1 step directions _____ follow 2 step directions _____ not yet follow directions

MEDICAL and PSYCHOSOCIAL HISTORY

Does your Child have a Medical Assistance (MA) card? If yes, please list the card number:

Name of Child's Physician:_____

Physician's address and/or phone:_____

Name of any other Physicians who are caring for your child, if any:

_____

Describe any significant medical problems past or current:

Surgeries:_____

Hospitalizations:_____

Serious Illnesses: _____

If your child has been given a diagnosis, please check and provide a copy of any reports (related to that diagnosis) that you may have in your possession.

_____Seizures _____ Asthma _____ Diabetes _____Chronic Ear Infections

___ Difficulty with bowel or bladder control

___ Attention Deficit Hyperactive Disorder(ADHD) ,By whom_____

___ Pervasive Developmental Disorder (PDD) , By whom_____

___ Autism Spectrum Disorder, By whom _____

___ Obsessive Compulsive Disorder (OCD), By whom_____

___Oppositional Defiant Disorder (ODD), By whom_____

___Sensory Integration Dysfunction, By whom_____

___Lead Poisoning , By whom_____

___ Vision Problems, have glasses been prescribed ____yes _____no By whom _____

___ Hearing Problems, have hearing aides been prescribed ____ yes ___no . By whom_____

___Allergies, if checked please describe _____

Other:_____

Is your child currently taking medication _____yes _____no (if yes please complete below)
Medication_____**Dosage**_____
Medication_____**Dosage**_____

Does your child usually play: _____ alone ____ near other children ____ with other children (sharing or turn taking)

Place a check next to any of the following that describes concerns you have about your child

_____Developmental Delays: needs a lot of help to learn new skills, does not seem to be learning at an average rate, delayed in accomplishing developmental milestones

_____Speech/Language:
_____ Articulation: difficulty pronouncing words
_____Expressive Language: difficulty putting words together to form sentences, few words
_____Receptive language: difficulty answering questions, following directions
_____Pragmatic language: difficulty using words to have wants/needs met, unable to carry on a conversation, talks about 1 topic only

_____Motor:
_____ Gross motor : clumsy, difficulty running, balance, poor body control
_____ Fine motor: difficulty with holding crayons/pencils, drawing, stacking blocks completing puzzles

_____Sensory Integration: difficulty having hands dirty /sticky, sensitive to loud noises, seeks deep pressure sensitive to touch, difficulty with haircuts

_____Self-Help: toileting, feeding, dressing problems

_____Socialization: does not play well with other children, difficulty separating from parent, will not work in a group, is left out of peer group activities

_____Attention: short attention span, changes activities frequently, difficulty completing play/activities without help

_____Behavior: tantrums, is not able to accept limits, resists rules, difficulty calming his/her self

_____Emotional: sudden changes in mood, is a danger to self or others

_____Hearing: does not seem to hear sounds/words, asks you to repeat or talk louder, turns up volume on the TV or radio

_____Vision: eyes turn in or turn out, squints, gets close to objects /books to see

Comments:

Form Completed by:_____

Relationship to child:_____ **Date:**_____

_____

EIRS#_____ **PELICAN#**_____