

# CHILD FIND INTAKE PACKET



Dear Parent/Guardian, please complete the following information and return it to:

Liberty Elementary School District #25

Attention: Tara Cooke

E-mail: [tcooke@liberty25.org](mailto:tcooke@liberty25.org)



**Please make sure you include the following information with the packet:**

- Proof of residency (copy of deed to house, mortgage statement, lease or utility bill (SRP, water bill etc...))
- Copy of birth certificate
- Any evaluations/screenings, hearing and vision test results if available

**Please Note\*\*\*\* Your child will not be scheduled for a screening until all paperwork is received**



| <b>PRENATAL</b> <input type="checkbox"/> <b>Information Unknown</b>   |  |
|---|--|
| Regular prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| Medications taken by the mother during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, what? _____ |  |
| Any illnesses or complications while pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, what? _____    |  |
| <b>SUBSTANCE USE DURING PREGNANCY</b> <input type="checkbox"/> <b>Not Applicable</b>  |  |
| <b>Cigarettes:</b>  | How many? _____ per <input type="checkbox"/> day <input type="checkbox"/> week                             |
| <b>Drinks:</b>  | How many drinks? _____ per <input type="checkbox"/> day <input type="checkbox"/> week                      |
| <b>Drugs:</b>   | Please describe type(s) of drug, frequency of use, and month of pregnancy use was stopped (if applicable): |

| <b>BIRTH HISTORY</b> <input type="checkbox"/> <b>Information Unknown</b>   |
|--|
| 1. <input type="checkbox"/> Premature at _____ weeks   |
| 2. <input type="checkbox"/> Full term at _____ weeks   |
| 3. Birth weight _____ Length _____   |
| 4. Did the child have difficulty breathing? <input type="checkbox"/> Yes <input type="checkbox"/> No                           |
| 5. Was the child admitted to the NICU? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes how long? _____         |
| 6. Birth defects? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 7. Did the child have any feeding problems? <input type="checkbox"/> Yes <input type="checkbox"/> No                           |
| 8. Receive oxygen? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 9. Have jaundice? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10. Passed newborn hearing screening? <input type="checkbox"/> Yes <input type="checkbox"/> No                                 |
| 11. Other health concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what diagnosis or health concerns? |

| MEDICAL HISTORY (if Yes, please explain)  |   |
|---|---|
| <b>Recent Hearing Test:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date: _____   | <b>Recent Vision Exam:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date: _____  |
| <b>History of ear infections?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Tubes?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Date of surgery?</b> _____ | <b>Wear glasses?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, please tell us why: _____  |
| <b>Allergies?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Allergic to:</b> _____   | <b>Asthma?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Does your child have an inhaler?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Prior head injury?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes please describe: _____   | <b>Loss of consciousness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes please describe: _____   |
| <b>Major Illnesses?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes please describe: _____   | <b>High fevers?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes please describe: _____   |
| <b>Seizures?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes please describe: _____  | <b>Any other medical concerns not listed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes please describe: _____                                     |

|                        |   |
|------------------------|---|
| <b>Hospitalization</b> | Has your child ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes why? |
|------------------------|---|

| DEVELOPMENTAL MILESTONES (Please write the age your child met milestones on the line. Use N/A if milestone has not been met) |   |   |   |
|--|---|---|---|
| Gross Motor  | Fine Motor  | Communication   | Adaptive  |
| _____ sat alone<br>_____ crawled<br>_____ walked alone<br>_____ ran well<br>_____ tricycle/bike                              | _____ use index finger to point or poke<br>_____ fed self with spoon<br>_____ scribbled | _____ babbled<br>_____ said first word<br>_____ began using 2 word combinations | Toilet trained:<br>_____ day<br>_____ night<br>_____ unable due to physical/health concerns |

