

Dear Richfield Family,

We are happy to welcome you to Richfield Public Schools and Early Childhood Screening. After you complete the scheduling process online, you will receive a confirmation email. A reminder email will be sent when your date is nearing.

What

Children are screened by trained professionals. Your child will be checked in four areas: social/emotional, motor skills, concepts, and communication skills. Most children enjoy the activities and attention. This is not an IQ test. Following screening, a teacher will talk with you about your child's results. The screening process takes about 55 minutes. For the most accurate results, it is best if parents are not in the same room as the child. Parents can be close by and can accompany a child if necessary. Please prepare your child for this before screening. Unfortunately, we cannot provide childcare for siblings. Please do not bring siblings to the screening appointment, but do bring all required forms available online.

Why

Screening helps you help your child get ready for school! You'll have the opportunity to discuss any concerns you may have about your child's development. The teacher may refer you and your child to another agency to be rechecked or to receive services that will help your child.

Where

Screening takes place at Central Education Center, 7145 Harriet Ave. South, Richfield, Minnesota. If you have questions or need help scheduling, please call (612) 243-3048 or email at ecscreening@rpsmn.org. Central Education Center, 7145 Harriet Ave. South, Door 5, Room 400, Richfield, MN 55423



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

___ 44 - Private Provider

___ 42 - Child and Teen Checkups/EPSTD

___ 43 - Head Start

___ 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

___ 64 - Referral to early childhood programs*

___ 61 - Referral to special education

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

___ 62 - Referral to health care provider

___ 65 – Referral offered, parent declined

___ 63 - Referral to special education AND health care provider

___ 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

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.

Gets 60 minutes or more of exercise each day

Has difficulty falling/staying asleep

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

Takes a nap: from ____ to ____

____ 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(use safety lock)

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 (Help to eat Oranges? Milk?)

Other: _____

Please check any of the following:

Says numbers 1 to 10	Understands other people
Has trouble speaking or is hard to understand	Able to follow directions
Has trouble being understood by others	Plays in a variety of ways
Seems clumsy when using hands	Walks or runs poorly (falls)