POUDRE SCHOOL DISTRICT
Early Childhood
EDUCATION PROGRAM

3-5 Enrollment Packet

220 North Grant Avenue, Fort Collins, CO 80521
Phone: (970) 490-3204 Fax: (970) 490-3134 Email: psdece@psdschools.org bit.ly/PSDpreschool

Emergency Contact Information

Child's first name: ______________ **Last name:** ______________ **Child's date of birth:** __________

Emergency contact name (other than parent): ______________________
Relationship to child: ______________________ Phone: ______________
☐ Able to sign out child ☐ Permission to pick up child ☐ This person is 16 years or older with a valid ID?

Emergency contact name (other than parent): ______________________
Relationship to child: ______________________ Phone: ______________
☐ Able to sign out child ☐ Permission to pick up child ☐ This person is 16 years or older with a valid ID?

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Home Language Form

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Student's first name: _____ **Middle name:** _____ **Last name:** _____

Date of birth: _____ **Place of birth:** _____

Date student entered Colorado: _____ **Date student entered US (if applicable):** _____

Home Language Survey

What language did your child first learn? _____

What language do **you** most frequently speak with your child? _____

What language does **your child** most frequently speak with you? _____

What is the language most often spoken in your child's home, regardless of what the child speaks? _____

What language(s) other than English does your child understand? _____

List any other languages spoken in the home that are not mentioned above:

_____

Educational History

Please complete the following educational history as accurately as possible.

Grade and Date(s)	School Name	School Location	Language of Instruction

Health Conditions

Student Name:_____ Date of Birth:_____/_____/_____

Health Care Provider/Medical Clinic:_____ Last exam date: _____

Dentist/Dental Clinic:_____ Last exam date: _____

Is your family currently on WIC ☐Yes ☐No

Medical Insurance:

☐ Medicaid/Health First ☐Colorado Health Plan Plus (CHP+) ☐None/Uninsured ☐ Other _____

Hospital Preference:

☐ Poudre Valley Hospital ☐McKee Medical Center ☐Medical Center of the Rockies ☐Banner Health

Health Conditions:

Response		Health Condition	Response		Health Condition
YES	NO	Allergy- Environmental / Animal	YES	NO	Hearing Impairment- Devices worn? YES NO
YES	NO	Allergy – Food	YES	NO	Heart Condition
YES	NO	Allergy – Insect	YES	NO	Kidney /Urinary
YES	NO	Allergy - Medication	YES	NO	Mental Health
YES	NO	Asthma	YES	NO	Neurological
YES	NO	Autism Spectrum Disorder	YES	NO	Orthopedic
YES	NO	Brain / Head Injury	YES	NO	Physical limitation/restrictions
YES	NO	Cancer	YES	NO	Premature or significant birth history
YES	NO	Chewing or swallowing troubles	YES	NO	Seizures/ Epilepsy
YES	NO	Diabetes	YES	NO	Special Diet
YES	NO	G-Tube	Yes	NO	Vision Problem – Glasses worn? YES NO
YES	NO	Genetic Disorder	OTHER:		

Explain any health condition(s)above:_____

_____

_____

Does your child need medication at school? YES☐ NO☐

Name of Medication(s):_____

**Print or request an *Authorization to Administer Medication* form from your school or from the PSD health services website:

Please list any other daily medication(s) that your child is taking at home: _____

I voluntarily provide this information and understand I must provide the following health documents for my child's health file: Complete immunizations, current physical exam, dental exam, and lead blood test results

_____

Parent/Guardian Signature **Date**

If you have developmental concerns, please complete these 3 pages.

