



Toltec School District
 3315 N Toltec Road
 Eloy, Arizona 85131
 District 520/466-2360

NEW STUDENT 45-DAY SCREENING FORM

Must be completed within 45 days of enrollment

- Toltec Elementary School 520-466-2350
 Arizona City Elementary School 520-466-2450

ENROLLMENT DATE: _____

STUDENT ID # _____ TEACHER: _____

TO BE COMPLETED AT TIME OF REGISTRATION BY PARENT

Student Name:	<input type="radio"/> Male <input type="radio"/> Female	Date of Birth:	Age:	Grade:	School:
Ethnicity:	Language spoken at home:	Language Spoken by student	First spoken language of student:		

TO BE COMPLETED BY SCHOOL NURSE

Check if student wears: <input type="radio"/> Glasses <input type="radio"/> Contacts <input type="radio"/> Hearing Aid		Tested with: <input type="radio"/> Glasses <input type="radio"/> Contacts <input type="radio"/> Hearing Aid	
Acuity Test: Distance: Both Eyes: Right Eye: Left Eye: <input type="checkbox"/> Pass <input type="checkbox"/> Fail Date: _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail Date Parent Notified _____	Hearing: <input type="checkbox"/> Pure Tone Test Right Ear: <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left Ear: <input type="checkbox"/> Pass <input type="checkbox"/> Fail Date Parent Notified: _____	Preschool Education <input type="checkbox"/> Yes <input type="checkbox"/> No	
Educationally relevant health information: <input type="checkbox"/> Unknown <input type="checkbox"/> Yes _____ <i>Please note relevant information above.</i>		Nurse signature: Date: _____	

TO BE COMPLETED BY CLASSROOM TEACHER

<p style="text-align: center;">VISION</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Holds book too close or too far</p> <p><input type="checkbox"/> <input type="checkbox"/> Squints or has trouble seeing board</p> <p><input type="checkbox"/> <input type="checkbox"/> Has trouble with eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty copying from board</p> <p>Other: _____</p>	<p style="text-align: center;">ORAL COMMUNICATION</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Has poor speech habits</p> <p><input type="checkbox"/> <input type="checkbox"/> Articulates poorly</p> <p><input type="checkbox"/> <input type="checkbox"/> Often stutters</p> <p><input type="checkbox"/> <input type="checkbox"/> Has difficulty expressing ideas</p> <p>Other: _____</p> <p><i>(Noted problems should be referred to speech/language pathologist.)</i></p>
<p style="text-align: center;">SOCIAL/BEHAVIORAL</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Displays externalizing behaviors (fighting, assaults, vandalism)</p> <p><input type="checkbox"/> <input type="checkbox"/> Displays internalizing behaviors (fears, phobias, depression, withdrawn)</p> <p><input type="checkbox"/> <input type="checkbox"/> Has difficulty with unstructured environments or transitions between activities</p> <p><input type="checkbox"/> <input type="checkbox"/> Has difficulty developing or maintaining peer or adult relationships</p> <p><input type="checkbox"/> <input type="checkbox"/> Displays inappropriate types of behaviors or feelings under normal circumstances</p> <p>Other: _____</p>	<p style="text-align: center;">HEARING</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Does not respond to oral cues in class</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequently asks for information to be repeated or asks "what?"</p> <p><input type="checkbox"/> <input type="checkbox"/> Has significantly delayed language</p> <p><input type="checkbox"/> <input type="checkbox"/> Has frequent earaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Seems to not pay attention</p> <p>Other: _____</p>

MOTOR SKILLS

Yes No

- Has short attention span
- Problems with gross motor development
- Problems with fine motor skills

Other: _____

COGNITIVE OR ACADEMIC

Yes No

- Learns very slowly compared to peers
- Attention span problems
- Below grade level in reading _____
- Below grade level in math _____
- Below grade level in writing _____
- Difficulty acquiring, retaining, recalling, manipulating information

ADAPTIVE/DEVELOPMENT

Yes No

- Poor self-care skills related to personal hygiene, dress, maintaining personal belongings
- Poor social skills related to working cooperatively with peers, social perceptions, response to social cues, or socially acceptable language
- Poor ability to understand directions, communicate needs, and express ideas
- Lack of coping behaviors in the school setting
- Other: _____

Teacher Signature _____

Date: _____

TRANSFER STUDENT RECORDS REVIEW

Last Grade Attended: _____ Year Attended: _____

Last School Attended: _____

Date records requested _____ Received _____

Date records reviewed _____ Reviewer _____

History of early intervention or special ed? Y N History of poor performance or progress in school? Y N _____

TO BE COMPLETED BY SPEECH/LANGUAGE PATHOLOGIST

(Recommended only when teacher notes concerns in oral communication above.)

Appears to have difficulty with:

- Articulation of sounds
- Language
- skills Voice
- Fluency
- Developmental errors: _____
- Other: _____
- No apparent difficulties
- No adverse educational impact

Signature of SLP _____

Date _____

Date _____

ADMINISTRATIVE ACTION

Yes No

- Parents notified within ten (10) school days if concerns were noted. (Date: _____)
- Current IEP/Special Education records received and reviewed.
- Referred to Grade Level Review and/or Student Study Team (Date: _____)
- Referred for 504 Plan (Date: _____)

Other: _____

Administrator Signature: _____ Date: _____

DOCUMENTATION OF FOLLOW-UP
