FOUR RIVERS SPECIAL EDUCATION DISTRICT
936 West Michigan Avenue Jacksonville, Illinois 62650-3113
Phone: 217-245-7174 Fax: 217-245-5533

Permission for a Developmental Screening

☐ I give permission for the above-named child to participate in a developmental screening at _____
Screening Location-Name of Preschool, Head Start, Daycare, etc.

☐ I give permission for the above-named child to receive a vision and hearing screening. In the event Four Rivers Special Education District does not conduct the screenings, I give permission for the vision and hearing screening agency to release the results to Four Rivers Special Education District.

_____ _____
Date Parent/Guardian/Authorized Agent

Release of Information for Nonpublic Entities (Head Start, Private School, Daycares, etc.)

To:_____ City:_____ State:_____
Name of Head Start, Private School, Daycare, etc.

☐ I give permission to Four Rivers Special Education District, and the agency or professional to whom this form is addressed above, to freely exchange personally identifiable oral and/or written school information regarding the above-named student. This information is intended for use in educationally and legal decision making. The undersigned acknowledges that refusal to sign will result in the information not being released. The undersigned intends that a photocopy or facsimile of this form will carry the same legal force and effect as the original. The undersigned further acknowledges that he/she has the right to revoke this consent in writing at any time, and to inspect, copy, or challenge the contents of the records being requested prior to release. Knowing this, the undersigned intends to authorize the release of the designated records pursuant to 105 ILCS 10/6(a)(8) of the Illinois School Student Records Act. This consent covers the full contents of the temporary and permanent files as these are defined in the Illinois School Student Records Act. Redisclosures of third party files are not allowed unless specifically authorized. The undersigned intends for this release to include any mental health files located in the school temporary record. This release grants permission for the exchange of birth certificate, developmental screening information, and hearing/vision screening information. This release expires one year from the signature date of the undersigned.

_____ _____
Date Parent/Guardian/Authorized Agent

Developmental Screening
Student Information

Child's First Name	Middle Name	Last Name	Primary Language	Resident District	Gender (M/F)

Street Address	City	Zip Code	Date of Birth	Age

Father's Name	Occupation	Phone # to be Reached
Mother's Name	Occupation	Phone # to be Reached
Legal Guardian's Name (If other than Parent)	Occupation	Phone # to be Reached
Email Address		

List Other People Residing in the Home	Relationship	Gender (M/F)	Age

Who does this student primarily live with?

☐	Both Parents
☐	Mother Only
☐	Father Only
☐	Mother/Stepfather
☐	Father/Stepmother
☐	Grandparent(s)
☐	Foster Parent
☐	Legal Guardian

What, if any, program does your child currently attend? (Preschool, Daycare, Private School, Head Start) _____
Has your child previously participated in a developmental screening through Four Rivers or any other agency? ____ Yes ____ N0

Please check if your child or family has received services from any of the following agencies.			
	Child & Family Connections (Birth – 3 Early Intervention)		Public Health Department
	School District 0-3 Program		WIC
	Division of Specialized Care for Children (DSCC)		Early Head Start (0-3)
	Department of Child & Family Services (DCFS) – child is involved with DCFS but resides with his/her families as part of DCFS's Intact Families program		Head Start (3-5)
	DCFS – child is in DCFS care & resides with a foster family		
	Free and Reduced Lunches		Community Counseling
	Medicaid/Kid Care Number:		Social Security
	Department of Rehabilitative Services		SNAP/Link Card

Please check if any of the following items apply to your child or family.			
	History of child abuse or neglect		DCFS involvement
	History of domestic violence		History of alcohol/drug abuse
	Chronic or terminal illness of child		Child has documented disability
	Chronic or terminal illness of immediate family member		Parent/guardian has a disability
	Teen parent when child was born		Parent/guardian has mental illness
	Low birth weight/Failure to thrive		Recent immigrant or refugee family
	Parent/guardian active in military		English not spoken in home Language in home:
	Parent/guardian deployed in the military		Parent/guardian incarcerated
	Parent/guardian did not complete high school		High mobility (Moves frequently)
	Parent/guardian has a GED		Immediate family member received special education services
	Parents/guardians are separated		Parents/guardians are divorced
	Parent/guardian is unemployed		A new baby is in the home
	Death in immediate family		

Please check any of the following medical conditions that apply to your child. If checked, please explain.		
	Premature birth?	Weight at birth:
	Received specialized care or treatment at birth? Explain:	
	Had surgery? Explain:	
	Been hospitalized? Explain:	
	Had convulsions or seizures? Explain:	
	Any medical diagnoses? Please list diagnoses and explain the current care for the medical diagnoses.	
	Takes medication? Please list.	
	Has allergies or asthma? Explain:	
	Has a physician? Physician's Name(s):	
	Has received services or is receiving services from an occupational therapist? Explain:	

Please check any of the following hearing concerns that apply to your child.			
	Often says “huh”		Seems to not be paying attention
	Difficulty following directions		Has articulation problems or speech delays
	Speaks loudly		Turns up volume on radio, TV, computer, etc.
	Asks people to repeat		Complains of ear aches and pains
	Did not pass the newborn hearing screening		Has tubes or had tubes in ears
	Has been evaluated by an audiologist		
	Has difficulty hearing? Explain:		

Please check any of the following vision concerns that apply to your child.			
	Squinting		Sitting close to the TV or holding books too close
	Tilting of the head		Frequently rubbing eyes
	Turning of an eye in or out		Sensitivity to light
	Wears glasses		
	Has difficulty seeing? Explain:		

Please check any of the following concerns that apply.			
	Has difficulty separating from parent or separates too easily		Has a short attention span
	Prefers to play alone		Does not seek or accept affection
	Is aggressive with others or toys		Continues to misbehave when asked to stop
	Has trouble calming self		Does not accept change in routine
	Does not engage in pretend play (being Superman; playing house; etc.)		Has tantrums
	Rarely makes eye contact		Is fearful or worries a lot
	Seems overly sensitive to touch		Doesn’t express a wide range of emotions (happy, sad, etc.)
	Flaps or spins		Refuses to eat certain kinds of food
	Uses unusual sounds, words, or repeats what is heard		Harms self
	Has difficulty transitioning from one task to another		Overreacts to sound
	Has your child received services from a developmental therapist? Explain:		

Please check any of the following speech or language concerns that apply.			
	Strangers have difficulty understanding your child speak		Has difficulty expressing wants/needs
	Does not speak in sentences		Has difficulty naming common objects around the home (toys, foods, etc.)
	Has difficulty answering questions		Has difficulty following directions
	Is your child receiving services or ever received services from a speech/language pathologist? Name the agency or provider.		

Is there anything about your child that causes you concern?_____

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