Child's Name:_____Child's Date of Birth: _____

Pregnancy & Birth		
Birth weight: _____lbs._____oz.	Child Born at:	☐ 40+ weeks ☐ Preterm at_____weeks due to _____
Please share any difficulties during pregnancy, labor, or delivery:		
Did your baby experience any difficulties after delivery (ie: seizures, trouble breathing):		
Any medications used during pregnancy: ☐ Yes ☐ No - List medications and reason:		
Describe how your child was as a baby:		

Health & Developmental History	
Toileting	
☐ Training started	☐ Diapered during the day
☐ Needs help toileting	☐ Toilet trained
Soiling or wetting concerns:	
Sleeping Habits	
Do you feel like your child gets enough sleep? ☐ Yes ☐ No	
Is your child easily soothed? ☐ Yes ☐ No Concerns:	

Family Considerations

Have there been any changes in the child's life such as a new sibling, divorce, marriage or death in the family? Please describe the child's reaction, if any.

Current Child Development

Does your child have an: ☐ IEP ☐ IFSP ☐ Private Therapy: _____
If so, please provide us a copy or request to sign a Release of Information form so we can access a copy.

Do you have concerns about your child in any of the following areas?

☐ Yes	☐ No	MOTOR SKILLS (walking, drawing)	☐ Yes	☐ No	ADAPTIVE SKILLS (feeding and dressing self)
☐ Yes	☐ No	SOCIAL – EMOTIONAL (behavior, social skills)	☐ Yes	☐ No	EARLY LEARNING (engaging in play, early concepts)
☐ Yes	☐ No	COMMUNICATION (speech intelligibility, language comprehension)	☐ Yes	☐ No	VISION IMPAIRMENT
			☐ Yes	☐ No	HEARING IMPAIRMENT

-- Developmental Inventory --

Thinking about the skills your child demonstrates consistently, does he or she:

Motor Skills

Does your child:	Yes	Not yet	N/A
Use crayons and/or markers to scribble, draw, or "write"			
Use scissors to snip the edge of a piece of paper			
Use one hand for most activities			
Run, walk, and jump			
Throw and kick a ball; try to catch a ball with both hands			

Social-Emotional

Does your child:	Yes	Not yet	N/A
Show an awareness of feeling, his/her own and those of others			
Want independence, but stills needs security of parents			
Enjoys playing with other children similar in age			
Verbally express what he/she wants or needs			
Show empathy toward familiar adults and friends			

Communication

Does your child:	Yes	Not yet	N/A
Listen and remember details of simple stories			
Understand simple 1-2 step directions			
Put 3-5 words together to speak in short sentences ("want more milk")			
Ask lots of questions			
Speak clearly so that most family members and friends understand him/her			

Adaptive Skills

Does your child:	Yes	Not yet	N/A
Feed himself/herself using a fork and/or spoon			
Wash and dry his/her own hands			
Help with dressing and undressing			
Drink from a cup			
Open doors and cupboards			

Early Learning

Does your child:	Yes	Not yet	N/A
Enjoy looking at books with an adult or independently			
Play with toys in expected way (drive and crash cars, take care of a doll)			
Name and match colors			
Sing along with familiar songs			
Ask for help with difficult activities			

Your specific concerns:

When did you first notice concerns in this area?

Have you pursued private services through your child's doctor?

Tell us About your Child's Behavior at Home or Childcare:

Describe your child's personality:				
Share your child's favorite activities?				
Does your child have the opportunity to play with other children?	☐ Yes	☐ No	Explain (@ the park, with her cousins, etc.):	
My child attends to an engaging play activity (non-screen related) for:	☐ < 5 mins	☐ 5-10 mins	☐ 10-30 mins	☐ 30+ mins
How much time a day does your child spend watching/using screens? _____hours _____minutes Does this concern you? ☐ Yes ☐ No				

Behavior

N/A	Yes	No	
			Do you have behavior concerns at home?
			Does your childcare provider have behavior concerns at childcare?
			Has anyone else (family or friend) expressed concerns about your child's behavior?
			Has your child ever been asked to leave a childcare setting due to behavior?

Anything else you would like us to know about your child?

Has your Child Attended Childcare / PreK Before?

Name of Childcare or Preschool:	Month/Year Attending:
Street Address:	
City/State/ZIP:	Phone Number:
Days/Hours:	☐ I agree to allow PSD to contact for further information