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

Parent Consent
Child Health & Developmental Screening

Child's Name:	Birth Date:	*(For office use)* *Child's MARSS ID or Record No.*
Parent's Name		

A. This screening includes:

- ❖ Review of your child's immunization record
- ❖ Check of your child's growth, such as height & 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 on 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 Checkups, 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 tests for possible problems
- ❖ Blood test for anemia
- ❖ Blood test for lead
- ❖ Other: _____

This screening <u>does not</u> replace on-going care from your health care provider or dentist.

<u>Child and Parent Rights, Obligations, and Assurances</u>

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. This requirement is met if your child has participated in a screening through Head Start, Child and Teen Checkups, or equivalent screening through another provider that includes all required ECS components within the past year. The screening summary results must be given 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.
4. You have the right to refuse any of this screening for your child and still receive any of the other screening parts.
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 & Developmental Screening checked below for _____
(Child's Name)

Check one (√)

ـ Complete screening as described above in A & B above.

ـ Screening described above except: _____

Parent/Guardian Signature	Date	Relationship to child

MINNESOTA DEPARTMENT OF HEALTH MDH Department of Education

Revised 8/2006

INFORMATION COLLECTION, USE AND RELEASE CONSENT
CHILD HEALTH & DEVELOPMENT SCREENING

Child's Name	Birth Date	(For office use) Child's MARSS ID or Record No.
Parent/Guardian's Name		

_____(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. 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.

Information may be used for the following purposes:

1. To obtain follow-up services for your child after the screening.
2. To arrange for further evaluation or assessment of your child's health, growth, development, or learning.
3. To fulfill the requirements for your child's entrance into public school.
4. To evaluate screening programs by the Minnesota Department of Health, Minnesota Department of Education, and/or the Department of Human Services. Your child's name will not be identified in any evaluation results.

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 (v) 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 (Medicare 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

MINNESOTA MDH DEPARTMENT OF HEALTH Department of Education

Revised 08/17/06

CHILD HEALTH AND DEVELOPMENTAL HISTORY (3-6 YEARS)

Child's Name:_____ ☐M ☐F Birthdate: _____ Age _____
(For office use only)
MARSS other ID: _____ Languages spoken at home:_____

Parent/Guardian Name(s): _____

Person completing form: _____ Date: _____

How often does your child see a doctor or nurse? _____ Date of last well child visit: _____

How often does your child see a dentist? _____ Date of last dental check-up: _____

Date of your child's most recent comprehensive vision (eye) exam, if your child received one: _____
The comprehensive vision exam is performed by an optometrist or ophthalmologist.

Does your child have health insurance? _____Yes _____No _____Applied

Please check the boxes if you or your child use, if any:

_____Early Childhood Family Education	_____Child & Teen Check-ups	_____Child care center
_____Early Childhood Special Education	_____School-based pre-K	_____Family/neighbor care
_____Follow Along program	_____ Private preschool	_____Library
_____Parenting Education	_____Head Start	_____WIC
_____Parks and Recreation programs	_____ Foster Care	_____Food shelf

HEALTH

Please check any concerns that apply to your child and describe:

☐ Allergies: ☐food ☐medicine ☐animals/insect ☐dust/mold ☐seasonal _____

☐ Takes medicines, herbs and/or vitamins: _____

☐ Visits to health specialist(s), hospital stays and/or surgeries: _____

☐ Serious injuries or illnesses, visit to Emergency Room. Reason and date: _____

☐ Head injuries (loss of consciousness?)_____

☐ Lead poisoning, level if known: _____

☐ Trouble breathing, coughing or asthma:_____

☐ Skin problems or rashes:_____

☐ Seizures, staring spells:_____

☐ Vision problem or wears glasses: _____

☐ Ear (PE) tubes or hearing problems: _____

☐ Teeth: one or more cavities: _____

☐ Eating, stomach concerns or constipation: _____

☐ Mental health concerns such as anxiety, depression or attention concerns? _____

☐ Adopted, if Yes, at what age: _____

☐ Problems during pregnancy or birth?_____

☐ Born more than three weeks early or late ____# weeks at birth. Child's birth weight: _____

☐ At birth, stayed in the hospital longer than mother, reason: _____

☐ Is it possible that before you knew you were pregnant you took medications, alcohol, cigarettes, or street drugs? _____

_____Please list any other concerns: _____

_____

Please check any Family Health problems (child's parents or siblings):

☐ Attention problems	☐ Vision problems	☐ Diabetes
☐ Allergy	☐ Learning Problems	☐ Growth Problems
☐ Asthma	☐ Mental Health Disorders	☐ Epilepsy/Seizures
☐ Deafness/Hearing	☐ Sickle Cell Anemia/Trait	☐ Other health problems

CHILD'S DAILY ROUTINES

_____Sleeps at___ pm. Wakes up at____am.

☐ Has difficulty falling/staying asleep

☐ Takes a nap: from ____to____

☐ Gets 60 minutes or more of exercise each day

☐ Is NOT able to/does NOT get 60 minutes of exercise

_____TV/Video Game/Screen Time: hours per day

Every day eats some foods from the food groups:

☐ 5-9 servings fruits/vegetables: oranges, apples, bananas, mangos, berries, spinach, corn, peas

☐ 3 servings calcium rich foods: milk, cheese, yogurt, soymilk, tofu

☐ 2-3 serving iron rich foods: fish, poultry, meat, beans, legumes, eggs

☐ 3 or more servings: whole grains: whole wheat bread, cereal, brown rice, tortillas, crackers, pasta

☐ More than one serving of sweets, fruit drinks or junk food each day

In the past 12 months, we worried whether our food would run out before we could buy more ○yes ○ no

In the past 12 months, the food we bought didn't last and we didn't have money to get more ○yes ◉no

HOME SAFETY

Current housing situation:

__◉__ renting or homeowner __○__ with friends or family __○__ hotel or motel

__○__ emergency shelter/transitional housing

Does your child live or play in a home or building built before: ☐ 1978 ☐ remodeled in last 5 years?

Does anyone at home or who cares for your child: ☐ use tobacco/smoke ☐ use alcohol ☐ have a gun

Do you have concerns that your child is exposed to: ☐ violence ☐ street drugs ☐ unsafe conditions

Do you and /or your child use/have the following:

☐ car seats ☐ bike helmets ☐ smoke detector ☐ carbon monoxide detector

LEARNING

☐ My child learned to do things at the same age as other children (sit, stand, walk, toilet trained, etc.)

If not, please explain:_____

My child needs help with: ☐ toileting ☐ activity/mobility ☐ dressing ☐ nutrition/eating

Other:_____

Please check any of the following:

☐ Says numbers 1 to 10

☐ Has trouble speaking or hard to understand

☐ Has trouble being understood by others

☐ Seems clumsy when using hands

☐ understands other people

☐ Able to follow directions

☐ Plays in a variety of ways

☐ Walks or runs poorly (falls)

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 (x)	**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