Registration for Early Childhood Screening

GENERAL INFORMATION AND INSTRUCTIONS: Page one of the registration form must be completed by the child's parent/guardian. Page two is completed by school district personnel only. Please print or fill in electronically.

Child's Legal Name: (First, Middle, Last): _____

Child's Nickname or Other Name (First, Middle, Last): _____

Child's Birth Date: _____ **Gender: Male** _____ **Female** _____

Parent/Guardian: _____ **Phone:** _____ **P.O. Box**: _____

Address: _____

City: _____ **State:** _____ **Zip**: _____

Parent/Guardian: _____ **Phone:** _____ **P.O. Box**: _____

Address: _____

City: _____ **State:** _____ **Zip**: _____

Please complete the state race/ethnicity question below: American Indian: Person having origins in any of the original peoples of North America and maintains cultural identification through tribal affiliation or community recognition. (choose ONE)

_____ NO, not American Indian _____ YES, American Indian

Please complete the federal race/ethnicity questions below. You may choose more than one answer in Part B. See top of page two for specifics on how to complete this section.

***Part A – Is the child Hispanic/Latino?** (choose ONE)

_____ NO, not Hispanic/Latino _____ YES, Hispanic/Latino

***Part B – What is your child's race?** (choose all that apply)

_____ American Indian/Alaska Native _____ Asian _____ Black/African American

_____ Native Hawaiian/Pacific Islander _____ White

PRIMARY/SECONDARY LANGUAGE INFORMATION

Which language did your child learn first? _____ English Other (specify) _____

Which language is most often spoken in your home? _____ English Other (specify) _____

Which language does your child usually speak? _____ English Other (specify) _____

PREVIOUS HEALTH AND DEVELOPMENTAL SCREENING INFORMATION

Has your child received comprehensive health and developmental screening as a preschooler (3-5-years-old)?

_____ YES _____ NO If yes, screening dates: _____ Location: _____

Has your child ever been evaluated for special education or ever received special education services through an Individual Education Program (IEP) or Individual Family Education Plan (IFSP)?

_____ YES _____ NO

PARENT/GUARDIAN VERIFICATION OF INFORMATION

I hereby verify that the above information is true and current to the best of my knowledge.

_____

Parent/Guardian Signature **Date**

Instructions and definitions for Part A and Part B race/ethnicity questions
The question for Part A is about ethnicity, not race. No matter what is selected in Part A, have the parent continue to answer the question in Part B indicating the child's race by marking one or more boxes.

American Indian or Alaska Native – Person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian – Person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Black or African American – Person having origins in any of the black racial groups of Africa.

Hispanic/Latino – A person of Cuban, Mexican, Puerto Rican, South or Central America or other Spanish culture of origin, regardless of race.

Native Hawaiian or Other Pacific Islander - Person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

White - Person having origins in any of the original peoples of Europe, the Middle East or North Africa.

TO BE COMPLETED BY SCHOOL DISTRICT PERSONNEL ONLY

Screening District Number and Type: _____

Screening Date: _____ Screening District Name: _____

Child's Resident District Name: _____

Resident Screening District Number and Type: _____

MARSS ID Number: _____

Check type of screening child received – STATE AID CATEGORY (SAC)
(To be completed by the Early Childhood Screening Coordinator)

___ 41 - Screening by District
___ 42 - Child and Teen Checkups/EPSDT
___ 43 - Head Start
___ 44 - Private Provider
___ 45 - Conscientious Objector, no screening

Check the **Primary** type of referral following the early childhood health and developmental screening using STATUS END CODES (SEC). Only one box may be checked. Must have a valid SEC for – STATE AID CATEGORY (SAC) 41. If unsure of referral status for SAC 42-44, use "no referral" SEC 60. **(To be completed by the Early Childhood Screening Coordinator.)**

Status End Codes:

___ 60 - No referral
___ 61 - Referral to special education
___ 62 - Referral to health care provider
___ 63 - Referral to special education AND health care provider
___ 64 - Referral to early childhood programs*

*(*School Readiness, Head Start, Early Childhood Family Education, family literacy)*

____ 65 – Referral offered, parent declined
____ 66 - Rescreen planned

SCHOOL DISTRICT VERIFICATION OF INFORMATION
I hereby verify that the above information is true and current to the best of my knowledge.

