

EARLY CHILDHOOD READINESS

Name: _____

Colors - Identifies (I) or Names (N)

Date				
red				
blue				
green				
yellow				
orange				
purple				
black				
brown				
white				
pink				
gray				

Shapes - Identifies (I) or Names (N)

Date				
circle				
square				
rectangle				
triangle				
diamond				
oval				

Creates sets

Date				
3				
5				
8				
10				
15				

Rote Counts

Date				
1 to 3				
1 to 5				
1 to 10				
1 to 12				
1 to 15				

Scissors

Date				
Snips paper				
Cuts paper in half				
Cuts on line				
Cuts on curve				
Cuts circle				
Cuts triangle				

Completes puzzle

Date				
inlay				
3-piece				
5-piece				
7 piece				
11-piece				

Recites ABCs in correct sequence

Date				
abc				
a-g				
a-l				
a-p				
a-s				
a-v				
complete				

Directional Concepts

Date				
on				
in front of				
behind				
down				
up				
under				
over				
below				
around				

EARLY CHILDHOOD READINESS-2

Name: _____

Letter Recognition - Identifies (I) or Names (N)

Date												
A /	B /	C /	D /	E /	F /	G /	H /	I /	J /	K /	L /	M /
N /	O /	P /	Q /	R /	S /	T /	U /	V /	W /	X /	Y /	Z /
a /	b /	c /	d /	e /	f /	g /	h /	i /	j /	k /	l /	m /
n /	o /	p /	q /	r /	s /	t /	u /	v /	w /	x /	y /	z /

Number Recognition - Identifies (I) or Names (N)

Date																			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

Body Parts - Identifies (I) or Names (N)

Date									
head		wrist		ankle		hips		eyelashes	
nose		jaw		elbow		fingers		toes	
eyes		hair		eyebrow		chin		knees	
ears		stomach		arms		legs		cheeks	
mouth		back		chest		forehead		neck	

Phone Number:

Date			
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No

Birthday:

Date			
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No

Address:

Date			
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No