**SOCIAL AND SENSORY (Please circle all that apply to your child for each category)**

|  |  |
|--|--|
| <b>Physical activity level:</b>                          | <input type="checkbox"/> low activity level <input type="checkbox"/> in between <input type="checkbox"/> high activity level   |
| <b>How does your child sleep?</b>                        | <input type="checkbox"/> sleeps through the night <input type="checkbox"/> has difficulty falling asleep<br><input type="checkbox"/> wakes occasionally <input type="checkbox"/> has difficulty staying asleep   |
| <b>How does your child do with eating?</b>               | <input type="checkbox"/> eats a variety of food <input type="checkbox"/> is a little picky <input type="checkbox"/> is very picky<br><input type="checkbox"/> avoids certain textures <input type="checkbox"/> chokes or gags on foods<br>If a picky eater, what foods will they eat? _____<br>_____<br>Has your child ever needed feeding therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, when and why? _____<br>_____ |
| <b>How does your child do with drinking?</b>             | <input type="checkbox"/> drinks from an open cup <input type="checkbox"/> uses a straw<br><input type="checkbox"/> drinks from a bottle <input type="checkbox"/> drinks from a sippy cup   |
| <b>Can your child dress themselves?</b>                  | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please tell us what they can do (shoes, socks etc.)   |
| <b>How does your child handle new environments?</b>      | <input type="checkbox"/> no change in behavior <input type="checkbox"/> cautious <input type="checkbox"/> scared/unsure  |
| <b>How does your child react to new people?</b>          | <input type="checkbox"/> very shy <input type="checkbox"/> takes some time to warm up <input type="checkbox"/> outgoing and engages with new people  |
| <b>Persistence with challenging activities:</b>          | <input type="checkbox"/> persists with challenges <input type="checkbox"/> persists with support <input type="checkbox"/> gives up easily  |
| <b>Sensitivity to noise:</b>                             | <input type="checkbox"/> does not like loud noises <input type="checkbox"/> some loud noises are ok <input type="checkbox"/> noise does not affect child<br>Are there specific noises that affect the child? (horns, loud music etc.)<br>_____   |
| <b>How does your child adjust to change in routines?</b> | <input type="checkbox"/> flexible with change <input type="checkbox"/> in between <input type="checkbox"/> difficulty with change in routine   |

|  |  |                                       |  |
|--|--|---------------------------------------|--|
| <b>Expression of feelings:</b>   | <input type="checkbox"/> affectionate  | <input type="checkbox"/> in between   | <input type="checkbox"/> unaffectionate            |
| <b>Pain tolerance:</b>   | <input type="checkbox"/> low tolerance | <input type="checkbox"/> in between   | <input type="checkbox"/> high tolerance            |
| <b>Does your child make eye contact?</b>   | <input type="checkbox"/> always        | <input type="checkbox"/> in between   | <input type="checkbox"/> rarely                    |
| <b>Does your child respond to their name?</b>  | <input type="checkbox"/> always        | <input type="checkbox"/> occasionally | <input type="checkbox"/> rarely                    |
| <b>Does your child have any repetitive motor behaviors (hand flapping, clapping etc.)</b>            | <input type="checkbox"/> Yes           | <input type="checkbox"/> No           | If yes, please describe behaviors:                 |
| <b>Do you have any safety concerns for your child? (running off, not responding to name etc.)</b>    | <input type="checkbox"/> Yes           | <input type="checkbox"/> No           | If yes, please describe behaviors:                 |
| <b>Does your child have any sensory aversions? (touching sticky items, bright rooms etc)</b>         | <input type="checkbox"/> Yes           | <input type="checkbox"/> No           | If yes, please describe:                           |
| <b>What does your child like to play with at home or activities they enjoy?</b>                      |  |                                       |  |
| <b>Does your child have a comfort item they have difficulty separating with? (blanket, toy etc.)</b> | <input type="checkbox"/> Yes           | <input type="checkbox"/> No           | If yes, please tell us what their comfort item is: |

| OBSERVED BEHAVIORS: (Check all that apply) |                          |                          |                                  |                          |                          |                      |                          |                          |
|--|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|
|  | Now                      | Past                     |                                  | Now                      | Past                     |                      | Now                      | Past                     |
| Nail biting                                | <input type="checkbox"/> | <input type="checkbox"/> | Worries                          | <input type="checkbox"/> | <input type="checkbox"/> | Headaches            | <input type="checkbox"/> | <input type="checkbox"/> |
| Nightmares                                 | <input type="checkbox"/> | <input type="checkbox"/> | Sniffs/licks/eats non-food items | <input type="checkbox"/> | <input type="checkbox"/> | Clumsy               | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive crying                           | <input type="checkbox"/> | <input type="checkbox"/> | Poor self-esteem                 | <input type="checkbox"/> | <input type="checkbox"/> | Aggressive behaviors | <input type="checkbox"/> | <input type="checkbox"/> |
| Lying                                      | <input type="checkbox"/> | <input type="checkbox"/> | Speech                           | <input type="checkbox"/> | <input type="checkbox"/> | Staring episodes     | <input type="checkbox"/> | <input type="checkbox"/> |
| Destructive behaviors                      | <input type="checkbox"/> | <input type="checkbox"/> | Stealing                         | <input type="checkbox"/> | <input type="checkbox"/> | Self-injury behavior | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive fears                            | <input type="checkbox"/> | <input type="checkbox"/> | Temper tantrums                  | <input type="checkbox"/> | <input type="checkbox"/> | Cruelty to animals   | <input type="checkbox"/> | <input type="checkbox"/> |
| Feelings easily hurt                       | <input type="checkbox"/> | <input type="checkbox"/> | Excessive dependence             | <input type="checkbox"/> | <input type="checkbox"/> | Stomach aches        | <input type="checkbox"/> | <input type="checkbox"/> |

| EDUCATIONAL HISTORY                                |   |
|--|---|
| Has your child ever attended preschool or daycare? | <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, where? _____<br>_____ |

