Date: ____________

SOUTHINGTON PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL EDUCATION

PRESCHOOL PARENT CONCERN FORM

RETURN TO: Stephanie Prior C/O Hatton Elementary School, 50 Spring Lake Road, Southington, CT 06489

Child's Name: ________________________ Birth Date: ___________ Age: _______ Gender: M F
First, Middle, Last

Parent/Guardian Name: _____________________ Parent/Guardian Name: _________________________
• *Address: _____________________________ • *Address: ___________________________________
_____________________________ ___________________________________
Email: _______________________________ Email: ______________________________________
Cell: _________________________________ Cell: ____
Home Phone: ___________________________ Home Phone:__________________________________
*Please check primary residence, if separate addresses.

Sibling Names and Ages: ____

Primary Language Spoken at Home: _______________________ Secondary Language: ________________

Does your child attend nursery school/day care? • Yes • No

If yes, where? ____________________________ Days: _________________ Times: __________

Has your child's teacher expressed concerns? • Yes • No If yes, please note concerns: __________

____
____

Please Note Your Specific Concerns: (Check all that apply and provide details in the areas provided)

Areas of Concern:	**Details:**
• Speech/Articulation (My child cannot say sounds and words as expected.)	
• Language (My child uses limited/no words to express wants and needs.) Sentence length: ____ words	
• Gross Motor (My child has difficulty walking, running, coordinating feet when climbing stairs, etc.)	
• Fine Motor (My child has difficulty holding a spoon, feeding self, drinking/holding cup, etc.)	

• Sensory Needs (My child does not like the feel of certain things, loud noises, etc.)	
• Behavior (My child has difficulty paying attention while a story is being rea, sitting down and finishing an activity, playing independently, following directions, has frequent temper tantrums, etc.)	
• Relationships (My child has difficulty getting along with others the same age or siblings, making friends, etc.)	

Health History:

My child's birth/delivery was normal. • Yes • No. If No, please explain: ____________________________
____

History of Ear Infections? • Yes • No Hearing Test Date: ________________
My child has a hearing loss: • Yes • No If Yes, note specifics: ____________________________
____
PE Tubes inserted in ears: • Yes • No If Yes, Date: _________________

Vision: • Normal • Wears glasses for: ____

My child is generally in good health. • Yes • No If No, note specifics: _______________________
____

My child is on medication. • Yes • No Name of Medication: ________________________________
____

My child has allergies. • Yes • No If Yes, specify: ____
____

Comments about my child's eating habits: ____

Pediatrician's Name: ____
Does your pediatrician express concerns regarding your child's development? • Yes • No If yes, please note concerns:
____
____
Was your child evaluated for or did your child receive B-3 services? • Yes • No Dates: __________

Does your child receive Private Services? (Check All That Apply)

• Occupational Therapy • Physical Therapy • Speech Therapy

Location: __________________________Frequency/Duration: ______________________________

Additional information that you would like to share about your child: _________________________________
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