Mercer Island School District
Early Childhood
Child Find Intake Form

For best results when filling out this form on your computer, download it first and open it in Adobe Acrobat Reader or the equivalent.

Date:_____

Child's name:_____Child's birth date:_____
(mm/day/year)

Parent 1 name:_____Parent 2 name:_____
(Last name) (First name) (Last name) (First name)

Address:_____
Parent 1 email:_____Parent 2 email:_____
Parent 1 phone numbers: (H):_____(W):_____(C):_____
Parent 2 phone numbers: (H):_____(W):_____(C):_____

Student"s primary language:_____Other, please specify:_____
Race/Ethnicity(choose one or more that apply): White ☐ Asian ☐ Black ☐ Hispanic ☐
Languages spoken at home:_____
Current Preschool:_____At what age did child enter preschool_____

Did the student ever receive B-3 services: Yes ☐ No ☐ Kindering ☐ Boyer ☐ Other, please explain:

If so please attach paper work (IFSP, Evaluation, etc.)

Please describe current concerns: (academic, social/emotional, behavioral, medical, etc.)

Problems or difficulty sleeping, frequent nightmares, sleepwalking, nail biting, stuttering, teeth grinding, oral fixations etc?
Yes ☐ No ☐ If yes, please explain:_____
Check any characteristics or behaviors that may apply to your child:

Shy ☐ Withdrawn ☐ Low energy ☐ Aggressive (ie. hits, bites, kicks) ☐ High energy ☐ Impulsive

Happy ☐ Friendly ☐ Affectionate ☐ Sad ☐ Difficult to console ☐ Curious ☐ Prefers to play alone

Easily frustrated ☐ Frequent temper tantrums ☐ Picky eater ☐ Sensitive to loud noise

Other concerns:

Medical/Developmental HIstory:

Child's condition at birth: ☐ Full term ☐ Premature
Child's birth weight:_____

Complication during pregnancy or delivery: ☐ Yes ☐ No If yes, please explain:

Drugs/Alcohol/Smoking during pregnancy: ☐ Yes ☐ No If yes, please explain:

Significant hospitalization or medical history (for child) ☐ Yes ☐ No If yes, please explain:

Approximate age when child: Please note that not all preschool aged children may have met these milestones write N/A indicate "not at this time."

Sat independently:_____Used words:_____Crawled:_____Walked:_____
Used Sentences:_____Dry at night:_____Toilet trained:_____
Ate independently:_____Drank from a cup:_____Use utensils:_____

Do you feel that your child's development has been equal to their peers?
Yes ☐ No ☐ If yes, please describe:

Medical/psychological evaluations or diagnoses:

Current private therapies:(eg. Speech, OT, PT, counseling, ABA, play therapy?)
Yes ☐ No ☐ If yes, please describe

Referral Source: ☐ Parent ☐ Preschool
Other, please explain:_____