Preschool Information Sheet

Child's Name: _____ Nickname: _____ Current age: _____ DOB: _____

Father's Name: _____ E-mail Address: _____

Mother's Name: _____ E-mail Address: _____

Siblings: _____

Does your child have any unusual fears? _____

Do you have any concerns with your child's speech? _____ Vision? _____ Hearing? _____

Is your child able (on his/her own) to button? _____ Snap? _____ Zipper? _____

Does your child have a pet/pets? _____ If so what are they and what are the pet's names? _____

_____

What form of discipline does your child respond to best? _____

_____

Does your child have any allergies? _____ If so what to and what is the reaction? _____

_____

_____

How would you describe your child's personality? _____

_____

What are some of your child's hobbies/interest? _____

_____

What would you like to see your child get out of this learning program? _____

_____

_____

Does your child have a normal rest/nap time? _____ If so when is it? _____

_____

CONFIDENTIAL

BELL SHOALS BAPTIST ACADEMY

BACKGROUND CHECK AUTHORIZATION

Bell Shoals Baptist Academy requires background checks for al] volunteers. You are asked to sign this release form authorizing such checks. These checks include verification of social security number as well as a criminal records check. If conviction is discovered, a determination will be made whether the conviction is related to working with children and would present a safety or security risk.

Any vqlunteer who provides misleading, erroneous or willfully deceptive information to the Academy will be eliminated from volunteering.

Print Name: _____

{First) (Middle) (Last) • (Malden)

Names of Children enrolled in the Academy: _____

Current Address: _____

(Street) (zip/State)

Social Security number: _____ Date of Birth: _____

Telephone Number: _____

Driver's License Number: _____

{PIease!3ttach a copy of License)

Are you a member of Bell Shoals Baptist Church? Y/N_ _

Have you previously volunteered with children or youth at Bell Shoals Baptist Church? Y/N___ _

Printed Name: _____

Signature: _____ Date: _____

Please include a check for $10.00 made payable to BSBA to cover the processing fee and a copy of your driver's license.
We will not be able to process this request unless both of these ar_e attached. Thank you!

(Admin Only) ___ paid ___ Shelby _ pending approval ___ approved

AdministrativeSignature: _____ Oate: _____

BSBA Allergy Action Plan

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Place Student's Picture Here

Please list all foods, medicines and/or environmental items that your child has a severe reaction to:

_____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely ingested/exposed.*

☐ If checked, give epinephrine immediately if the allergen was *definitely ingested/exposed*, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

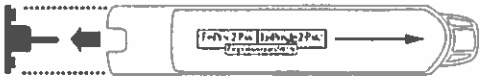
Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER

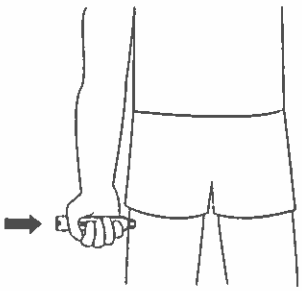
Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

EpiPen Auto-Injector and EpiPen Jr Auto-Injector Directions

- First, remove the EpiPen Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EpiPen Auto-Injector and massage the area for 10 more seconds

EpiPen 2-Pak® | EpiPen Jr 2-Pak®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

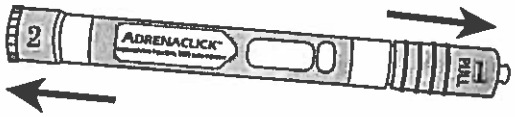
<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

An allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this BSBA Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___)_____-_____) Doctor:_____ Phone: (___)_____-_____

Parent/Guardian:_____ Phone: (___)_____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___)_____-_____

Name/Relationship: _____ Phone: (___)_____-_____

Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

Potty Training Policy

PLEASE READ CAREFULLY

It is BSBA's policy that your child be completely potty trained. **NO PULL-UPS, DIAPERS or TRAINING PANTS** of any kind are permitted in our 3 or 4 year old program. The following policy is from our handbook regarding potty training.