Is there anything else you would like us to know about your child? What developmental areas do you have concerns with? When did you first start noticing these concerns?

## PRESCHOOL FINE MOTOR

Do you have any concerns regarding your child's fine motor development? (This includes his/her ability to scribble, pick up small objects, hold a spoon, etc...)  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Has the child received or is receiving any outside occupational therapy?  Yes  No

If yes, dates you attended therapy: \_\_\_\_\_

**Instructions: Find the age range questions that match the child's age. Answer each question by checking yes or no. If the child has no experience with the skill, answer with the best prediction of how the child could perform.**

### **Age 1 to 2 years:**

1. Can the child hold a crayon?  Yes  No
2. Can the child isolate the index finger to poke/point?  Yes  No
3. Can the child pick up small items using a pincer grasp (thumb & index finger)?  Yes  No
4. Can the child stack a 3-4 block tower?  Yes  No

### **Age 2 to 3 years:**

1. Can the child imitate a straight up and down line with marker/crayon/paint?  Yes  No
2. Imitate a horizontal line with marker/crayon/paint?  Yes  No
3. Can the child turn pages in a book?  Yes  No
4. Can the child stack a 10 block tower?  Yes  No

### **Age 3 to 4 years:**

1. Can the child cut with scissors? If not, have they had exposure to scissors?  Yes  No
2. Can the child string beads?  Yes  No
3. Can the child copy a circle from a model?  Yes  No

### **Age 4 to 5 years:**

1. Can the child copy a triangle from a model with marker/crayon?  Yes  No
2. Can the child copy a square from a model with marker/crayon?  Yes  No

## **PRESCHOOL GROSS MOTOR**

Do you have any concerns regarding your child's gross motor development? (This includes his/her ability to walk, run, jump, crawl, climb, throw, etc...)  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Has the child received or is receiving any outside physical therapy?  Yes  No

If yes, dates you attended therapy: \_\_\_\_\_

**Instructions: Find the age range questions that match the child's age. Answer each question by checking yes or no. If the child has no experience with the skill, answer with the best prediction of how the child could perform.**

### **Age 2.9 to 3.4 years:**

1. Can the child move quickly or run without falling?  Yes  No
2. Can the child jump with both feet leaving the ground at least once?  Yes  No
3. Does the child use the steps with rails at the park, store, or home?  Yes  No
4. Does the child play ball by kicking, throwing, catching, or trying to bounce it?  Yes  No

### **Age 3.5 to 4 years:**

1. Can the child run across sand or uneven ground, and around obstacles?  Yes  No
2. Does the child use his arms and body to catch a large ball?  Yes  No
3. Does the child imitate standing on one foot, galloping, or touching toes?  Yes  No
4. Does the child alternate feet when going up stairs, at least sometimes?  Yes  No

### **Age 4.1 to 5 years:**

1. Does the child throw a ball overhand in the direction he/she wants it to go?  Yes  No
2. Can the child stand on one foot for several seconds?  Yes  No
3. Does the child pedal a tricycle or Big Wheel?  Yes  No  
If not, has he/she had an opportunity to ride this type of toy?  Yes  No
4. Does the child jump forward several times?  Yes  No

## **PRESCHOOL SOCIAL EMOTIONAL**

Do you have any concerns regarding your child's social/emotional development? (This includes his/her ability to play, take turns, interact with others, cooperate, attend to tasks for an appropriate length of time, etc...)