_____ _____
School District Early Childhood Screening Coordinator Signature Date

Early Childhood Screening Consent

Child's Name: _____ Birthdate:_____
(For office use only)
MARSS other ID: _____ Parent/Guardian Name(s): _____

Early childhood developmental screening helps a school district identify children who may benefit from district and community resources available to help in their development. Early childhood developmental screening includes a vision screening that helps detect potential eye problems, but is not a substitute for a comprehensive eye exam. This screening does not replace on-going care from your health care provider or dentist.

A. This Screening includes:

- Review of your child's immunization record
- Check of your child's growth, such as height and weight
- Tests for possible hearing problems
- Tests for eye health, including how well your child can see
- Review of any other factors that might interfere with your child's health, growth, development or learning
- Check of your child's development
- Your report of your child's growth and learning
- Information about your child's health care and insurance
- Information about community resources and programs based on your child's or family's needs

B. If this screening is a Child and Teen Checkup, Head Start, or other equivalent screening it may also include:

- Check of your child's present, past, or other family health
- Check of your child's pulse, respirations and blood pressure
- Unclothed physical screening of your child's skin, head, eyes, ears, nose, throat, mouth, neck, chest, heart, lungs, abdomen, genitals, arms, legs, spine, and muscles
- Check of your child's teeth, gums, and mouth
- Test for exposure to tuberculosis
- Urine test for possible problems
- Blood test for anemia
- Blood test for lead
- Other

Child and Parent Rights, Obligations, and Assurances

1. The standards for screening are the same for every child regardless of race, income, creed, sex, national origin, or political beliefs.
2. Screening is required for your child's entry into public school kindergarten or first grade. You can also meet this requirement if your child has participated in a screening in the past year through Head Start, Child and Teen Checkups, or an equivalent developmental screening through another health provider that includes all required early childhood screening components. You or your provider will need to give summary results of the equivalent to your child's school district.
3. Screening is not required for your child's entry into kindergarten or first grade if you are a conscientious objector to screening. You will need to provide a written statement to your child's school district that documents your conscientious objector status.
4. You have the right to refuse to answer questions or provide information and still receive the rest of the required screening components.
5. You have the right to refuse referral for assessment, diagnosis, and possible treatment for your child.
6. Your child's medical assistance eligibility or eligibility in any other health, education, or social service programs will not be affected if you refuse this screening or any parts of this screening.

I give permission for the Child Health and Development Screening checked below for:

Child's Name:_____
Check One:
____***Complete screening as described above in A and B***
____***Screening described above except:*** _____

Parent/Guardian Signature _____Date _____Relationship to Child _____

REV: 11/2016

Early Childhood Screening Release of Information

Child's Name: _____ Birthdate: _____
(For office use only)
MARSS other ID: _____ Parent/Guardian Name(s): _____

_____(This organization) uses information from the Child Health and Developmental Screening to identify any possible problems that might interfere with your child's health, growth, development or learning. Under Minnesota law, screening results are classified as private data. This means the results cannot be released or discussed with anyone without your consent. If you refuse to release this information, it will not affect your child's eligibility for medical assistance or any other health, education, or social service program. Summary data about groups of children that does not include information about individual children may be shared without consent.

Information from Your Child's Screening May be Used for the Following Purposes:

1. To obtain follow-up services for your child after the screening, if you choose to participate.
2. To arrange for further evaluation or assessment of your child's health, growth, development, or learning, if you choose to participate.
3. To fulfill the requirements for your child's entrance into public school or Early Learning Scholarship, School Readiness or Voluntary Pre-Kindergarten programs.
4. To evaluate screening programs by the Minnesota Departments of Education, Health and Human Services. Your child's name will not be identified in any evaluation results.
5. To develop appropriate educational programs to meet student needs and to design appropriate health education programs for the district.
6. To plan for early childhood programs and school entry.
7. To provide access to and accountability for government funds paid to the local school district for providing required early childhood screening services.

Your signature indicates that you have read, understand and agree that the information can be used as stated above.

CONSENT TO RELEASE INFORMATION

I hereby authorize release of my child's screening information to the following checked programs or services for the purpose of evaluation, assessment, diagnosis, follow-up and /or programming. (Please provide names and addresses where available).