All children 3 years and older enrolling in Bell Shoals Baptist Early Learning Center **MUST** be fully toilet-trained by the start of school. "Pull-Ups" are not appropriate undergarments during your child's school day. We are not licensed for diapering. We do recognize, however, that 2 1/2-,3-, and 4-year olds have accidents, and they are reminded often. Repeated "accidents" (three or more in a five day period) could result in a probationary period where the child is kept home until toilet training is successful.

Step 1: After three accidents occur within five school days, a note will go home to the parents to be signed and returned to school.

Step 2: A conference with parents will be scheduled if an additional two accidents occur within five school days.

Step 3: If an additional two accidents occur, the child will be placed on one-week probation (potty contract) where the child will not be allowed at school so they can work on potty training.

Step 4: If after the one-week probation has ended and the child is not potty trained then the student will be dismissed from the school.

(Potty – Trained means being self – sufficient in the bathroom, with little or no help from staff)

Please sign and return this policy to your student's teacher on your one-on-one. You may contact the office with any questions you may have regarding this policy.

_____ _____

Parent Signature Date

_____

Child's Name (Please Print)

During the 2009 legislative session, a new law was passed that requires child care facilities, family day care homes and large family child care homes provide parents with information detailing the causes, symptoms, and transmission of the influenza virus (the flu) every year during August and September.

My signature below verifies receipt of the brochure on *Influenza Virus, The Flu, A Guide to Parents:*

Name:_____

Child's Name: _____

Date Received:_____

Signature:_____

Please complete and return this portion of the brochure to your child care provider, in order for them to maintain it in their records.

What should I do if my child gets sick?

Consult your doctor and make sure your child gets plenty of rest and drinks a lot of fluids. Never give aspirin or medicine that has aspirin in it to children or teenagers who may have the flu.

CALL OR TAKE YOUR CHILD TO A DOCTOR RIGHT AWAY IF YOUR CHILD:

- Has a high fever or fever that lasts a long time
- Has trouble breathing or breathes fast
- Has skin that looks blue
- Is not drinking enough
- Seems confused, will not wake up, does not want to be held, or has seizures (uncontrolled shaking)
- Gets better but then worse again
- Has other conditions (like heart or lung disease, diabetes) that get worse

How can I protect my child from the flu?

A flu vaccine is the best way to protect against the flu. Because the flu virus changes year to year, annual vaccination against the flu is recommended. The CDC recommends that all children from the ages of 6 months up to their 19th birthday receive a flu vaccine every fall or winter (children receiving a vaccine for the first time require two doses). You also can protect your child by receiving a flu vaccine yourself.

What can I do to prevent the spread of germs?

The main way that the flu spreads is in respiratory droplets from coughing and sneezing. This can happen when droplets from a cough or sneeze of an infected person are propelled through the air and infect someone nearby. Though much less frequent, the flu may also spread through indirect contact with contaminated hands and articles soiled with nose and throat secretions. To prevent the spread of germs:

- Wash hands often with soap and water.
- Cover mouth/nose during coughs and sneezes. If you don't have a tissue, cough or sneeze into your upper sleeve, not your hands.
- Limit contact with people who show signs of illness.
- Keep hands away from the face. Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.

When should my child stay home from child care?

A person may be contagious and able to spread the virus from 1 day before showing symptoms to up to 5 days after getting sick. The time frame could be longer in children and in people who don't fight disease well (people with weakened immune systems). When sick, your child should stay at home to rest and to avoid giving the flu to other children and should not return to child care or other group setting until his or her temperature has been normal and has been sign and symptom free for a period of 24 hours.

For additional helpful information about the dangers of the flu and how to protect your child, visit: http://www.cdc.gov/flu/ **or** http://www.immunizeflorida.org/

What is the influenza (flu) virus?

Influenza ("the flu") is caused by a virus which infects the nose, throat, and lungs. According to the US Center for Disease Control and Prevention (CDC), the flu is more dangerous than the common cold for children. Unlike the common cold, the flu can cause severe illness and life threatening complications in many people. Children under 5 who have the flu commonly need medical care. Severe flu complications are most common in children younger than 2 years old. Flu season can begin as early as October and last as late as May.

