

1301 W. Cossitt LaGrange, IL 60525
Phone: 708.354.5730 Fax: 708.354.0733 TTY: 708.352.5994
www.ladse.org

Dr. Sheri Wernsing
Executive Director

REQUEST FOR EARLY CHILDHOOD EDUCATION EVALUATION (Revised 3/2017)

Child's Legal Name _____

(First) (Middle) (Last)

Birth Date _____ M _____ F _____

Race/Ethnicity

Of Hispanic or Latino ethnicity: yes no

American Indian or Alaska Native Asian Black or African America Hispanic/Latino Native Hawaiian or Other Pacific Islander Two or More Races White

Address _____ City _____ Zip Code _____

Home Telephone _____ Resident School District _____ School _____

Name of Father or Guardian _____ Work Phone _____ Cell Phone _____

Name of Mother or Guardian _____ Work Phone _____ Cell Phone _____

Email Addresses- Father _____ Mother _____

Sibling(s): Names and Ages _____

REASON FOR REFERRAL:

___ Phonological (*attach Hodson screen*) ___ Preschool Screen (*attach screen protocols*)
___ Early Intervention (*attach EI paperwork*) ___ Parent initiated (*attach screen protocols*)
___ Private evaluation (*attach any information*) ___ Classroom team (*complete referral questionnaire*)

PRESCHOOL SCREENING RESULTS: Please mark as **PASS**, **FAIL**, or **RE-SCREEN** in each area

(Screening results are not required for children transitioning from Early Intervention)

___ Cognitive-Verbal ___ Perceptual-Motor ___ Vision ___ Hearing
___ Communication ___ Gross Motor ___ Behavior

PARENT CONCERNS INCLUDE:

___ play skills ___ fine motor skills (color, cutting) ___ social skills
___ pre-academics/learning ___ gross motor skills (running, jumping) ___ communication skills
___ behaviors ___ sensory processing ___ speech articulation

Please further explain your concerns in any areas checked above:

Supporting education for all children in the community school districts:

53 Butler	94 Komarek	102 LaGrange	107 Pleasantdale
61 Darien	95 Brookfield-LaGrange Park	103 Lyons	204 Lyons Township High School
62 Gower	96 Riverside	105 LaGrange South	208 Riverside Brookfield High School
92 1/2 Westchester	101 Western Springs	106 LaGrange Highlands	

LANGUAGE:

Is your child exposed to a language other than English? Yes ___ No___. If yes, see page 4

Can one parent communicate in English? Yes ___ No___. Name/phone: _____

PREVIOUS EVALUATION EXPERIENCES:

Has your child been evaluated by anyone in the last year? Yes _____ No ___z_____

____ Occupational therapy. If yes, where _____

____ Physical therapy. If yes, where _____

____ Speech/language therapy. If yes, where _____

____ Hearing/Vision. If yes, indicate pass/fail results: _____ Hearing _____ Vision

____ Other. (Specify). Where _____

CURRENT SERVICES:

What services does your child currently receive?

___ Developmental Therapy ___ Social Work ___ Physical Therapy ___ Speech/Language Therapy

___ Occupational Therapy ___ Other: _____

Does your child have an EI service coordinator? If yes, who is it? _____

SCHOOL EXPERIENCE:

If your child has attended or is attending a preschool or day care program, please indicate:

Name of school _____ Teacher/Director Name _____

Address _____

Phone _____ Days of attendance _____

Does your child have any diagnosis which might affect educational programming? Please specify.

Does your child have any other health needs? _____

Do you have any other concerns about your child that are not listed here? _____

What do you hope to accomplish through this evaluation? _____

Parent Signature

Date

District Administrator Signature

Date

Classroom Based Referral Questionnaire

Child's name _____

Teacher's name _____ School _____

Email: _____ Phone: _____

Attendance days/times _____

Current services _____

Classroom team members _____

What concerns do you have for this student? _____

What are the student's strengths? _____

What strategies have you tried so far and what was the response? _____

What would you like to accomplish with this referral? _____

Please attach any available classroom assessment information (MCLASS, Teaching Strategies Gold, etc.)

Completed by: _____

Date: _____

Home Language Survey

What language is heard most often by your child? _____

What percent of the time is the child exposed to English? (circle one)

0-25%	26-50%	51-80%	80-100%
-------	--------	--------	---------

What percent of the time is the child exposed to a language other than English? (circle one)

0-25%	26-50%	51-80%	80-100%
-------	--------	--------	---------

What languages does your child hear from parents, siblings, grandparents, childcare providers, etc.?

Family/Caregivers	Languages the child hears?
Parents	
Siblings	
Grandparents	
Childcare providers /babysitters	
Others	

What languages does my child understand? (follow directions or answer questions)

My child....

Understands mostly home language and little English	Understands home language and English equally	Understands mostly English and little home language
---	---	---

What languages does my child speak?

My child...

Speaks mostly home language and little English	Speaks mostly home language and English equally	Speaks mostly English and little home language
--	---	--