MADISON LOCAL SCHOOLS
SPEECH LANGUAGE AND HEARING SURVEY
KINDERGARTEN ONLY

Child's Name _______ Today's Date _____
Date of Birth _____

Parent's Name _____ Phone _______

PLEASE FILL IN APPROPRIATE AREAS:

HEARING

_____Tubes Dr. _____ When _____

_____Child has history of ear infections. If so, approximate number _____

_____Hearing Loss. Describe _____

SPEECH AND LANGUAGE

_____**Has received Speech services. Where** _____
When _____. **How Long?** _____

_____**Is now receiving speech services. Where** _____

_____Difficulty producing speech sounds. List examples _____

_____Omits words or word endings.

_____Doesn't use complete sentences.

_____Voice problem. Describe _____

_____Cleft palate and/or cleft lip. Describe Medical Treatment _____

_____.

_____Does your child presently stutter?

PLEASE ADD ANY ADDITIONAL COMMENTS: