Elmsford Union Free School District
22 South Hillside Avenue
Elmsford, New York 10523
(Phone) 914-592-2092 ext 3001 (Fax) 914-592-2163

Deborah Earle
Carl L. Dixson Primary School Principal
Dearle@eufsd.org

Dear Parents/Guardians,

To better ensure the safety of your child, we are asking that all parents/guardians fill out the attached Pick-up Release Form. We realize that there may be times when someone other than you may have to pick up your child at school.

Only people listed on your Pick-up Release Form will be allowed to pick up your child. You still need to send a note authorizing the pick-up.

Please notify the people on your list that **they must bring photo ID** when picking up your child.

If there is a time when you need to have someone who is not on your pick-up list pick up your child at school you must send a note to your child's teacher (we cannot accept phone calls for this change.) The note should include the date of the pick-up, name and telephone number of the person you are authorizing and your signature and a phone number where we can reach you.

If the Pick-up Form is not completed and returned to your child's teacher, we will not be able to release your child to anyone other than the parents/guardian.

Lastly, **after 3:00 PM children will not be dismissed through the office**. If you arrive to pick up your child after 3:00 PM, please go to the designated area to pick up your child at the 3:20 (2:55 on early release days, and 11:35 AM on half a day) dismissal time.

We thank you for your cooperation in maintaining a safe environment for all our students.

Sincerely,

Ms. Deborah Earle
Carl L. Dixson Primary School Principal

Elmsford Union Free School District
22 South Hillside Avenue
Elmsford, New York 10523
(Phone) 914-592-2092 ext 3001

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Carl L. Dixson Primary School Principal
Dearle@eufsd.org

FIELD TRIP RELEASE

Dear Parents or Guardians:

From time to time during the school year, it is advantageous or necessary to send children during school hours to some point in Elmsford or points beyond. If you wish your child to have the advantage of these trips, please give consent and release of any responsibility in case of an accident, not due to our negligence, by signing below.

Estimados Padres o Tutores:

De vez en cuando durante el año escolar, los niños toman una excursión durante el horario escolar dentro o fuera de Elmsford. Si desea que su hijo tenga la ventaja de estos viajes, por favor dé su consentimiento y liberación de cualquier responsabilidad en caso de accidente, que no se deba a nuestra negligencia, firmando a continuación.

Sincerely,
Atentamente,

Deborah Earle
Principal/Directora

_____
Student's Name
Nombre del Estudiante

_____
Parent's Signature
Firma del Padre/Tutor

_____
Date/Fecha

UFSD

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Carl L. Dixson Primary School Principal
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Parent Pick-up Release Form

By signing below, I verify that I have read and agree to the Student Pick-up policies described on the attached sheet and authorize Carl L. Dixson School.

Student Name: _____ Teacher Name: _____

Parent Name: _____ Address: _____

Phone Number: _____

****ONLY THE FOLLOWING PEOPLE WILL BE ALLOWED TO PICK UP THE CHILD(REN):**

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I authorize the persons listed above to pick up my child from Carl. L.Dixson Primary School.

Parent Signature: _____ Date: _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name: Sex: ☐ M ☐ F DOB:

School: Grade: Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached

☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached

☐ Yes, indicate type ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached

☐ Yes, indicate type ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

☐ Yes, indicate type ☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:

Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) ICD-10 Code

_____ _____

_____ _____

_____ _____

_____ _____

☐ Additional Information Attached

Name:	DOB:

SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	

Deviation Degree: Trunk Rotation Angle:

Recommendations:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature: **Date:**

Provider Name: *(please print)* Stamp:

Provider Address:

Phone:

Fax:

Please Return This Form To Your Child's School When Entirely Completed.

Dental Health Certificate

Elmsford Public Schools

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ❑ Male ❑ Female

Will this be your child's first visit to a dentist? ❑ Yes ❑ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities?
❑ Yes ❑ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

❑ Yes, The student listed above is in fit condition of dental health to permit him/her attendance at the public schools.

❑ No, The student listed above is not in fit condition of dental health to permit him/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp)

Dentist's Signature

Optional Sections - If you agree to release this information to school, parent please initial here.

II. Oral Health Status (check all that apply).

❑ Yes ❑ No

Caries Experience/Restoration History – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

❑Yes ❑ No

Untreated Caries – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

❑ Yes ❑ No

Dental Sealants Present

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

❑ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

❑ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

❑ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

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Deborah Earle
Principal of Primary School Carl L. Dixson
Dearle@eufsd.org

Dear Parents and Guardians,

As you know, there are many exciting activities constantly taking place in our schools as well as celebrations of our students' accomplishments. We are often approached by the media (newspapers, radio, television and our own webmaster) for permission to photograph and publish our students' work.