How can I tell if my child has a cold, or the flu?

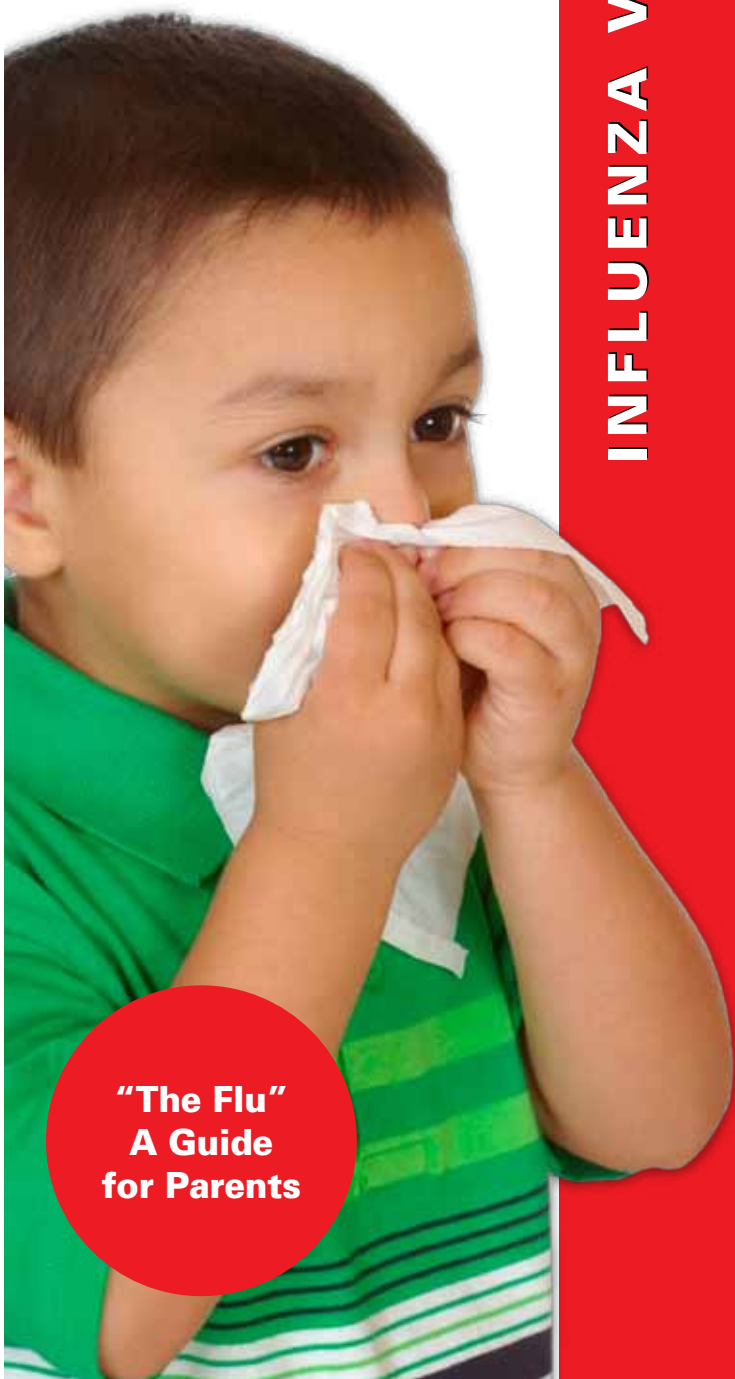
Most people with the flu feel tired and have fever, headache, dry cough, sore throat, runny or stuffy nose, and sore muscles. Some people, especially children, may also have stomach problems and diarrhea. Because the flu and colds have similar symptoms, it can be difficult to tell the difference between them based on symptoms alone. In general, the flu is worse than the common cold, and symptoms such as fever, body aches, extreme tiredness, and dry cough are more common and intense. People with colds are more likely to have a runny or stuffy nose. Colds generally do not result in serious health problems, such as pneumonia, bacterial infections, or hospitalizations.

