

Bentonville  
Early Childhood Special Education  
Preschool Screening Permission  
(479)254-5071 Fax (479)271-1123

Name of Child: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Additional Phone: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Child's native language: \_\_\_\_\_

Concern that warranted this request: \_\_\_\_\_

\_\_\_\_\_

Preschool attended: \_\_\_\_\_

Days attend: M T W TH F

Time: \_\_\_\_\_

I give ( ) do not give ( ) permission for you to share results with preschool/day care workers. Not applicable ( )

I give the Bentonville Early Childhood Special Education Program permission to screen my child. I understand that screening, evaluation, and treatment records will be disclosed by authorized personnel employed by this school district.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_