Yes    No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**Instructions: Find the age range questions that match the child's age. Answer each question by checking yes or no. If the child has no experience with the skill, answer with the best prediction of how the child could perform.**

### **Age 2.9 to 3.4 years:**

1. Does the child show affection toward others?    Yes    No
2. Does the child show interest in other children?    Yes    No
3. Can the child entertain himself/herself with toys for 10 minutes?    Yes    No
4. Does the child enjoy being a "helper"?    Yes    No
5. Does the child point to indicate needs or share excitement?    Yes    No

### **Age 3.5 to 4 years:**

1. Has the child begun to show an interest in pretend play?    Yes    No
2. Does the child play interactively with other children for at least short periods?    Yes    No
3. Can the child (sometimes) share toys or food?    Yes    No
4. Can the child regulate frustration without too many tantrums?    Yes    No
5. Can the child solve problems with peers without hitting/shoving/biting?    Yes    No

### **Age 4.1 to 5 years:**

1. Does the child separate from parents without excessive distress?    Yes    No
2. Does the child enjoy dramatic play (dress ups, house, superheroes, etc...)?    Yes    No
3. Can the child follow a group routine (sit in a circle, line up)?    Yes    No
4. Does the child show concern for siblings/playmates in distress?    Yes    No
5. Can the child stay with a single task of his/her choice (not TV) for 20 minutes?    Yes    No

## **PRESCHOOL SELF-HELP**

Do you have any concerns regarding your child's adaptive or self-help skills? (This includes skills in the area of dressing, feeding, toileting, washing hands, etc...)  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**Instructions: Find the age range questions that match the child's age. Answer each question by checking yes or no. If the child has no experience with the skill, answer with the best prediction of how the child could perform.**

### **Age 2.9 to 4.0 years:**

1. Can the child care for his/her own toileting needs with minimal help?  Yes  No
2. Can the child put on shorts or pants with elastic waistbands?  Yes  No
3. Can the child understand and play away from common dangers?  Yes  No
4. Can the child help put toys away or help with other household tasks?  Yes  No
5. Can the child wash and dry his/her own hands?  Yes  No

### **Age 4.1 to 5 years:**

1. Does the child dress himself/herself, except for fasteners?  Yes  No
2. Is the child independent with toileting?  Yes  No
3. Does the child blow or wipe his/her own nose?  Yes  No
4. Does the child get a drink of water from a fountain or water dispenser?  Yes  No
5. Does the child spread butter or jelly on bread or crackers?  Yes  No

## PRESCHOOL COMMUNICATION

Do you have any concerns regarding your child's communication skills? This can include what they are understanding and what they are expressing.  Yes  No

If yes, please explain: \_\_\_\_\_

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**Instructions: Answer each question by checking yes or no.**

1. Has the child received or is receiving any outside speech therapy?  Yes  No

If yes, dates you attended therapy: \_\_\_\_\_

2. Does the child follow one-step related directions?  Yes  No

3. Does the child follow two-step related directions?  Yes  No

4. Does the child use more words than gestures to communicate (pointing, or pulling etc...)?  Yes  No

5. Does the child combine two to three word sentences (I want apple etc...)?  Yes  No

6. Does the child identify pictures in a story when being read to?  Yes  No

7. Does the child answer yes/no questions?  Yes  No

8. Does the child answer basic "what" questions (what are you doing etc...)?  Yes  No

9. Does the child know some shapes?  Yes  No

10. Does the child count to 5?  Yes  No

11. Does the child point to some colors?  Yes  No

12. Approximately how many words can your child say?

0-5     6-10     11-20     20-50     50-100     100-200     200+

13. If your child is producing 10 words or less please list words your child consistently uses: \_\_\_\_\_

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14. Does your child use sign language?  Yes  No If yes, what signs does your child know?

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**Articulation:**

1. Is the child easily understood by others?  Yes  No

2. Does your child get frustrated when not understood?  Yes  No



**Arizona Department of Education**  
Office of English Language Acquisition Services

**Home Language Survey**

The responses to this Home Language Survey (HLS) are used by the school to provide the most appropriate instructional programs and services for the student. **The answers below will determine if a student will take the Arizona English Language Learner Assessment (AZELLA).** Please respond to each of the three questions as accurately as possible. If you need to correct any of your responses, this must be done **before** the student takes the AZELLA Placement Test.

**1. What language do people speak in the home *most* of the time?**

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**2. What language does the student speak *most* of the time?**

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**3. What language did the student *first* speak or understand?**

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|                                |                          |
|--------------------------------|--------------------------|
| Student Name_____              | District Student ID_____ |
| Date of Birth_____             | SSID_____                |
| Parent/Guardian Signature_____ | Date_____                |
| District or Charter_____       |                          |
| School_____                    |                          |

Please provide a copy of the Home Language Survey to the EL Coordinator/Main Contact on site.

In AzEDS, please enter all three HLS responses.

These HLS questions are in compliance with Arizona Administrative Code (R7-2-306(B)(1),(2)(a-c)). (Revised 05-2023)

Parent/Guardian Signature: \_\_\_\_\_

Date \_\_\_\_\_

For official use only:

Date received: \_\_\_\_\_ Name: \_\_\_\_\_