











# Preschool Home Note

Student: \_\_\_\_\_

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

Teacher: \_\_\_\_\_

<p><b><u>Greeting Time</u></b></p>  <p> <input type="checkbox"/> I sat on my space  <input type="checkbox"/> I greeted my teaches &amp; friends  <input type="checkbox"/> I paid attention &amp; participated in Shared Reading  <input type="checkbox"/> I sang songs &amp; nursery rhymes  <input type="checkbox"/> I moved my body to music  <input type="checkbox"/> I followed 1-2 step directions  <input type="checkbox"/> I counted            Notes:         </p>	<p><b><u>Breakfast/Snack</u></b></p>  <p> <input type="checkbox"/> I sat at the table  <input type="checkbox"/> I opened my milk  <input type="checkbox"/> I used utensils  <input type="checkbox"/> I used my napkin  <input type="checkbox"/> I cleaned up  <input type="checkbox"/> I threw away my tray              I ate: <input type="checkbox"/> Well <input type="checkbox"/> Some <input type="checkbox"/> Nothing            Notes:         </p>	<p><b><u>Work Time</u></b></p>  <p>           I worked in the _____ area            I used _____            I worked on:  <input type="checkbox"/> fine motor skills  <input type="checkbox"/> language  <input type="checkbox"/> matching  <input type="checkbox"/> counting  <input type="checkbox"/> attending  <input type="checkbox"/> putting toys away  <input type="checkbox"/> playing with a friend            Notes:         </p>	<p><b><u>Lunch</u></b></p>  <p> <input type="checkbox"/> I sat at the table  <input type="checkbox"/> I opened my milk  <input type="checkbox"/> I used utensils  <input type="checkbox"/> I used my napkin  <input type="checkbox"/> I cleaned up  <input type="checkbox"/> I threw away my tray              I ate: <input type="checkbox"/> Well <input type="checkbox"/> Some <input type="checkbox"/> Nothing            Notes:         </p>	<p><b><u>Rest Time</u></b></p>  <p> <input type="checkbox"/> I slept  <input type="checkbox"/> I rested quietly  <input type="checkbox"/> I looked at a book  <input type="checkbox"/> I did a table activity            Notes:         </p>
<p><b><u>Bathroom</u></b></p>  <p> <input type="checkbox"/> I urinated <input type="checkbox"/> Had a B.M.  <input type="checkbox"/> I washed my hands  <input type="checkbox"/> I washed &amp; dried my hands  <input type="checkbox"/> I brushed my teeth              I requested bathroom by using:  <input type="checkbox"/> words <input type="checkbox"/> PECS <input type="checkbox"/> signs  <input type="checkbox"/> Augmentative Device              I had an accident:  <input type="checkbox"/> U <input type="checkbox"/> B.M.         </p>	<p><b><u>Transition Skills</u></b></p>  <p>           I transitioned with:  <input type="checkbox"/> Physical prompting  <input type="checkbox"/> Visual schedule  <input type="checkbox"/> Verbal direction  <input type="checkbox"/> Gestural prompting  <input type="checkbox"/> Independently            Notes:         </p>	<p><b><u>Communication</u></b></p>  <p> <input type="checkbox"/> I used a voice output device  <input type="checkbox"/> I used PECS  <input type="checkbox"/> I used gestures  <input type="checkbox"/> I used words  <input type="checkbox"/> I spoke in phrases  <input type="checkbox"/> I spoke in short sentences  <input type="checkbox"/> I had a conversation            I signed _____            Notes:         </p>	<p><b><u>Therapies</u></b></p>  <p> <input type="checkbox"/> I had Language  <input type="checkbox"/> I had speech  <input type="checkbox"/> I had in-class speech  <input type="checkbox"/> I had O.T.  <input type="checkbox"/> I had P.T.  <input type="checkbox"/> I had orientation &amp; mobility            Notes:         </p>	<p><b><u>General Mood</u></b></p>  <p> <input type="checkbox"/> I was happy  <input type="checkbox"/> I was upset  <input type="checkbox"/> I was frustrated  <input type="checkbox"/> I had a tantrum            Notes:         </p>

Other: \_\_\_\_\_

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