Check any persons/agencies that you wish to receive screening information about your child.

__ Child Care provider _____
__ Dentist (Name) _____
__ Early Childhood Family Education (ECFE) _____
__ Early Childhood Special Education _____
__ Follow Along Program _____
__ Head Start (Name) _____
__ Health Care Provider (Medical Clinic) _____
__ Interagency Early Intervention Committee (IEIC) _____
__ Mental Health Agency _____
__ Public Health Agency (WIC) _____
__ School District (Name) _____
__ School Readiness _____
__ Other (regionally specific programs) _____

_____ **Understand Information** _____ **Authorize release of information**

Parent/Guardian Signature: _____ Date: _____ Relationship to Child: _____

REV: 11/2016

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Child Information Form

Early Childhood Screening is a chance to learn about your child's health and development and get community resources before kindergarten. Completion of this form is voluntary. Declining to answer any questions will not prevent your child from enrolling in kindergarten. Please complete all forms before your screening appointment and bring them with you. Thank you!

Child's Full Name_____ Date of Birth _____ ☐ Male ☐ Female

Parent's Name _____ Phone (home) _____

Phone (cell) _____ Phone (work) _____

Address _____ Language(s) spoken in the home_____

City & Zip _____ _____

Please list all persons living in the home, including adults, child being screened and other children:

First and Last Name	Relationship to Child	Birthdate	Male or Female

Have there been recent situational or environmental changes in your child's life? Please check all that apply.

☐ Divorce/separation ☐ New baby ☐ Moved to new residence ☐ Change in guardianship ☐ Other_____

Please detail any information that you want screening staff to know about your family's cultural background and heritage (language, traditions) that might make a difference in the assessment of learning and/or behavior. _____

_____

Check the boxes if you or your child use:

☐ Early Childhood Family Education
☐ Preschool -Name: _____
☐ Childcare -Name: _____
☐ Head Start
☐ Adult Basic Education
☐ Child and Teen Checkups
☐ Follow-Along Program
☐ WIC
☐ Parenting Education

Describe your child's strengths:_____

What are your main concerns for your child? Please check all that apply.

☐ Gross Motor (balance, coordination, running , walking)
☐ Fine Motor (writing, cutting, stacking blocks)
☐ Adapting to changes in routine/environment
☐ Behavior (tantrums, aggression)
☐ Pre-Academics (counting, naming colors/shapes/letters)
☐ Speech/Language
☐ Attention/Hyperactivity
☐ Social Interactions
☐ Self Help (eating, dressing, toileting)
☐ Other_____

Check the boxes if you have questions, concerns, or want information about:

☐ child care
☐ discipline
☐ sleep issues
☐ seat belts/car seats
☐ crying/whining
☐ nutrition/eating habits
☐ child development
☐ kindergarten/school
☐ bike/sports helmets
☐ TV watching
☐ toilet training
☐ family relationships
☐ personal safety
☐ gun safety

Other questions or concerns: _____

Turn Page

Check all boxes that describe your child:

- ☐ Says numbers from 1 to 10
- ☐ Copies a circle or other shapes
- ☐ Follows two-step verbal directions
- ☐ Prints first name or part of it
- ☐ Understands "one", gives you just one when asked
- ☐ Can feed self independently, using utensils
- ☐ Plays in a variety of ways
- ☐ Knows how many fingers are on each hand
- ☐ Compares things, for example, says "This one is bigger, etc."
- ☐ Can hold and use markers, pencils, scissors
- ☐ Has balance and control when walking, hopping, running
- ☐ Has trouble sitting still
- ☐ Seems quiet/withdrawn
- ☐ Has unusual fear of _____
- ☐ Has difficulty forming good relationships with peers/adults
- ☐ Acts much younger than age
- ☐ Seldom plays with other children
- ☐ Seems unhappy, cries, whines
- ☐ Seems more active than other children his/her age
- ☐ Seems bothered by certain textures; e.g. food, clothing

Check the frequency that best describes your child in the areas below:

Hits or takes toys from others
☐ seldom/never ☐ sometimes ☐ usually/always

Has trouble paying attention
☐ seldom/never ☐ sometimes ☐ usually/always

Seems overly aggressive
☐ seldom/never ☐ sometimes ☐ usually/always

Clings or gets very upset when leaving parent/caregiver
☐ seldom/never ☐ sometimes ☐ usually/always