Our productions are regularly transmitted on local cable stations.

Although the district will carefully monitor what information is disseminated to the media, we do not want any child's name, photograph or likeness, voice or creative work(s) on television, radio, motion pictures or any other electronic/digital or print media without parental consent.

If you do not want your child's name, photograph or likeness, voice or creative work(s) on television, radio, motion pictures or any other electronic/digital or print media, please send a letter to your child's principal indicating your request.

Thank you for your continued support.

PLEASE RETURN WITH YOUR CHILD'S FOLDER

I give permission for my child to be photograph, voice or creative work(s) on television, radio, motion pictures or any other electronic/digital or print media be used.

YES _____

I DO NOT give permission for my child to be photograph, voice or creative work(s) on television, radio, motion pictures or any other electronic/digital or print media

NO _____

Students name: _____ Parent signature _____

Date: _____

ELMSFORD PUBLIC SCHOOLS
HEALTH HISTORY REGISTRATION FORM

KINDLY COMPLETE THIS FORM AND RETURN TO SCHOOL WITH REGISTRATION PACKET

Child's name _____ Sex M ____ F ____
Last Name First Name

Date of Birth _____ Place of Birth _____
City, State, Country

Mother's Name _____ Father's Name _____

BIRTH HISTORY

Was mother ill during pregnancy?	YES ____	NO ____
Was birth normal?	YES ____	NO ____
Was child premature?	YES ____	NO ____
Child's weight at birth?	____ Lbs.	____ Oz.

HEALTH HISTORY AND DEVELOPMENT

Does your child have any speech difficulty? YES ____ NO ____

If YES please specify difficulty

_____

Are there any special habits your child has such as:

Thumb sucking	YES ____	NO ____	Head banging	YES ____	NO ____
Fears	YES ____	NO ____	Rocking	YES ____	NO ____
Nail biting	YES ____	NO ____	Emotional problems	YES ____	NO ____

If YES explain _____

Does your child have frequent ear infections? YES ____ NO ____
If YES which ear _____
Does your child have hearing loss? YES ____ NO ____
If YES which ear _____
Is he/she presently under care for this? YES ____ NO ____

Does your child have a vision problem?
If YES, explain _____

When were eyes last examined professionally? Date _____

Does your child wear glasses? YES ____ NO ____

Has your child ever been to a dentist? YES ____ NO ____

If YES, has dental care been completed? YES ____ NO ____

Does your child have asthma? YES ____ NO ____

Does your child have allergies? YES ____ NO ____
Including medications, bee and insect bites

If YES, what are they? _____

Is your child allergic to peanuts, peanut products, nuts of any kind? YES ____ NO ____

Does your child take medication treatments, either on a part-time or regular basis? YES ____ NO ____
If YES, what are they?_____

Has your child had the following:

Operations	YES ____	NO ____	Serious Accident	YES ____	NO ____
Fractures	YES ____	NO ____	Head Injuries	YES ____	NO ____

If YES, give details: _____

Has your child been hospitalized for any condition? YES ____ NO ____
Name of condition or disease _____
Hospital _____ Date_____

Please check any ofthe following conditions that your child might have or have had:

seizures	____	diabetes	____	chicken pox	____
chronic rashes	____	headache	____	cerebral palsy	____
rheumatic fever	____	frequent nosebleeds	____	frequent sore throats	____
scarlet fever	____	tuberculosis	____	pneumonia	____

Other illness (specify) _____

Please check any conditions that immediate family have had:

asthma	____	anemia	____	diabetis	____
hypertension	____	tuberculosis	____	nervous problem	____
convulsion	____	heart attack under the age of 45			____

Are there any health conditions in your family that are a problem to you and your child? YES ____ NO ____

Are there any health problem NOT already mentioned? YES ____ NO ____

If YES, explain_____

Parent's Signature _____ Date _____

Family Physician _____
Phone Number _____

ELMSFORD PUBLIC SCHOOLS
HEALTH SERVICES

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Student name_____ Birthdate_____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

I hereby authorize my child's physician(s) listed above to exchange the following information with

☐ **School Nurse**	☐ **Immunizations/physical exams to comply with NYS regulations**
☐ **Physical Therapist**	☐ **Social History**
☐ **Occupational Therapist**	☐ **Psychological evaluations/report**
☐ **Speech Therapist**	☐ **Medical clearances as needed following an injury or change in condition**
☐ **Audiologist**	☐ **Medical orders required for therapy needs;evaluations**
☐ **Vision Department**	☐ **Authorization for medications during the school day or on school trips**
☐ **Admissions Officer**	☐ **Medical condition/treatment plans that may have an impact in the school environment**
☐ **School Social Worker**	☐ **Physician referral for services (OT,PT)**
☐	☐ **Other**

