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| Child’s First Name Middle Name Last Name | | | | Primary Language | | | | Resident District | | | Gender (M/F) | |
| Street Address | | | City | | | | Zip Code | | | Date of Birth | | Age |
| Father’s Name | Occupation | | | | Phone # to be Reached | | | | | Who does this student primarily live with?   |  |  | | --- | --- | |  | Both Parents | |  | Mother Only | |  | Father Only | |  | Mother/Stepfather | |  | Father/Stepmother | |  | Grandparent(s) | |  | Foster Parent | |  | Legal Guardian | | | |
| Mother’s Name | Occupation | | | | Phone # to be Reached | | | | |
| Legal Guardian’s Name (If other than Parent) | Occupation | | | | Phone # to be Reached | | | | |
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| List Other People Residing in the Home | | Relationship | | | | Gender (M/F) | | | Age |
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**Permission to Screen**

I give permission for the above-named child to participate in a developmental screening at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Screening Location-Name of Preschool, Head Start, Daycare, etc.

I give permission for the above-named child to receive a vision and hearing screening. In the event Four Rivers Special Education District does not conduct the screenings, I give permission for the vision and hearing screening agency to release the results to Four Rivers Special Education District.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Parent/Guardian/Authorized Agent

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**Release of Information for Nonpublic Entities (Head Start, Private School, Daycares, etc.)**

To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_

Name of Head Start, Private School, Daycare, etc.

I give permission to Four Rivers Special Education District, and the agency or professional to whom this form is addressed above, to freely exchange personally identifiable oral and/or written school information regarding the above-named student. This information is intended for use in educationally and legal decision making. The undersigned acknowledges that refusal to sign will result in the information not being released. The undersigned intends that a photocopy or facsimile of this form will carry the same legal force and effect as the original. The undersigned further acknowledges that he/she has the right to revoke this consent in writing at any time, and to inspect, copy, or challenge the contents of the records being requested prior to release. Knowing this, the undersigned intends to authorize the release of the designated records pursuant to 105 ILCS 10/6(a)(8) of the Illinois School Student Records Act. This consent covers the full contents of the temporary and permanent files as these are defined in the Illinois School Student Records Act. Redisclosures of third party files are not allowed unless specifically authorized. The undersigned intends for this release to include any mental health files located in the school temporary record. This release grants permission for the exchange of birth certificate, developmental screening information, and hearing/vision screening information. This release expires one year from the signature date of the undersigned.

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Date Parent/Guardian/Authorized Agent

What, if any, program does your child currently attend? (Preschool, Daycare, Private School, Head Start) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child previously participated in a developmental screening through Four Rivers or any other agency? \_\_\_\_ Yes \_\_\_\_ N0

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| **Please check if your child or family has received services from any of the following agencies.** | | | |
|  | Child & Family Connections (Birth – 3 Early Intervention) |  | Public Health Department |
|  | School District 0-3 Program |  | WIC |
|  | Division of Specialized Care for Children (DSCC) |  | Early Head Start (0-3) |
|  | Department of Child & Family Services (DCFS) – child is involved with DCFS but resides with his/her families as part of DCFS’s Intact Families program |  | Head Start (3-5) |
|  | DCFS – child is in DCFS care & resides with a foster family |  |  |
|  | Free and Reduced Lunches |  | Community Counseling |
|  | Medicaid/Kid Care |  | Social Security |
|  | Department of Rehabilitative Services |  | SNAP/Link Card |

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| **Please check if any of the following items apply to your child or family.** | | | |
|  | History of child abuse or neglect |  | DCFS involvement |
|  | History of domestic violence |  | History of alcohol/drug abuse |
|  | Chronic or terminal illness of child |  | Child has documented disability |
|  | Chronic or terminal illness of immediate family member |  | Parent/guardian has a disability |
|  | Teen parent when child was born |  | Parent/guardian has mental illness |
|  | Low birth weight/Failure to thrive |  | Recent immigrant or refugee family |
|  | Parent/guardian active in military |  | English not spoken in home Language in home: |
|  | Parent/guardian deployed in the military |  | Parent/guardian incarcerated |
|  | Parent/guardian did not complete high school |  | High mobility (Moves frequently) |
|  | Parent/guardian has a GED |  | Immediate family member received special education services |
|  | Parents/guardians are separated |  | Parents/guardians are divorced |
|  | Parent/guardian is unemployed |  | A new baby is in the home |
|  | Death in immediate family | | |

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| **Please check any of the following medical conditions that apply to your child. If checked, please explain.** | | |
|  | Premature birth? | Weight at birth: |
|  | Received specialized care or treatment at birth?  Explain: | |
|  | Had surgery? Explain: | |
|  | Been hospitalized? Explain: | |
|  | Had convulsions or seizures? Explain: | |
|  | Any medical diagnoses? Please list diagnoses and explain the current care for the medical diagnoses. | |
|  | Takes medication? Please list. | |
|  | Has allergies or asthma? Explain: | |
|  | Has a physician? Physician’s Name(s): | |
|  | Has received services or is receiving services from an occupational therapist? Explain: | |
|  | Has received services or is receiving services from a physical therapist? Explain: | |

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| **Please check any of the following hearing concerns that apply to your child.** | | | |
|  | Often says “huh” |  | Seems to not be paying attention |
|  | Difficulty following directions |  | Has articulation problems or speech delays |
|  | Speaks loudly |  | Turns up volume on radio, TV, computer, etc. |
|  | Asks people to repeat |  | Complains of ear aches and pains |
|  | Did not pass the newborn hearing screening |  | Has tubes or had tubes in ears |
|  | Has been evaluated by an audiologist | | |
|  | Has difficulty hearing? Explain: | | |

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| **Please check any of the following vision concerns that apply to your child.** | | | |
|  | Squinting |  | Sitting close to the TV or holding books too close |
|  | Tilting of the head |  | Frequently rubbing eyes |
|  | Turning of an eye in or out |  | Sensitivity to light |
|  | Wears glasses | | |
|  | Has difficulty seeing? Explain: | | |

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| **Please check any of the following concerns that apply.** | | | |
|  | Has difficulty separating from parent or separates too easily |  | Has a short attention span |
|  | Prefers to play alone |  | Does not seek or accept affection |
|  | Is aggressive with others or toys |  | Continues to misbehave when asked to stop |
|  | Has trouble calming self |  | Does not accept change in routine |
|  | Does not engage in pretend play (being Superman; playing house; etc.) |  | Has tantrums |
|  | Rarely makes eye contact |  | Is fearful or worries a lot |
|  | Seems overly sensitive to touch |  | Doesn’t express a wide range of emotions (happy, sad, etc.) |
|  | Flaps or spins |  | Refuses to eat certain kinds of food |
|  | Uses unusual sounds, words, or repeats what is heard |  | Harms self |
|  | Has difficulty transitioning from one task to another |  | Overreacts to sound |
|  | Has your child received services from a developmental therapist? Explain: | | |

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| **Please check any of the following speech or language concerns that apply.** | | | |
|  | Strangers have difficulty understanding your child speak |  | Has difficulty expressing wants/needs |
|  | Does not speak in sentences |  | Has difficulty naming common objects around the home (toys, foods, etc.) |
|  | Has difficulty answering questions |  | Has difficulty following directions |
|  | Is your child receiving services or ever received services from a speech/language pathologist? Name the agency or provider. | | |

Is there anything about your child that causes you concern?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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