Prefers to play alone rather than with other children
☐ seldom/never ☐ sometimes ☐ usually/always

Has difficulty in switching activities or places
☐ seldom/never ☐ sometimes ☐ usually/always

Only likes certain foods; e.g. picky eater, unusual combinations
☐ seldom/never ☐ sometimes ☐ usually/always

Uses toys in unusual ways; e.g. lines up toys rather than playing with them
☐ seldom/never ☐ sometimes ☐ usually/always

Destroys or damages things on purpose
☐ seldom/never ☐ sometimes ☐ usually/always

Has specific interest or behavior that preoccupies or is unusual in its intensity
☐ seldom/never ☐ sometimes ☐ usually/always

When your child becomes very frustrated or upset, what does he/she do?
☐ Cries ☐ Screams ☐ Hits others ☐ Hits self ☐ Pushes ☐ Other _____
Length of outbursts: ☐ Less than 15 minutes ☐ 15 to 45 minutes ☐ 45 minutes or longer
Frequency of outbursts: ☐ Daily ☐ Weekly ☐ Monthly

I have concerns about my child's speech or language development. ☐ Yes ☐ No
If yes, please explain:_____
_____
_____
Estimated percentage of child's language you can understand: _____% Comments:_____

I have been and/or am currently concerned about my child's development. ☐ Yes ☐ No
If yes, please explain:_____
_____
_____

Child Safety Issues:
When traveling in a car/vehicle, how often is your child in federally approved child safety seat? ☐ Never ☐ Usually ☐ Always

Does your child wear a safety helmet when biking ? ☐ Yes ☐ No ☐ My child does not ride a bicycle or tricycle

Do you have any guns in your home? ☐ Yes ☐ No If Yes, are the guns locked? ☐ Yes ☐ No

Please check if your child is (or has been) exposed to: ☐ Second-hand smoke ☐ Violence ☐ Street drugs ☐ Unsafe conditions
Comments:_____

Signature of Parent/Guardian: _____ **Date:** _____

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Medical Health History Form

The following information is helpful for the Health Care Specialist to provide improved medical services to the students of Spring Lake Park Schools. The health information provided will be confidentially shared with staff to assist in educational planning. It will be kept on file in your child's health record. Completion of this form is voluntary.

Child's Full Name_____ Date of Birth _____ ☐ Male ☐ Female

HEALTH INSURANCE/HEALTH CARE INFORMATION

Do you have health insurance for your child? ☐ Yes ☐ No Insurance plan name: _____

Is your child on Medical Assistance? ☐ Yes ☐ No

How often does your child see: a health care provider? _____ a dentist? _____

Date of last well-child check-up: _____ Date of last dental visit: _____

Indicate which if the following your child has had or currently has. Check all boxes that apply:

☐ Allergies	☐ Cancer	☐ Hyperactivity/Attention Deficit Disorder	☐ Vision/Eye Concerns
☐ Asthma	☐ Diabetes	☐ Learning Disability	☐ Other (list)
☐ Autism/ASD	☐ Headaches	☐ Mental Illness	_____
☐ Bleeding Disorder	☐ Heart Conditions	☐ Seizures	
☐ Bowel/Bladder Concerns	☐ Hearing/Ear Concerns	☐ Skin Conditions	

Please explain all checked conditions: _____

_____

_____

My child is allergic to _____ Is an Epi pen required? ☐ Yes ☐ No

List all medications your child is currently taking: _____

_____

If your child had a severe reaction requiring emergency medical attention, please explain: _____

_____

Please indicate any other significant medical history and/or past illnesses (e.g. injuries, surgeries, hospitalizations): _____

_____

Does your child have any physical limitations that may affect his/her performance in school? ☐ Yes ☐ No

If yes, please explain:_____

_____

I understand the information that I have given is correct to the best of my knowledge and it is my responsibility to inform the school's Health Care Specialist of any changes in my child's medical status.

Parent Signature: _____ Date: _____

Early Childhood Immunization Form

*Must be on file **before** a child attends any early childhood programs**

Name _____

Birthdate _____

Date of Enrollment _____

Minnesota law requires children enrolled in early education programs to be immunized against certain diseases or file a legal medical or conscientious exemption.

*Early childhood programs are defined as programs that provide instructional or other services to support children's learning and development and:
- Serve children from birth to kindergarten.
- Meet at least once a week for at least six weeks or more during the year.

This includes but not limited to early childhood family education (ECFE), early childhood special education (ECSE), school readiness programs, and other public and private preschool and pre-kindergarten programs.

Parent/Guardian:
You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

Additionally, if a parent or guardian would like to give permission to the early education program to share their child's immunization record with Minnesota's immunization information system, they may sign section 3 (optional).

For updated copies of your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

Type of Vaccine DO NOT USE (✓) or (×)	**1st Dose** Mo/Day/Yr	**2nd Dose** Mo/Day/Yr	**3rd Dose** Mo/Day/Yr	**4th Dose** Mo/Day/Yr	**5th Dose** Mo/Day/Yr
Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)					
Diphtheria, Tetanus, and Pertussis (DTaP, DTP) • 3 doses during 1st year *(at 2-month intervals)* • 4th dose at 12-18 months • 5th dose at 4-6 years *Indicate vaccine type: DTaP or DTP*					5th dose not required if 4th dose was given on or after the 4th birthday
Polio (IPV, OPV) • 2 doses in the first year • 3rd dose by 18 months • 4th dose at 4-6 years			4th dose not required if 3rd dose was given on or after the 4th birthday		
Measles, Mumps, and Rubella (MMR) • Required for children 15 months and older • 1st dose on or after 1st birthday • 2nd dose at 4-6 years					
***Haemophilus influenzae* type b (Hib)** • 2-3 doses in the first year • 1 dose required after 12 months or older • For unvaccinated children 15-59 months, 1 dose is required • Not required for children 5 years or older					
Varicella (chickenpox) • Required for children 15 months and older • 1st dose on or after 1st birthday • 2nd dose at 4-6 years					
Pneumococcal Conjugate Vaccine (PCV) • Required for children age 2 - 24 months • 3 doses in the first year • 4th dose after 12 months • At least 1 dose is recommended for children age 24-59 months in child care					
Hepatitis B (hep B) • 2-3 doses in the first year • 3rd dose (final dose) by 18 months					
Hepatitis A (hep A) • 2 doses separated by 6 months for children 12 months and older					
Recommended					
Rotavirus (2-3 doses between 2 and 6 months)					
Influenza (annually for children 6 months or older)					

Name _____

Instructions, please complete:
Box 1 to certify the child's immunization status
Box 2 to file an exemption (medical or concientious)
Box 3 to provide consent to share immunization information (optional)

1. Certify Immunization Status. Complete A or B to indicate child's immunization status.

A. Children who are 15 months or older:
For children who are 15 months or older and who have received all the immunizations required by law for early childhood programs:

I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.

_____
Signature of Parent / Guardian OR Physician / Nurse Practitioner / Physician Assistant / Public Clinic

_____ Date

B. Children who are younger than 15 months:
For children who are younger than 15 months OR have not received all required immunizations:

I certify that the above-named child has received the immunizations indicated. In order to remain enrolled this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:

_____
Signature of Physician / Nurse Practitioner / Physician Assistant / Public Clinic

_____ Date

2. Exemptions to Immunization Law. Complete A and/or B to indicate type of exemption.

A. Medical exemption:
No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:

I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

_____
Signature of physician/nurse practitioner/physician assistant

_____ Date

*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in _____ (year)

_____
Signature of physician/nurse practitioner/physician assistant (If disease occured before September 2010, a parent can sign.)

B. Conscientious exemption:
No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:

I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):

_____
Signature of parent or legal guardian

_____ Date

Subscribed and sworn to before me this:
_____ day of _____ 20_____

_____
Signature of notary (A copy of the notarized statement will be forwarded to the commissioner of health.)

3. Parental/Guardian Consent to Share Immunization Information (optional):

Your child's early childhood program is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect children from disease and allow easier access for you to retrieve your child's immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.

I agree to allow early childhood program personnel to share my child's immunization documentation with Minnesota's immunization information system:

_____
Signature of parent or legal guardian Date

Developed by the Minnesota Department of Health - Immunization Program www.health.state.mn.us/immunize (12/13)