Florida Department of Children & Families

For additional information, please visit www.myflorida.com/childcare or contact your local licensing office below:

CF/PI 175-70, June 2009

This brochure was created by the Department of Children and Families in consultation with the Department of Health.



INFLUENZA VIRUS

"The Flu" A Guide for Parents

Getting In; Getting Out...

Out: Check the Back Seat

- In just **10 minutes**, a car's temperature can increase by **19°**
- Before getting out of your car, check the back seat ... **Don't forget your child!**
- **Never** leave your child alone in a car and **call 911 if you see any child locked in a car!**
- Place something in the back seat that you will need at work, school, or home (your laptop; your lunch).

Developed by:
PREVENTION UNIT
Office of Family and Community Services

Getting In; Getting Out...

In: Check Behind The Car

- **Before getting in the car and starting the engine,** walk around the car and **check for kids, toys, and pets!**
- Make sure there is **nothing under or behind your car** that could attract a young child.
- **Pick up toys, bikes, chalk, or any type of equipment** around the driveway so that these items don't entice kids to play.

Developed by:
PREVENTION UNIT
Office of Family and Community Services

ASQ-3 Ages & Stages Questionnaires®

23 months 0 days through 25 months 15 days

24 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender: ◯ Male ◯ Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

Street address: _____

City: _____ State/ Province: _____ ZIP/ Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Parent Signature: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____

P101240100

ASQ-3

24 Month Questionnaire

23 months 0 days through 25 months 15 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Without your showing him, does your child *point* to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" *(She needs to identify only one picture correctly.)*	○	○	○	___
2. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? *(Mark "yes" even if her words are difficult to understand.)*	○	○	○	___
3. Without your giving him clues by pointing or using gestures, can your child carry out at least *three* of these kinds of directions?	○	○	○	___
○ a. "Put the toy on the table." ○ d. "Find your coat."				
○ b. "Close the door." ○ e. "Take my hand."				
○ c. "Bring me a towel." ○ f. "Get your book."				
4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly *name* at least one picture?	○	○	○	___
5. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? *(Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?")* Please give an example of your child's word combinations:	○	○	○	___

COMMUNICATION *(continued)*

	YES	SOMETIMES	NOT YET	
_. Does your child correctly use at least two words like "me," "I," "mine," and "you"?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*	○	○	○	___
2. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? *(If your child already kicks a ball, mark "yes" for this item.)* 	○	○	○	___
3. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall. 	○	○	○	___
4. Does your child run fairly well, stopping herself without bumping into things or falling? 	○	○	○	___
5. Does your child jump with both feet leaving the floor at the same time? 	○	○	○	___
6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward? 	○	○	○	___*

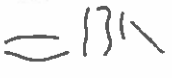
GROSS MOTOR TOTAL ___

**If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."*

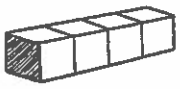
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?	○	○	○	___
2. Does your child turn the pages of a book by herself? *(She may turn more than one page at a time.)*	○	○	○	___
3. Does your child use a turning motion with his hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	○	○	○	___
4. Does your child flip switches off and on?	○	○	○	___
5. Does your child stack seven small blocks or toys on top of each other by herself? *(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)*	○	○	○	___
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? 	○	○	○	___
			FINE MOTOR TOTAL	___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in *any direction*? *(Mark "not yet" if your child scribbles back and forth.)* Count as "yes"  Count as "not yet" 	○	○	○	___
2. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? *(Do not show him how.) (You can use a soda-pop bottle or baby bottle.)*	○	○	○	___
3. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food?	○	○	○	___
4. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his bed, and dishes go in the kitchen?	○	○	○	___
5. If your child wants something she cannot reach, does she find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?	○	○	○	___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? *(You can also use spools of thread, small boxes, or other toys.)* 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child drink from a cup or glass, putting it down again with little spilling?	○	○	○	___
2. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	○	○	○	___
3. Does your child eat with a fork?	○	○	○	___
4. When playing with either a stuffed animal or a doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?	○	○	○	___
5. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?	○	○	○	___
6. Does your child call herself "I" or "me" more often than her own name? For example, "I do it," more often than "Juanita do it."	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain: ○ YES ○ NO

