

| |
|-----------------------|
| Date Requested: _____ |
| Date Received: _____ |

**TANGIPALOOA PARISH PUPIL APPRAISAL SERVICES
CHILD IDENTIFICATION
CHILD SEARCH**

STUDENT:

Name: _____

LAST

FIRST

MIDDLE

Social Security Number: _____

Sex: Male Female Birthdate: _____

Ethnic Background: White Black Hispanic Other _____

Parent(s) / Guardian(s): (If both parents are in the home, put both first names) (If custody is shared, complete this section.)

Name: _____

LAST

FIRST

Mailing Address: _____

STREET

CITY

STATE

ZIP

Home Telephone: _____ Work Telephone: _____

If the child's parents are not living in the same home, is the father listed on birth certificate? Yes No

If parents are divorced, is custody shared? Yes No

If the child lives with someone other than parents, do you have legal guardianship papers? No Yes (attach copy)

Primary Language: English Other (List) _____ If Other, is interpreter needed? Yes No

Has this child ever had a vision problem? Yes No

Has this child ever had a hearing problem? Yes No

Does this child have a medical diagnosis? Yes No (If so list: _____)

Does your child attend a preschool program? Yes No (If so, which one?: _____)

Has your child ever been evaluated? Yes No (If so, by whom?: _____)

Referred by: Parent Head Start Other _____

Form completed by: _____

Reason for Concern: Speech Hearing Vision Developmental Delay Behavior

Does your child receive private therapy in speech occupational therapy physical therapy?

Agency Name: _____

*******FOR SCHOOL BOARD USE ONLY*******

Medical Information Sent For: _____ Agency Name: _____

Date Sent: _____

REFERRAL/SCREENING DATA

Child _____ DOB _____

Does your child fall easily when walking or running? ____ Yes ____ No Explain: _____

Describe your child's eating behavior: _____

Does your child have a speech problem? ____ No ____ Yes What is the problem? _____

Does your child have a motor problem? ____ No ____ Yes What is the problem? _____

Does your child have a behavior problem? ____ No ____ Yes What is the problem? _____

Does your child learn new tasks quickly? ____ Yes ____ No

Does your child remember information that has been taught? ____ Yes ____ No Explain: _____

Does your child enjoy good health? ____ Yes ____ No What is the problem? _____

Does your child play well with other children? ____ Yes ____ No What is the problem? _____

| BEHAVIOR | AGE | BEHAVIOR | AGE |
|------------------|-----|----------------------|-----|
| Rolled over | | Put words together | |
| Sat alone | | Dressed self | |
| Crawled | | Toilet Trained | |
| Walked alone | | Stayed dry all night | |
| Spoke first word | | Fed self | |

**TANGIPAHOA PARISH SCHOOL SYSTEM
SCHOOL LEVEL SENSORY SCREENING**

Student's Name: _____ School: _____

Grade: _____ Teacher's Name: _____

Vision Screening

_____/_____/_____
Month Day Year

Note: Normal results have been obtained within the past 24 months for enrolled students and within the past 12 months for non-enrolled children.

- ____ Not At Risk
- ____ At Risk
- ____ Acuity Right (Near Point)
- ____ Acuity Left (Near Point)
- ____ Acuity Right (Far Point)
- ____ Acuity Left (Far Point)
- ____ Color Blindness
- ____ Muscle Balance
- ____ Adapted Methods Used
- ____ Screened With Glasses

Comments: _____

Hearing Screening

_____/_____/_____
Month Day Year

Note: Normal results have been obtained within the past 24 months for enrolled students and within the past 12 months for non-enrolled children.

- ____ Not At Risk
- ____ At Risk
- ____ Loss of 20db in one of 1000, 2000, 4000 Hz frequencies in at least one ear
- ____ Loss of 25db in two or more frequencies in at least one ear
- ____ Middle ear pressure outside range of -200 and +50 mm H₂O in either ear
- ____ Excessively stiff or flaccid tympanogram in either ear
- ____ Adapted Methods Used
- ____ Screened With Hearing Aid

Comments: _____

SIGNATURE