

Series Number 501.3.2.1P Adopted April 1994 Revised June 2019

Title Child History Questionnaire

**Early Childhood Health
and Developmental Screening**
(Required before school entrance)

Bring a copy of your child's birth certificate to their Early Childhood Screening appointment.

Dear Parent/Guardian:

To help ensure success in school, the State of Minnesota requires all children entering public school be screened before entering kindergarten (or before entering first grade, if your child did not attend kindergarten). The law encourages parents/guardians to have their child screened prior to their fourth birthday. The screening may be done by District 196, another school district or by a public or private health care provider or organization. Your child need not be screened by District 196 if the child has received comparable screening by another provider or organization within the preceding year and those records are submitted to the District 196 not later than 30 days after your child first attends public school.

To make sure your child is screened, District 196 has scheduled an appointment for you. Please call us if you do not wish to keep this appointment or wish to reschedule it. All children residing in the district are welcome to come through screening even if they will attend a nonpublic school. There is no charge for Early Childhood Screening.

Early Childhood Screening is a careful review and check of your child's health, well-being and development. Together parents and professionals identify strengths and areas that may require special attention before your child enters school. The screeners do not recommend whether your child is ready for kindergarten. At the end of the screening, a staff person will conduct a summary interview and address any concerns you have regarding your child's health or development. You will have the opportunity to be with your child the entire time and you will receive a copy of the screening results. All information will remain private. The screening process takes approximately 60 minutes.

We have scheduled the following appointment for your child to attend the district's screening. Please call to reschedule if this time does not work for you or if your child has already been screened.

Day

Date

Time

Place

**Independent School District 196 - District Service Center
14301 Diamond Path, Apple Valley, MN 55124 (see map on back)**

To cancel or change your appointment, contact the Early Childhood Screening Office at www.district196.org/ecscreening-signup, ecscreening@district196.org or 651-423-7899. Please reschedule your appointment if your child has a communicable disease such as chicken pox, "pink-eye," strep-throat, impetigo, etc.

We suggest that you do not bring other children with you to the screening appointment.

NOTE TO PARENTS: Please complete the remainder of this form and bring it with you to your child's appointment. The information will help us provide your child with a comprehensive health and developmental screening. Completion of this form is optional. You may also decline to answer questions or provide information about family circumstances that might affect development and identification of risk factors that may influence learning. Declining to answer such questions or provide such information will not prevent your child from enrolling in school if all other screening components are met. The information collected on this form and in the screening will be used for screening purposes by District 196 employees and agents with responsibilities related to the screening program. It may also be shared with the Department of Education, or as otherwise authorized by law. You are not required to provide requested information, however your refusal may prevent the district from completing the mandatory screening. Early Childhood Screening is not a substitute for ongoing health care from your family physician, dentist or other health care providers.

GENERAL AND FAMILY INFORMATION

Person completing form _____ Date completed _____

Child _____ Sex _____ Birthdate _____
last first middle

Address _____ Home # () _____
street city zip

1st Head of Household _____ Relationship to child biological adoptive
 stepparent legal guardian

Job _____ Work # () _____

2nd Head of Household _____ Relationship to child biological adoptive
 stepparent legal guardian

Job _____ Work # () _____

Language(s) spoken in the home ⁽¹⁾ _____ ⁽²⁾ _____ ⁽³⁾ _____

For parents with adopted children (Biological and genetic factors can contribute to development. In a thorough screening it is important to factor in biological information if problems are found.)

Child's age when adopted _____ U.S. born Foreign born (specify) _____

How long has your child been in the U.S.? _____

Please add any comments that may be helpful. _____

Family members (adults and children) and other people who live in the same household.

Name	Relationship to Child	Age

Please check the box(es) if you have concerns or questions about your child's . . .

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Growth | <input type="checkbox"/> Eyes/vision | <input type="checkbox"/> Teeth | <input type="checkbox"/> Skin/bruising/rashes |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Wearing glasses | <input type="checkbox"/> Breathing/coughing | <input type="checkbox"/> Friends/social skills |
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Ears/hearing | <input type="checkbox"/> Stomach | <input type="checkbox"/> Learning |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Mouth | <input type="checkbox"/> Walking/balance | <input type="checkbox"/> Behavior |
| <input type="checkbox"/> Sleeping habits | <input type="checkbox"/> Nose | <input type="checkbox"/> Talking | <input type="checkbox"/> Feelings/moods |
| <input type="checkbox"/> Eating habits/diet | <input type="checkbox"/> Seizures | <input type="checkbox"/> Activity level | <input type="checkbox"/> Other _____ |

NOTES: _____

Do you have health insurance? Yes No

NOTES: _____

Date of last visit to: doctor _____ dentist _____ other health specialist _____ eye dr. _____

Serious illnesses _____

Hospital stays and/or surgeries _____

Type of Vaccine (month, day & year of each vaccine)*	1 st Dose	2 nd Dose	3 rd Dose	4 th Dose	5 th Dose
Diphtheria, Tetanus, Pertussis (DTaP/DTP)	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr
Polio (IPV)	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr
Haemophilus influenzae type b (Hib)	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	
Hepatitis B	mo/day/yr	mo/day/yr	mo/day/yr		
Hepatitis A	mo/day/yr	mo/day/yr			
Measles, Mumps & Rubella (MMR)	mo/day/yr	mo/day/yr			
Varicella (chicken pox)	mo/day/yr	mo/day/yr			

* **OR** please bring a copy of your child's immunization records from your physician with you to your screening appointment.

HEALTH HISTORY

Child's birth weight _____ Child's birth height _____ Delivered at _____ weeks gestation

Did the child's mother experience any problems during pregnancy? No Yes If yes, explain (medication, measles, toxemia, etc.) _____

Were there any problems with labor, delivery or during the newborn period? No Yes If yes, explain (caesarian delivery, fetal distress, respiratory distress syndrome, resuscitation required, jaundice, etc.) _____

NOTES: _____

Developmental Milestones

At what age did your child:

Sit alone _____ Walk alone _____ Say single words _____ Say two-word sentences _____ Toilet-train _____

Child was primarily attached to: Mother Father Both Other _____

Feeding and sleeping cycles were: Regular Irregular Child was: Easy to care for "Challenging"

Were there any changes in the child's primary caregivers during the first three years (different babysitter, mother started work, etc.)? No Yes If yes, at what age and under what circumstances? _____

Have you or anyone else ever had concerns about your child's overall physical growth and/or intellectual, social, emotional or motor development? No Yes If yes, explain _____

Describe your child's strengths and/or special needs _____

Add any comments or questions regarding your child's early development _____

Check the appropriate box(es) if you are concerned about the following behaviors in your child . . .

- | | | |
|--|---|---|
| <input type="checkbox"/> Unable to share | <input type="checkbox"/> Unsure of self, seems to lack confidence | <input type="checkbox"/> Inappropriate attention-seeking |
| <input type="checkbox"/> Bites nails | <input type="checkbox"/> Seems worried or anxious | <input type="checkbox"/> Daydreams, seems preoccupied |
| <input type="checkbox"/> Sucks thumb | <input type="checkbox"/> Sibling jealousy | <input type="checkbox"/> Distractible, short attention span, difficulty concentrating, restless |
| <input type="checkbox"/> Holds breath | <input type="checkbox"/> Seems immature compared to other children his or her age | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Lies | <input type="checkbox"/> Very dependent on adults | <input type="checkbox"/> Uncooperative, defiant, disobedient |
| <input type="checkbox"/> Destroys things | | <input type="checkbox"/> Aggressive towards others, verbally or physically |
| <input type="checkbox"/> Sensitive, feelings hurt easily, cries easily | | |
| <input type="checkbox"/> Other (please explain) _____ | | |

Agencies or programs your child has participated in: (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Public Health Nursing | <input type="checkbox"/> Early Childhood Special Education | <input type="checkbox"/> Women, Infant and Children (WIC) |
| <input type="checkbox"/> Dakota County Social Services | <input type="checkbox"/> Early Childhood Family Education | <input type="checkbox"/> Mothers and Children (MAC) |
| <input type="checkbox"/> Family counseling center | <input type="checkbox"/> Religious institution | <input type="checkbox"/> Preschool |

Would you like information about: (check all that apply)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Meeting other families | <input type="checkbox"/> Childcare | <input type="checkbox"/> Clothing |
| <input type="checkbox"/> Parenting groups | <input type="checkbox"/> Recreational programs | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Help with personal problems | <input type="checkbox"/> GED | |
| <input type="checkbox"/> Preschool programs | <input type="checkbox"/> English classes | |

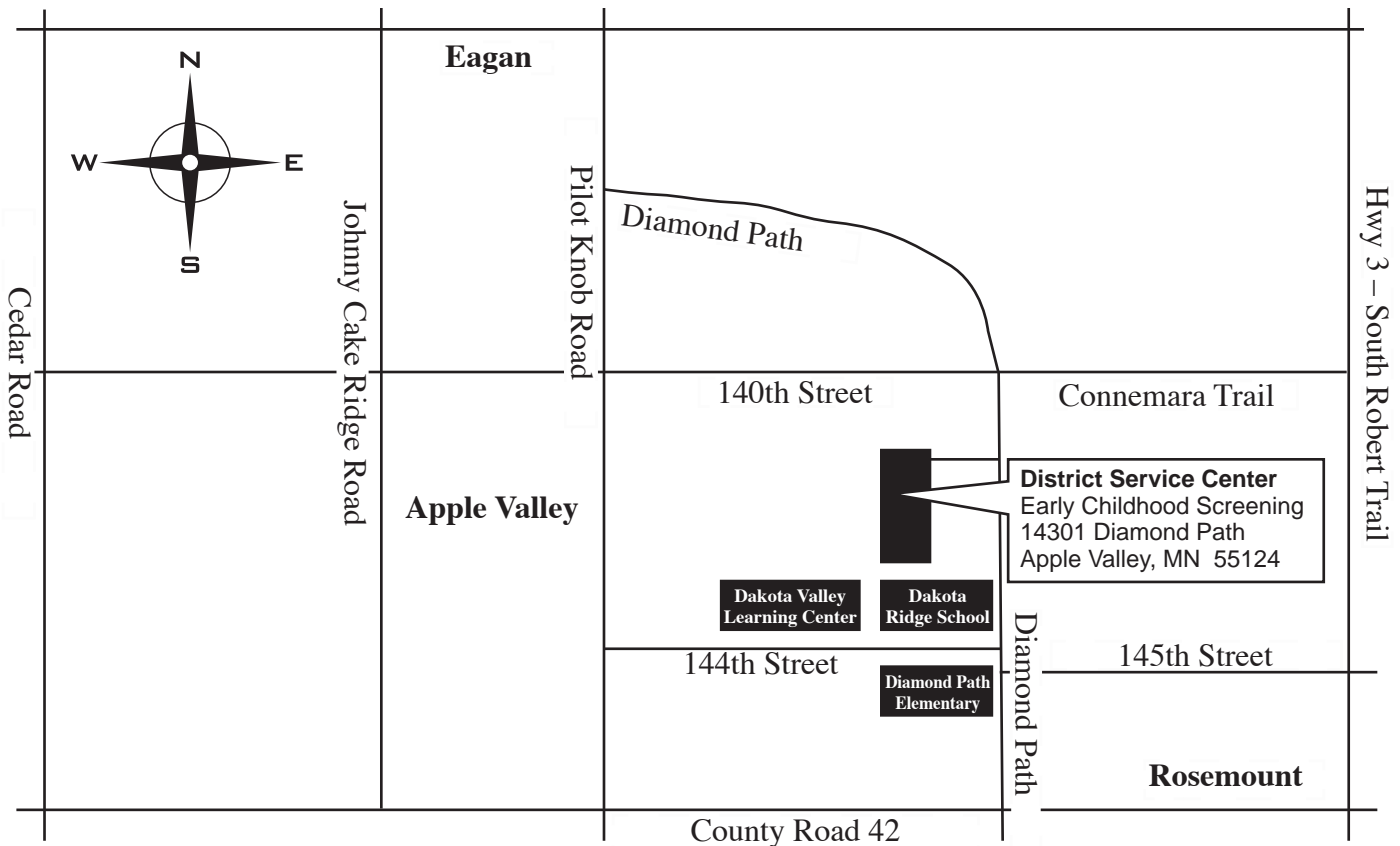
INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools

DISTRICT SERVICE CENTER

Early Childhood Screening
14301 Diamond Path
Apple Valley, MN 55124

IMPORTANT
Independent School District 196 Early Childhood Screening
Appointment and Information Enclosed

PRP/Procedures/500 series/501.3.2.1P-print/501.3.2.1P.indd/District 196 Graphics/6-19



For more information, contact 651-423-7899 or ecscreening@district196.org.