Alachua County Public Schools

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:_____