NWAESC
Early Childhood Program
Making a Difference!
4 N. Double Springs Road, Farmington AR 72730
479-267-5960 Fax: 479-267-5965

SCREENING REQUEST FORM

Revised 5/19/20

Child's Name_____ M F DOB_____

SS#_____ Medicaid? N Y #_____

Parent/Guardian Name_____ School District:_____

Address_____ City_____ Zip_____

Phone #_____ Cell or Emergency Phone #_____

Email Address_____

Language Spoken in Home_____ Translator for Parents? Y N

Preschool Program_____ Teacher_____ Phone #_____

Child Enrolled in: _____Head Start _____ABC _____Daycare _____Preschool _____None

I give permission for Northwest Arkansas Education Service Cooperative to screen my child. I give permission for screening, evaluation, and treatment records to be disclosed to authorized personnel of NWAESC for the purpose of evaluation and establishment of a treatment program, if appropriate.

Parent/Guardian Signature_____ Date_____

PARENT COMPLETES TOP PORTION ONLY

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To Be Completed by Screening Staff:

DIAL-4 Screening Date_____

	Child's Score	7% (1.5 SD) Cutoff
Motor	_____	_____
Concepts	_____	_____
Language	_____	_____
Self-Help	_____	_____
Social	_____	_____

Intelligibility:
_____Good
_____OK
_____Poor

Other Screening Instrument:_____ Scores:_____

Hearing:_____ PASS FAIL Vision:_____ PASS FAIL

Behavior Concerns: N Y *If yes, explain below and attach any documentation

_____

Any Other Concerns?_____

Program Directions:

1. Parent completes top section
2. Teacher completes bottom section
3. Send to Central Office
4. Mail or fax copy to 479-267-5965

**********EC USE**********

Rec'd Date:_____ Recommendation: _____Pass _____Refer _____Rescreen