LEADS Head Start Speech Screen



0221

ticily Ochow M. B. Detor	1/- 0 20
Child's Name: MF Date:	
0.1100	12 10 16
Screener: Pri Hany C . FSW: Mcau Age:	001 (10
Enrollment Date: O O Parent's Name: O Por Hothu Ph.	# <u>231-672</u> -
Is child currently receiving speech/language interventions through an individual	zed plan? Y N
If yes, through who? LEA SLIP Private	
Please circle and list School District	Where? If yes, please explain.
1. Is this child ESL (English as a Second Language)? If yes, what is the child's Primary Language?	[] Yes [V] No
2. Has the Parent expressed any concerns about the child's speech/language? Explain:	[] Yes [V] No
3. Does the child have difficulty following directions? Explain:	[] Yes [JNo
4. Does the child have difficulty-expressing him/herself verbally? (i.e., knows names of things, uses a variety of words, puts together words in sentences) Explain:	[] Yes [YNo
5. Does the child have difficulty answering simple questions? Explain:	[] Yes [JNo
6. Does the child have difficulty asking questions? Explain:	[] Yes [JNo
7. Does the child isolate him/herself from others or have difficulty playing with others? Explain:	[] Yes [JNo
8. Is it difficult to understand what the child says? Explain:	[] Yes MNo
9. Does the child have difficulty responding appropriately to the topic being discussed? Explain:	[] Yes [] No
10. Does the child stutter? Explain:	[] Yes [YNo
11. Does the child's voice sound unusual, i.e., raspy or hoarse? Explain:	[] Yes [YNo
12. Any language concerns indicated on the Brigance Screen? Explain:	[] Yes [YNo
no additional speech assessment (passed) [] speech screening by SLP (did not pass) ***FSW be sure to input date of screen and then the results in the GE smart form	presm 07/16 MAS