List school district name here
 Parents as Teachers Missouri Curriculum Partner

Insert your school district logo here

 **DEVELOPMENTAL SCREENING SUMMARY**

|  |
| --- |
| **CHILD INFORMATION** |
| LAST NAME | FIRST NAME | DATE OF BIRTH |
| **HEALTH REVIEW** |
| HEALTH RECORD COMPLETE DATE | IMMUNIZATIONS UP-TO-DATE Yes No N/A |
| NOTES FROM HEALTH REVIEW |
| **DENTAL** |
| DENTAL CHECK COMPLETE DATE |
| NOTES FROM THE DENTAL REVIEW |
| **HEARING SCREENING RESULTS** |
| HEARING SCREENING RESULTS Pass Possible Concern Under a Physician’s Care | DATE | CHILD’S AGE |
| notes |
| **VISION SCREENING RESULTS** |
| VISION SCREENING RESULTS Pass Possible Concern Under a Physician’s Care | DATE | CHILD’S AGE |
| notes |
| **DEVELOPMENTAL AND SOCIAL-EMOTIONAL SCREENING RESULTS** |
| OVERALL RESULTS | DATE | CHILD’S AGE |
| DEVELOPMENTAL SCREENING INSTRUMENT USED | SOCIAL-EMOTIONAL SCREENING INSTRUMENT USED (IF DIFFERENT) |
|  | RESULTS | WHAT YOUR CHILD CAN DO | WHAT WILL COME NEXT |
| COGNITIVE |  |  |  |
| LANGUAGE |  |  |  |
| MOTOR |  |  |  |
| SOCIAL-EMOTIONAL |  |  |  |
| NOTES ON DEVELOPMENTAL AND SOCIAL-EMOTIONAL SCREENING |
| *\*This screening is not a substitute for regular physical examinations by a healthcare provider.* |
| **FOLLOW-UP RESOURCES DISCUSSED** |
|  |
| **IDEAS/SUGGESTIONS THAT SUPPORT YOUR CHILD’S DEVELOPMENT** |
|  |
| DATE RESULTS SHARED WITH PARENT(S)/GUARDIAN(S) – (PERSONAL CONFERENCE IS RECOMMNEDED BUT REQUIRED IF A DELAY IS DETECTED)\_\_\_/\_\_\_/\_\_\_\_ Personal Conference \_\_/\_\_/\_\_\_\_ Shared During Personal Visit \_\_/\_\_/\_\_\_\_ Mailed Out |
| **AUTHORIZATION TO EXCHANGE INFORMATION (AS NEEDED)** |
| I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to exchange information/recordsregarding my child’s screening with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.They may share/request (check all that apply): The results of this screening and a request for further evaluation can be shared verbally and/or electronically A copy of this screening summary My child’s health record My child’s immunization record Results of my child’s hearing screening Results of my child’s vision screening My child’s developmental screening protocol My child’s social-emotional developmental screening protocol (if different than above) My child’s milestones record Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_This authorization is valid for one calendar year, unless revoked sooner by notifying my parent educator or program supervisor in writing.Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |