Lower Columbia College Head Start/ECEAP
P.O. Box 3010
Longview, WA 98632

DEVELOPMENTAL/HEALTH SCREENING SUMMARY

Dear Parent/Guardian:_____ Date: _____

Child's Name: _____Teacher: _____ Loc ID: _____

The Head Start/ECEAP developmental/health screening is designed to assist the staff in assessing whether your child may need further evaluation in the areas listed below.

☐ Your child's development is within normal limits.

☐ Screening indicates the need for further evaluation and/or monitoring in the following areas:

☐ Your child is being served on an IEP:

Already being served on an IEP in:	**Area requiring further evaluation (E) or monitoring (M):**
☐ Cognition/Pre-academic ☐ Communication ☐ Social/Emotional ☐ Fine Motor ☐ Gross Motor	☐ Cognition/Pre-academic ☐ Communication ☐ Social/Emotional ☐ Fine Motor ☐ Gross Motor
Vision ☐ *Within Normal Limits* ☐ Other (i.e. glasses) ☐ Needs to be rechecked ☐ Needs referral	**Hearing** ☐ *Within Normal Limits* ☐ Other (i.e. hearing aids) ☐ Needs to be rechecked ☐ Needs referral

We were unable to complete the screening process in the area(s) of:

_____and the follow up plan is:

_____

_____ _____

Parent Signature Date

If you have any further questions or concerns please contact either your child's teachers or your Family Advocate.

White: Parent Yellow: Site File Pink: Disability Specialist *(C: 10/00; R: 07/22)*