



Student Support Services
Educational Screening Record

Student Name: _____ Date: _____
Student #: _____ School: _____ Grade: _____
Date of Birth: _____ Gender: _____ Ethnicity: _____ Primary Language at Home: _____
Parent/Guardian Name: _____
Parent/Guardian Address: _____
Parent/Guardian Home Phone: _____ Other Phone Number: _____

Review of Educational Records:

Enrollment History: Number of Schools Attended: _____ (Please attach enrollment history from Skyward)
Number of Retentions: _____ At What Grade Level(s): _____
Attendance History: (Please attach attendance history from IC)
Previous Year: ___ Excused Absences ___ Unexcused Absences ___ Total Absences ___ Total Tardies
Current Year: ___ Excused Absences ___ Unexcused Absences ___ Total Absences ___ Total Tardies
Action Taken: _____

- Currently enrolled in ESE (program names): _____
- Previously enrolled in ESE (program names): _____ Date of Dismissal: _____
- Currently enrolled in ESOL (date): _____ Previously enrolled in ESOL (date of dismissal): _____
- 504 Plan (date): _____ PMPlan Previous Psychoeducational evaluation (date): _____
- Prior EPT Reading Writing Math Science
 Attendance Other: _____

Dates Parents Attended EPT/IEP meetings: Meeting #1: _____ Meeting #2: _____

Standardized Test Results: (Please attach test scores from Skyward)

Stanford Achievement Test 10:(date) _____ Comprehension:(date) _____ Problem Solving:(date) _____
FSA Reading:(year) _____ SS: _____ Level: _____
FSA Math:(year) _____ SS: _____ Level: _____
FSA Science:(year) _____ SS: _____ Level: _____
FSA Writing:(year) _____ Level: _____
Other Reading:(name/date) _____ SS: _____ Percentile: _____
Other Math:(name/date) _____ SS: _____ Percentile: _____

School Counselor's Signature: _____ Date: _____

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Review of Health Records: *(Please check all that apply)*

- Allergies Asthma/Respiratory ADHD Heart/Blood Disorder
- Muscular Skeletal Neurological Impairment Seizures Head Injury
- Premature Birth Developmental Delay
- Wears glasses/corrective lenses
- P.E. tubes placed (please specify age): _____
- Other:*(please specify)* _____
- Operations/Accidents/Serious illness:*(dates & description)*

- No concerns indicated in the records

Sensory Screening:

Vision: Right: _____/_____ Left: _____/_____ Date: _____ Follow-Up: _____

Hearing: Right: _____ Left: _____ Date: _____ Follow-Up: _____

Nurse/Trained PreK Designee Signature: _____ Date: _____

Speech/Language Screening Records:

Language: Normal Limits Follow-Up Needed Enrolled Date: _____

Speech: Normal Limits Follow-Up Needed Enrolled Date: _____

Fluency: Normal Limits Follow-Up Needed Enrolled Date: _____

Voice: Normal Limits Follow-Up Needed Enrolled Date: _____

Clinician's Signature: _____ Date: _____