

Name: \_\_\_\_\_ Teacher: \_\_\_\_\_ Date: \_\_\_\_\_

Time of Year:      Beginning \_\_\_\_\_      Middle \_\_\_\_\_      End \_\_\_\_\_

# Class Summary Sheet

Child's Name	Word Parts	Beginning Sound	Letter Recognition	Word Knowledge	Listening Comprehension	Oral Counting	Number Identification
1.							
2.							
3.							
4.							
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19.							
20.							

**Notes:** \_\_\_\_\_  
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