Early Childhood Screening
Robbinsdale Area Schools
Family Information

Child's Name: _____ Birth Date:_____
month/day/year

Parent/Guardian Name(s): Phone(s):

_____ _____

_____ _____

e-mail address:_____

Who lives with your child? _____

Languages(s) spoken in the home: _____

Do you have health insurance? ☐ yes ☐ no Do you have dental insurance? ☐ yes ☐ no

Has your child had a comprehensive eye exam? ☐ yes ☐ no If yes, date of exam_____

Do you have questions or concerns about your child? We can talk about them today.

Please list your concerns:_____

_____

Please describe your child's special needs and strengths:_____

_____

Has there been any unusual stress in your family that might affect your child? Examples: new brother or sister, divorce, death of a family member, moving, financial problems, not enough food for the family.

*Please explain.*_____

_____