Family Partnership Summary

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Child and Family Strengths

Parent/Guardian _____ Child _____

Entry Date _____ 45 days from entry _____ 90 days from entry _____

Child's Date of Birth _____ **EHS ONLY**: Date child turns 30 months old _____

Date	Child Strength	Date	Family Strength

Family Partnership Summary

Program Focus Areas

Family Name: _____

Code	Early Learning Program Focus Areas		
SR/C	Child School Readiness/Child	ES	Economic Stability
SR/F	Family School Readiness/Family	T	Transition
RC	Resiliency Conversation	DD/DIS	Developmental Delay/Disability
FE	Family Engagement		

Code	Health/Nutrition Required School Readiness Activities
CIS	**Immunization Record** ☐ Needs Complete Date: _____ ☐ Exempt
PN	**Prenatal/Postnatal Services (EHS)** ☐ Postpartum Maternal Depression Screening ☐ Prenatal Maternal Depression Screening ☐ Two Week Postpartum Nurse Visit
WCE	**Well Child Exams** ☐ 2 week ☐ 1 month ☐ 2 month ☐ 4 month ☐ 6 month ☐ 9 month ☐ 12 month ☐ 15/18 month ☐ 24 month ☐ 3 year ☐ 4 year ☐ 5 year
DE	**Dental Exams** Due _____ Received _____ Due _____ Received _____ Due _____ Received _____ Due _____ Received _____
Lead	**Lead Test** 12 Mo Date _____ Results _____ 24 Mo Date _____ Results _____ 3-5 yrs Date _____ Results _____
Hct/Hgb	**Hematocrit/Hemoglobin** ☐ 9-24 months Date _____ Results _____ ☐ 2-5 yrs Date _____ Results _____
H	**Sensory Hearing** Due _____ Received _____
V	**Sensory Vision** Due _____ Received _____

Code	Required School Readiness Activities
Ht/Wt	**Growth: Height/Weight** ☐ Fall ☐ Spring
DS	**Developmental Screen** (ASQ,ESI,DIAL) Due _____ Completed _____
BS	**Behavior Screen** (DECA, ASQ-SE) Due _____ Completed _____

As Needed			
D-Tx	Dental Treatment/Follow-up	CHP	Child Health Plan(s)
WCE-Tx	WCE Treatment/Follow-up	NU	Nutrition
DS-Tx	Developmental Screen/Follow-up	BS-Tx	Behavior Screen/Follow-up

Family Partnership Summary

Goals, Services, and Needs

Parent/Guardian _____ **Child Name:** _____

Date Identified by family/staff	Goals, Services, and Needs		Staff to Follow-up	Referral/ Service Date*	Initial Follow-up Date**	Date Complete or O=Ongoing
	1					
	2					
	3					
	4					
	5					
	6					
	7					
	8					
	9					
	10					
	11					
	12					
	13					
	14					
	15					
	16					
	17					
	18					

*Date of referral or service provided for parent/child.
**Date when staff checked in with family regarding quality or results of referral/service.