



Child's Name: _____

Date of Birth: _____

District 47 Pre-K Referral Form

Please check all areas of concern

*Please see other side for contact information

Learning/Self-help/Health/Other

- Difficulty with early school concepts (colors, shapes, etc)
- Difficulty with self-help tasks (arrival/departure routines, hand washing, etc)
- Concerns for Hearing/Vision/other Health concerns. Explain _____
- Other _____

Speech-Language

- Gestures instead of speaking
- Speech is difficult to understand
- Difficulty following verbal directions
- Difficulty answering questions
- Dysfluencies (stuttering) present in speech
- Sentences less mature than peers

Fine & Visual Motor

- Difficulty with manipulating small items
- Immature grasp patterns
- Difficulty using 2 hands to string, lace, use scissors
- Difficulty with coloring, pre-writing, drawing
- Difficulty with puzzles, imitating, or completing projects
- Difficulty with self-care tasks

Gross Motor

- Frequently falls
- Unusual gait when running or walking
- Tends to lay/lean on objects for physical support
- Difficulty maintaining one position for long periods
- Frequently falls out of chair

Social-Emotional/Play

- Prefers to play alone
- Does not initiate contact with peers
- "Gets stuck" on certain toys or activities
- Aggressive with peers
- Difficulty with separation
- Does not give eye contact when speaking to someone
- Extremely quiet-allows others to speak for them

Self-Regulation

- Difficulty with transitions or coping with changes in routines
- Difficulty with controlling emotions
- Difficulty with controlling behaviors
- Difficulty following adult direction
- Easily frustrated

Sensory Processing

- Over responding to sights, sounds, touch, movement (*please circle all that apply*)
- Under responding to sights, sounds, touch, movement (*please circle all that apply*)
- Easily over-stimulated, over-active, rough with objects or peers
- Takes a lot of input to get & maintain attention

Rate this child's overall development as compared to other children

Above 5 4 3 2 1 Below

REFERRAL

Teacher:

I would like to recommend this child for a preschool screening

Preschool Teacher signature

Preschool Teacher's Name(s) _____

Name of Preschool _____

Preschool telephone # _____

Days/Hours child attends _____

Parent concerns:

My child's teacher has reviewed these concerns with me

I give permission for my child's teacher to contact the school district with this referral.

Parent's signature

date

Parent Name(s) _____

Address _____

Phone Number(s) _____

***For questions regarding referral process please contact:**

**Principal, Dr. Anastasia Gruper
at 815-788-3100
Fax: 815-477-5547
at the District 47 Glacier Ridge Pre-K Program***

For District 47 Office Use Only

Date received _____

Follow-up:

Screening date _____ *Parent contact* _____ *Other* _____