

Educational Developmental Screening/Assessment

(Cover page – please attach original or copy of the screening/assessment)

Child's Name: _____ Unit: _____

Screening date: ____/____/____ Assessment date: ____/____/____

Completed by: Head Start Staff _____

LEA/ED Coop/Other _____

Domain	Score	Instrument Used	Results	Comments
Motor			No Concern Concern Monitor Re-test	
Cognitive/ Concepts			No Concern Concern Monitor Re-test	
Language			No Concern Concern Monitor Re-test	
Overall Development			No Concern Concern Monitor Re-test	

IEP date: ____/____/____ Primary Disability: _____

Attached: IEP
 Evaluations
 Determination of Eligibility

*Referral was made by Head Start Staff to determine eligibility for special education services: Yes No
If yes attach a copy of the SCCD, Inc. Developmental Screening Referral Form.

*Referral was made by LEA/ED Coop to determine eligibility for special education services: Yes No