

INITIAL CONCERNS
 Parents / Carers

PUPIL INFORMATION			
Name		DoB	
Year Group		Class Teacher	
Home language			
Pre-school setting			
Previous school/s?			
Medical information			
Specialist services involved to date -Health -Education -Social Services			

Only give details of any strengths and concerns.

Language & Communication	
<ul style="list-style-type: none"> • Speech Sounds • Expressive • Receptive • Social and functional 	

Literacy	
<ul style="list-style-type: none"> • Phonics • High Frequency Words • Spelling • Reading • Writing 	

Number and calculation	
<ul style="list-style-type: none"> • Number recognition • Times tables • Shape • Time • Money • Calculations • Problem solving 	

Readiness for learning	
<ul style="list-style-type: none"> • Concentration • Memory • Co-operation • Independence • Engagement • Confidence • Self-esteem • Organisation • Self-control 	

Sensory	
<ul style="list-style-type: none"> • Sensory seeking • Sensory avoidance / overload • Visual Impairment • Hearing Impairment 	

Physical	
<ul style="list-style-type: none"> • Motor skills • Mobility • Continence 	

Other / Additional notes

Completed by:

Relationship to child:

Date: