



**The Early Learning Coalition  
of Sarasota County**  
1750 17<sup>th</sup> Street, Building L, Sarasota, 34234  
Tel: (941) 954-4830 ext. 231

**Please mail or fax to:**  
Attn: Valerie Walton  
The Early Learning Coalition  
of Sarasota County  
1750 17<sup>th</sup> Street, Building L,  
Sarasota 34234  
Fax: 941-954-4831

**Screening Consent and Referral Information**

The Early Learning Coalition of Sarasota County offers an onsite developmental screening for children under the age of six years. This is a free service to the community and will be provided at your child's child care center. The purpose of this screening is to determine whether your child's development corresponds to what is typically expected for a child at his or her age. Areas that can be screened include: speech-language skills, fine motor skills (i.e., feeding, cutting, writing), gross motor skills (i.e., walking, running, posture, balance). The screening process involves an early childhood specialist who observes your child as he or she participates in daily activities and interacts with teachers and peers. The screening also involves the professional interacting with your child using various play-type activities in a routine manner. If you are interested in a screening for your child, please complete the form below. If a more complete assessment is indicated, a referral will be recommended.

**Referral Information**

Date of Referral \_\_\_\_\_

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Name of Child Care Provider & Director: \_\_\_\_\_

Child Care Address, City, Zip: \_\_\_\_\_

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

Teacher's name: \_\_\_\_\_

**Is your child receiving support for/from any of the following? (please initial)**

\_\_\_\_\_ Speech Therapy  
if yes, name of agency: \_\_\_\_\_

\_\_\_\_\_ Healthy Families participant

\_\_\_\_\_ Occupational Therapy  
if yes, name of agency: \_\_\_\_\_

\_\_\_\_\_ Children and Family Services  
if yes, name of Case Manager \_\_\_\_\_

\_\_\_\_\_ Physical Therapy  
if yes, name of agency: \_\_\_\_\_

\_\_\_\_\_ Mental Health Therapy  
if yes, name of agency: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_ City, St, Zip \_\_\_\_\_

Telephone # Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Reason for Screening Request: \_\_\_\_\_

**Consent & Release**

I, \_\_\_\_\_, the parent/guardian of \_\_\_\_\_, hereby authorize The Early Learning Coalition of Sarasota County to perform a developmental screening on my child at his/her child care center. I understand that I will be notified of the results, which are confidential. **My initials** below give permission for The Early Learning Coalition of Sarasota County to release a copy of the screening results to the child care director/teacher and if referred, to FDLRS (School Board), Early Steps or The Florida Center for Early Childhood Inc.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Initials