This information will be used to provide a safe and healthful environment and develop appropriate program for this student at school. Enrollment is not contingent up on obtaining this release, however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. This release expires on the last day of enrollment of the above student in school and may be revoked at any time by sending a request to cancel this permission in writing to the address above. Such revocation will not affect made prior to this receipt. Protected health information will not be disclosed without consent per FERPA regulations. A copy of this release has been provided to me and will be sent to the appropriate provider when requests are made.

☐ I wave my right to receive a copy of this notice.

_____ _____

Signature of student over 18 or Parent/Guardian Date

If a student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is a signing authority to act on student's behalf sign here _____.

This form complies with all HIPPA regulations.

MEDICATION POLICY

ELMSFORD PUBLIC SCHOOLS
HEALTH SERVICE

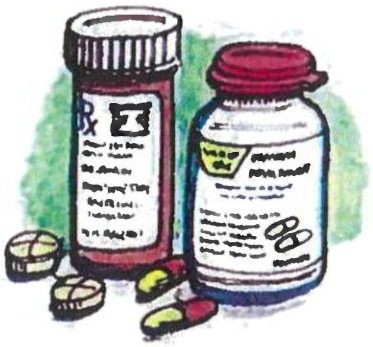
The New York State Education Department requires that all students who must take medication during school hours have the following:

A. A written request to school authorities signed by the parent or legal guardian.
B. A written request from the physician on his prescription form or letterhead stating:
    a. Child's Name
    b. Diagnosis
    c. Name of Medication
    d. Dosage
    e. Mode of Administration
    f. Frequency
    g. Dates of duration.

The medication must be brought to school in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law.

This procedure must be followed for administering non-prescription drugs also.

Upon receiving the request to give medication, a form will be sent home for the parent or legal guardian to sign and return to school as soon as possible.



THIS POLICY WILL BE STRICTLY ENFORCED!

ELMSFORD UNION FREE SCHOOL DISTRICT ILLNESS GUIDELINES

Dear Parents,

It is our priority to keep all of our students healthy and in school. One way that we can all work together to do this is to prevent the spread of illness. If your child is not feeling his/her best, please use the following guidelines to determine whether or not he/she should be in school.

	Child should not be at school or in contact with other children:	**If child feels well enough, he/she may attend school:**
Runny nose	Cloudy or yellow/green discharge with congestion, fever	Clear drainage as with allergies
Cough	Frequent or uncontrollable, producing mucous or accompanied by fever	Infrequent, no mucous is being coughed up and/or child has been on antibiotics for at least 24 hours before returning to school, no fever
Fever	If temperature is above 100°F or if symptoms of headache or cough accompany any elevated temperature.	If temperature is below 100° for 24 hrs. without taking a fever-reducing medication and there are no other symptoms
Diarrhea or vomiting	One episode of vomiting/more than one occurrence of diarrhea	Single incident of diarrhea and no other symptoms (i.e., fever, vomiting); must be 24 hours after the last episode of vomiting
Strep throat	Sore throat, headache, nausea, fever (children do not always have fever or complain of a sore throat.) The only way to rule out Strep is with a throat culture.	After 24 hours on antibiotics and fever free for 24 hours
"Pink eye" Conjunctivitis	Eye is red with complaint of burning or itching; crusty, white or yellow drainage is occurring	With a note from the doctor
Rash/Skin infection	Any child with rash or signs of skin infection not having been evaluated by doctor	Rash free/written release from doctor/after 24 hours on antibiotic for skin infection
Flu	Fever/temp above 100°F with accompanying sore throat, cough, runny nose, congestion, body aches, extreme tiredness, vomiting, or diarrhea	After fever free (less than 100°F oral temp) for 24 hours without having been given fever reducing medication or release from physician if diagnosed with any type of flu

If you think that your child might have a fever, please check his/her temperature before sending him/her to school. Your child should not be sent to school until he/she has been fever free for at least 24 hours without taking a fever reducing medication.

ELMSFORD UNION FREE SCHOOL DISTRICT
Carl L. Dixson Primary School

Parent questionnaire for students entering Pre-K and Kindergarten

CHILD NAME_____ DOB_____ AGE: Yrs____ Mos_____

PARENTS NAME(S) _____Date form completed_____

Read each Question carefully. Mark with an X the statement which best describes your child. Remember that there are no right or wrong answers. These statements are merely descriptions of behavior exhibited by your child.