2. Do you think your child talks like other toddlers her age? If no, explain: ○ YES ○ NO

OVERALL *(continued)*

3. Can you understand most of what your child says? If no, explain: ○ YES ○ NO

4. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain: ○ YES ○ NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

6. Do you have any concerns about your child's vision? If yes, explain: ○ YES ○ NO

7. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

OVERALL *(continued)*

Do you have any concerns about your child's behavior? If yes, explain: ○ YES ○ NO

9. Does anything about your child worry you? If yes, explain: ○ YES ○ NO

ASQ-3 24 Month ASQ-3 Information Summary

23 months 0 days through 25 months 15 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	25.17		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	38.07		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	35.16		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	29.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	31.54		●	●	●	●	●	●	●	○	○	○	○	○	○

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1.	Hears well? Comments:	Yes	**NO**	6.	Concerns about vision? Comments:	**YES**	No
2.	Talks like other toddlers his age? Comments:	Yes	**NO**	7.	Any medical problems? Comments:	**YES**	No
3.	Understand most of what your child says? Comments:	Yes	**NO**	8.	Concerns about behavior? Comments:	**YES**	No
4.	Walks, runs, and climbs like other toddlers? Comments:	Yes	**NO**	9.	Other concerns? Comments:	**YES**	No
5.	Family history of hearing impairment? Comments:	**YES**	No				

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ▭ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▤ area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

___ No further action taken at this time

_____ Other (specify): _____

5. Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101240800

ASQ-3 Ages & Stages Questionnaires®

30 Month Questionnaire

28 months 16 days through 31 months 15 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:
◯ Male ◯ Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:
◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider
◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

Street address: _____

City: _____ State/ Province: _____ ZIP/ Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Parent Signature: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____

P101300100

ASQ-3

30 Month Questionnaire

28 months 16 days through 31 months 15 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly *name* at least one picture?	○	○	○	___
2. Without your giving him clues by pointing or using gestures, can your child carry out at least *three* of these kinds of directions?	○	○	○	___
○ a. "Put the toy on the table." ○ d. "Find your coat."				
○ b. "Close the door." ○ e. "Take my hand."				
○ c. "Bring me a towel." ○ f. "Get your book."				
3. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least *seven* body parts? *(She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.)*	○	○	○	___
4. Does your child make sentences that are three or four words long? Please give an example:	○	○	○	___
5. Without giving your child help by pointing or using gestures, ask him to "put the book *on* the table" and "put the shoe *under* the chair." Does your child carry out both of these directions correctly?	○	○	○	___
6. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture (for example, "barking," "running," "eating," or "crying")? You may ask, "What is the dog (or boy) doing?"	○	○	○	___

COMMUNICATION TOTAL ___

E101300200

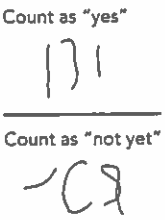
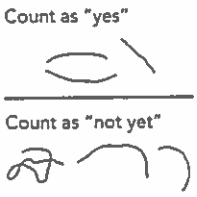
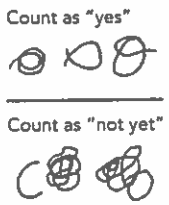
GROSS MOTOR

		YES	SOMETIMES	NOT YET	
1. Does your child run fairly well, stopping herself without bumping into things or falling?		○	○	○	___
2. Does your child walk either up or down at least two steps by himself? He may hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*		○	○	○	___
3. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?		○	○	○	___
Does your child jump with both feet leaving the floor at the same time?		○	○	○	___
5. Does your child walk up stairs, using only one foot on each stair? *(The left foot is on one step, and the right foot is on the next.)* She may hold onto the railing or wall.		○	○	○	___*
6. Does your child stand on one foot for about 1 second without holding onto anything?		○	○	○	___

