DOVER-SHERBORN SCHOOLS
PRESCHOOL SCREENING INTAKE FORM

Student Name: _____ Date of Birth: ____/____/____

Address: _____

Place of Birth: _____ Gender: _____

Language Spoken at Home: _____

1. Parent/Guardian Name:	2. Parent/Guardian Name:
_____	_____
Address (if different from child):	Address (if different from child):
_____	_____
Telephone: Home: _____-_____-_____	Telephone: Home: _____-_____-_____
Work: _____-_____-_____	Work: _____-_____-_____
Cell: _____-_____-_____	Cell: _____-_____-_____
Email:_____	Email:_____

Student is presently enrolled at: _____

Outside agency/services involvement, if any: _____

Contact person and phone for outside agency/provider:_____

Permission to contact outside agency/provider: ☐ Yes ☐ No

Areas of Concern:

- ❏ Speech &/or Language: _____
- ❏ Vision &/or Hearing: _____
- ❏ Physical &/ Motor Skills: _____
- ❏ General Development: _____
- ❏ Behavior: _____
- ❏ Other: _____
- ❏ Major Medical Problems or medications: _____

Screening requested by:

☐ Parent/Guardian ☐ Early Intervention ☐ Other _____

Please send completed forms due by 10/17/18 to:	**For Internal Use Only**
Donna Fiori, Special Education Administrative Assistant Chickering School 29 Cross Street Dover, MA 02030 fiorid@doversherborn.org	Completed by:_____ Date Received:_____ Screening Date: _____ Appointment Time:_____ ☐ Dover ☐ Sherborn