1. In general, how does your child move around the house or yard?
   ___Very hesitant in movement
   ___sometimes bumps into objects or falls
   ___sure of body

Additional comments: _____
_____

2. How well can your child dress himself/herself?
   ___ cannot dress himself/herself
   ___fair, but with a great deal of assistance
   ___can put on all clothes, but needs help with buttoning, tying, zipping
   ___can dress himself/herself independently

Additional comments: _____
_____

3. Which hand does your child use most of the time for eating, drawing or picking up toys?
   ___ right ___left ___uses both equally

Additional comments: _____
_____

4. How does your child take care of his/her toys?
   ___carelessly; destroys toys
   ___takes toys apart; unable to put back together
   ___very careful

Additional comments: _____
_____

5. How does your child respond to strangers?
   ___very fearful ___timid or shy at first ___usually friendly ___ very outgoing

Additional comments: _____
_____

PARENT QUESTIONNAIRE FOR PRE-K & KDGN

6. How well does your child adjust to new activities and situations?
___very cautious ___shy at first takes a little time to get involved
___seems eager to get involved right away
Additional comments: _____

_____

7. Have there been any separations from parent?
___ hospitalization of parent or child?
Age of child___ length of separation period___
Additional comments: _____

_____

8. What form of punishment does your child respond to:
___spankings ___denial of favorite things ___scolding or raised voice
___isolation-sitting in chair or going to bed ___talking things over
Additional comments:

_____

_____

9. How does your child act when you have to leave him/her?
___reluctant cries most of the time ___adjusts well
___fine, except for occasional circumstances
Additional comments: _____

_____

10. When does your child look for your affection?
Additional comments: _____

_____

11. What things upset your child?
Please comment: _____

_____

12. How does your child get along with other children?
___fights cries, is self-centered ___shy at first, then plays well
___boss, leader, wants things his/her own way
___communicates and plays very well with others
Are other children at home or in the neighborhood available for play? ___
Please comment: _____

_____

_____

PARENT QUESTIONNAIRE FOR PRE-K & KDGN.

13. Does your child have any fears? ___
Please comment:

_____

_____

14. What kind of things does your child generally play with?
Please comment:

_____

_____

15. How long will your child stay with an activity such as puzzles, blocks, picture books?

___Less than 5 minutes ___at least 15 minutes ___for 1/2 hour
___as long as 1 hour

Additional comments: _____

_____

16. What kind of things does your child draw?
___not interested in drawing yet ___scribbling ___detailed drawings
___definite shapes or objects ___drawings that depict a story

17. What colors can your child name?
___none
___a few of the basic colors: e.g.; red, yellow, blue, green, purple, orange, brown, black
___all of the basic colors plus a few others: e.g.; pink, white, etc.

18. How does your child count?
___names only a few numbers in random order ___ counts beyond 10
___counts to 10 but misses or skips some numbers
___counts to 10, always in correct order

19. How well does your child pronounce his/her words?
___I hardly understand him/her at all
___I understand; but he/she has trouble with some sounds
___pronunciation is good
Additional comments: _____

_____

20. How well does your child verbally express his/her thoughts?
___very clear ___usually clear ___sometimes clear ___poorly
Additional comments: _____

_____

PARENT QUESTIONNAIRE FOR P-K & KDGN.

21. How well can your child find things that you name?
___rarely understands what I mean ___will ask when words are unfamiliar
___can point to a few objects when I name them
___seems to understand all the words I use
Additional comments: _____

_____

22. Does your child follow directions?
___rarely; only if interested ___follows 2 or 3 directions in a row
___will follow one simple command
___remembers long sets of instructions and will carry them out
Additional comments: _____

_____

23. Does your child like to be read to?
___likes this a lot ___just started to like this
___doesn't like being read to
Additional comments: _____

_____

24. What does your child remember about a story?
___remembers the story, anticipates what's coming and often fills in words
___asks for favorite story by telling general idea of it
___doesn't seems to remember the story from one time to the next
Additional comments: _____

_____

25. Describe your child's ability to remember past events in his/her life.
___Seems to forget things very quickly ___remembers only recent events
___recalls some things at least in part for a long time
___remembers many events in careful detail

26. How does your child tell you about things he/she has done?
___ will try to explain only when asked
___will explain occasionally well enough that I can understand
___tells about everything that he/she does, describes events in detail

27. Use the remainder of this page to provide us with any other information you feel would assist us in planning for your child's education in the fall.

_____

_____

_____

_____