SOLON SCHOOL DISTRICT

PRE-SCHOOL AND KINDERGARTEN SPEECH AND HEARING SURVEY

CHILD'S NAME _____ **DATE** _____

PARENT'S NAME _____ **PHONE** _____

Please check all the appropriate boxes below. You may make additional comments, if desired, on the back of this form.

YES	NO	HEARING
____	____	Child has history of ear infection(s). If so, approximate number_____ Treated by Dr. _____
____	____	Child complains of frequent earaches.
____	____	Child had "draining ears" and some liquid other than wax has been noted more than once in the outer ear.
____	____	Child may have a hearing problem.
____	____	Child has known hearing loss. If so, please describe on back.
____	____	Child turns up the TV louder than other members of the family.
____	____	Child makes you talk loudly or repeat frequently.

SPEECH AND LANGUAGE

____	____	Child has difficulty making and using **MANY** sounds.
____	____	Child has difficulty making and using a new sound. If possible, list examples on back.
____	____	Child speaks one or two words at a time and rarely uses complete sentences. May have difficulty with language structures.
____	____	Child becomes confused in following more than two verbal directions at a time.
____	____	Child has difficulty remembering things for a short time.
____	____	Child may have a voice problem: pitch, volume, rate, quality (hoarseness, harshness and nasality).
____	____	Child is not fluent - repeats, hesitates, prolongs sounds or grimaces during speech.
____	____	I would like to speak with the speech language and hearing therapist concerning my child's speech or language development.
____	____	Did your child attend pre-school? If so what school? _____