CENTRAL BUCKS SCHOOL DISTRICT

School ______________________________ Date ________________

Child's Name _________________________ Date of Birth ____________

Parent's Name ________________________ Phone _______________

Address ____

Please check all the appropriate areas below. You may make additional comments, if desired, on the back of this form.

YES	NO	HEARING
☐	☐	Child has history of ear infection(s). If so, approximate number ________
		Treated by Dr. ______________________________
☐	☐	Child complains of frequent earaches.
☐	☐	Child has "draining ears" and some liquid other than wax has been noted more than once in the outer ear.
☐	☐	Child may have a hearing problem.
☐	☐	Child has a known hearing loss. If so, please describe: ____________

YES	NO	SPEECH AND LANGUAGE
☐	☐	Child has difficulty making and using many sounds.
☐	☐	Child has difficulty making and using a few sounds.
		If possible, list examples: ______________________
☐	☐	Child talks very little.
☐	☐	Child speaks one or two words at a time and rarely uses complete sentences.
☐	☐	Child may have a voice problem: pitch, volume, rate, quality (hoarseness, harshness, nasality).
☐	☐	Child is not fluent; repeats, hesitates, prolongs sounds, or grimaces during speech.
☐	☐	Child may need help from the Speech/Language Therapist concerning his/her speech or language development.