GROSS MOTOR TOTAL ___

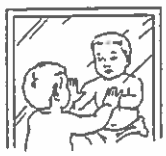
**If Gross Motor Item 5 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."*

FINE MOTOR

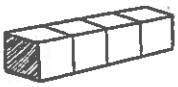
	YES	SOMETIMES	NOT YET	
. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	○	○	○	—
2. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction? 	○	○	○	—
3. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? 	○	○	○	—
4. After your child watches you draw a line from one side of the paper to the other side, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction? 	○	○	○	—
5. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle? 	○	○	○	—
6. Does your child turn pages in a book, one page at a time?	○	○	○	—

FINE MOTOR TOTAL —

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When looking in the mirror, ask, "Where is _____?" *(Use your child's name.)* Does your child point to her image in the mirror? 	○	○	○	—
2. If your child wants something he cannot reach, does he find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?	○	○	○	—

PROBLEM SOLVING (continued)

	YES	SOMETIMES	NOT YET	
3. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? *(You can also use spools of thread, small boxes, or other toys.)* 	○	○	○	___
4. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? *(Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.")* Please write your child's response here: 	○	○	○	___
5. When you say, "Say 'seven three,'" does your child repeat *just* the two numbers in the same order? *Do not repeat the numbers.* If necessary, try another pair of numbers and say, "Say 'eight two.'" Your child must repeat just one series of two numbers for you to answer "yes" to this question.	○	○	○	___
6. After your child draws a "picture," even a simple scribble, does she tell you what she drew? *(You may say, "Tell me about your picture," or ask, "What is this?" to prompt her.)*	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. If you do any of the following gestures, does your child copy at least one of them?	○	○	○	___
○ a. Open and close your mouth. ○ c. Pull on your earlobe.				
○ b. Blink your eyes. ○ d. Pat your cheek.				
2. Does your child use a spoon to feed himself with little spilling?	○	○	○	___
3. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if she cannot turn?	○	○	○	___
4. Does your child put on a coat, jacket, or shirt by himself?	○	○	○	___
5. After you put on loose-fitting pants around her feet, does your child pull them completely up to her waist?	○	○	○	___
6. When your child is looking in a mirror and you ask, "Who is in the mirror?" does he say either "me" or his own name?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

arents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain: ○ YES ○ NO

2. Do you think your child talks like other toddlers her age? If no, explain: ○ YES ○ NO

3. Can you understand most of what your child says? If no, explain: ○ YES ○ NO

4. Can other people understand most of what your child says? If no, explain: ○ YES ○ NO

5. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain: ○ YES ○ NO

6. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

OVERALL *(continued)*

7. Do you have any concerns about your child's vision? If yes, explain: ○ YES ○ NO

8. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

9. Do you have any concerns about your child's behavior? If yes, explain: ○ YES ○ NO

10. Does anything about your child worry you? If yes, explain: ○ YES ○ NO

ASQ-3 30 Month ASQ-3 Information Summary

28 months 16 days through 31 months 15 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	33.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	36.14		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	19.25		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	27.08		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	32.01		●	●	●	●	●	●	●	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Hears well? Yes **NO**
   Comments:
2. Talks like other toddlers his age? Yes **NO**
   Comments:
3. Understand most of what your child says? Yes **NO**
   Comments:
4. Others understand most of what your child says? Yes **NO**
   Comments:
5. Walks, runs, and climbs like other toddlers? Yes **NO**
   Comments:
6. Family history of hearing impairment? **YES** No
   Comments:
7. Concerns about vision? **YES** No
   Comments:
8. Any medical problems? **YES** No
   Comments:
9. Concerns about behavior? **YES** No
   Comments:
10. Other concerns? **YES** No
    Comments:

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ▭ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▤ area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

____ No further action taken at this time

_____ Other (specify): _____

5. Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101300800