POTOSI R-3 SCHOOL PARENTS AS TEACHERS

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PERMISSION TO SCREEN: Parents as Teachers will be screening Potosi R-3 children at your childcare center or preschool in the areas of development, speech, vision, hearing and dental. The results of this screening will be shared with the parents, childcare director and school district following the screening process or when you pick up your child. Any questions regarding the screening process or the results, please call Parents as Teachers or contact your local childcare provider. *(Please Print)*

Child_____ Birthdate_____

Parent Names_____ Date_____

Address_____ City_____ Phone_____

I give my permission for Parents As Teachers Potosi R-3, to screen my child and share the information with the teacher. *Signature* _____

HEALTH (Use back if needed)

Is there any reason for concern about your child's general growth or development?_____
If so, why? _____
Has your child had Chicken Pox? Yes____ No_____ Date_____
Immunizations up to date? Yes_____ No_____ **Male** ☐ **Female** ☐

VISION *Mark any concerns- circle or underline*

Do you have any concerns about vision? (eyes crossed, reddened eyes, encrusted eyelids, sties, eyes in constant motion, eyelids droop, tilts the head, places an object close to the eyes to look at it, closes one eye, squints, blinks excessively, complains of pain, bothered by light, watery eyes, unable to see distant objects, turns head to use one eye, rubs eyes, stumbles over objects) _____
_____

Has your child ever had a vision examination or treatment? _____
Is there a history of lazy eye in family? _____
Is there a history of vision problems in the family such as near or farsightedness or astigmatism? _____

HEARING *Mark any concerns- circle or underline*

Do you have any concerns about hearing? (difficulty hearing, family history of hearing problems, seems to favor one ear, makes you talk loudly, or difficult to understand speech)_____
_____
Has your child had ear infections this last year? _____ How many? _____
Does your child have tubes? _____
Has your child ever had a hearing examinations or treatment? _____

DENTAL *Mark any concerns- circle or underline*

Does anything appear abnormal? (Swelling, redness, apparent decay) on the child's teeth or gums?
Yes____ No____ Number of teeth _____
Has your child had a dental examination or treatment? Yes____ No____