St Patrick's Catholic Primary School

Cnr York & Melbourne Streets, East Gosford NSW 2250
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SCHOOL ENTRANCE SCREENER KINDERGARTEN ONLY

CHILD'S NAME: _____
(Christian Names **(Surname)**

DATE OF BIRTH:_____**AGE AS AT 1/2/** ____ **years** ___**months**

ADDRESS:_____**Post Code**_____

MOTHER'S NAME:
_____

Telephone : (Home)_____**Work** _____

FATHER'S NAME:
_____

Telephone: (Home)_____**Work** _____

MEDICAL HISTORY

Does your child have any medical conditions? **YES/NO**
(eg asthma, heart problems, allergies, etc)
Comments:_____
_____
_____
_____

Does your child take any regular medication? **YES/NO**
Comments:_____
_____
_____
_____

Has your child ever had difficulties with behaviour? **YES/NO**

Has your child ever had a Psychological Assessment? **YES/NO**
Where: _____
When: _____
Results: _____
Report Given: _____

VISION

Has your child ever had a Vision Assessment? YES/NO

Where: _____
When: _____
Results: _____
Report Given: _____

HEARING

Does your child suffer from recurring ear infections or glue ears? YES/NO
Does your child have grommets? YES/NO
Has your child ever had a Hearing Assessment? YES/NO

Where: _____
When: _____
Results: _____
Report Given: _____

SPEECH AND LANGUAGE

Can your child:

- **Speak in complete sentences? YES/NO**
- **Remember simple instructions? YES/NO**
- **Retell a given message? YES/NO**
- **Tell simple stories? YES/NO**
- **Pronounce all sounds correctly and fluently YES/NO**
- **Does your child have a lisp? YES/NO**
- **Is another language spoken at home other that English? YES/NO**
- **If yes, what language is spoken _____**
- **Has your child ever had a Speech/Language Assessment YES/NO**

Where:

_____

When:

_____

Results:

_____

Report Given:

_____

GROSS AND FINE MOTOR

Has your child had an Occupations therapy Assessment? YES/NO

Where: _____

When: _____

Results: _____

Report Given: _____

Can your child cut with scissors? YES/NO

Does your child have an appropriate pencil grip? YES/NO

What is you child's :

Preferred handwriting LEFT/RIGHT

Preferred foot for kicking a ball? LEFT/RIGHT

GENERAL INFORMATION

Has your child had any other assessments? (eg. Psychological, Cognitive) YES/NO

If yes, please comment:

_____

_____

Please list the names and ages of all children in your family?

_____

_____

_____

_____

Do we have your permission to contact any of the relevant agencies (eg DOCS, Centre Care, Yarran Early Intervention and/or relevant professional (eg Paediatrician, GP, Psychologist, Other Specialists). YES/NO

COMPLETE THE FOLLOWING INFORMATION

Has your child been to a Pre-School or Long Day Care Centre YES/NO

Where? _____Phone_____

How often?_____

Do we have permission to contact the Pre-School regarding your child? YES/NO

Please write down any other information about your child you feel we should know.

_____

_____

_____

_____

To the best of my knowledge all the above information is true and correct

Signature _____ Date _____

Parent/Guardian