Alachua County Public Schools

Student Support Services

Pre-K Educational Planning Team Screening Record

Student Name: _____ Today's Date: _____

Student #: _____ Zoned School: _____ Grade: _____

Date of Birth: _____ Sex: _____ Race: _____ Primary Language at Home: _____

Parent/Guardian Name: _____

Parent/Guardian Address: _____

Parent/Guardian Primary Phone: _____ Additional Phone: _____

Referral Source: Part C: _____ Community Referral: _____

Service Coordinator: _____

Parent/Guardian Conferences:

1. Date: _____ Person(s) Involved (Name/Title): Transition
   Summary: _____
2. Date: _____ Person(s) Involved (Name/Title): Evaluation
   Summary: _____
3. Date: _____ Person(s) Involved (Name/Title): Return Eval.
   Summary: _____

Review of Social/Development History:

Parent Concerns: _____

Counseling Involvement: _____

Social/Medical: Community Agencies Involved: _____

Problems w/Pregnancy: _____ Problems w/Birth: _____

Early Development (0-4): Walked @ _____ 1st Words @ _____ Sentences @ _____

Accidents/Illnesses/Operations (dates): _____

Attends: _____

Sensory Screening:

Vision: Right_____ Left_____ Date: _____ Near Vision Binocular, or Functional:

Hearing: Right_____ Left_____ Date: _____ W/A OAE, or Functional:

	Date	Normal Limits	Follow-Up Needed	Check if Enrolled	Enrollment Date
Language:	_____	☐	☐	☐	_____
Speech:	_____	☐	☐	☐	_____
Fluency:	_____	☐	☐	☐	_____
Voice:	_____	☐	☐	☐	_____

Clinician's Signature: _____

_____ mth ASQ Screening Results: _____ WNL or Areas of Concern: _____

Comm: _____ G. Motor: _____ F.Motor: _____ Problem Solving: _____ Personal Social: _____

_____ mth ASQ Screening Results: _____ WNL or Areas of Concern: _____

Notes: