



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. Dixon 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. Dixon Primary School Principal



Elmsford Union Free School District

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

Deborah Earle

Carl L. Dixon 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



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. Dixon Primary School Principal
Dearle@eufsd.org

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. Dixon 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.Dixon 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: <input type="checkbox"/> M <input type="checkbox"/> 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	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> 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/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis	Negative	Positive	Referral	
Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> 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
- | | | |
|---|---|---|
| <input type="checkbox"/> Brace*/Orthotic | <input type="checkbox"/> Colostomy Appliance* | <input type="checkbox"/> Hearing Aids |
| <input type="checkbox"/> Insulin Pump/Insulin Sensor* | <input type="checkbox"/> Medical/Prosthetic Device* | <input type="checkbox"/> Pacemaker/Defibrillator* |
| <input type="checkbox"/> Protective Equipment | <input type="checkbox"/> Sport Safety Goggles | <input type="checkbox"/> 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 NYSISReceived 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: / / Sex: Male Female Will this be your child's first visit to a dentist? Yes No
Month Day Year

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 1/2 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.



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
Principal of Primary School Carl L. Dixon
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: _____

Carl L. Dixson Primary School

ARRIVAL AND DISMISSAL FORM

It is important to have this information for the safety of the children

Student's Name: _____

Address: _____

Phone Number: _____ Teacher's Name: _____

Please indicate how your child will be traveling to and from school:

TO SCHOOL

_____ Dropped off at school

_____ By bus from home address: Bus # & Stop _____
(Please circle) EVERYDAY MON TUE WED THU FRI

_____ By bus from other location: Bus # & Stop: _____
(Please circle) EVERYDAY MON TUE WED THU FRI

Include Daycare/Sitter Name: _____

Address: _____

Contact Number: _____

HOME FROM SCHOOL

_____ By bus to home address Bus # & Stop: _____
(Please circle) EVERYDAY MON TUE WED THU FRI

Will be met by _____ Phone #: _____

_____ By bus to another location: Bus # & stop: _____
(Please circle) EVERYDAY MON TUE WED THU FRI

Include Daycare/Sitter Name: _____

Address: _____

Contact Number: _____

PICKED UP AT SCHOOL **(Please circle)** EVERYDAY MON TUE WED THU FRI

Adults allowed to pick up your child, name, relationship, and phone number.

1. _____

2. _____

3. _____

Parent's signature _____ Date: _____

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 of the 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	___	diabetes	___
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

<input type="checkbox"/> School Nurse	<input type="checkbox"/> Immunizations/physical exams to comply with NYS regulations
<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Social History
<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Psychological evaluations/report
<input type="checkbox"/> Speech Therapist	<input type="checkbox"/> Medical clearances as needed following an injury or change in condition
<input type="checkbox"/> Audiologist	<input type="checkbox"/> Medical orders required for therapy needs;evaluations
<input type="checkbox"/> Vision Department	<input type="checkbox"/> Authorization for medications during the school day or on school trips
<input type="checkbox"/> Admissions Officer	<input type="checkbox"/> Medical condition/treatment plans that may have an impact in the school environment
<input type="checkbox"/> School Social Worker	<input type="checkbox"/> Physician referral for services (OT,PT)
<input type="checkbox"/>	<input type="checkbox"/> 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 <u>not</u> 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. Dixon 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 & K DGN

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 & K DGN.

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 & K DGN.

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 seem 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.

