Please note: The fillable form needs to be downloaded and saved to your computer, and then completed and saved again. After you have it completed and saved to your desktop, attach it in an email to ecscreening@rpsmn.org

This form can be filled out via phone as well. For assistance request: Email ecscreening@rpsmn.org

Student ID# _____
(**Student ID number**)

Parent/Guardian Consent for Early Childhood Screening (ECS) Collection Use & Release

Screening date(s):

Child's Name	Gender ☐ M ☐ F	Birthdate:	Age:
Address:	Telephone:		
City: Zip:	Child's language:		
Parent(s)/Guardian:	Relationship to child:		
Child resides with: ☐ parent(s) ☐ grandparent ☐ other (please list relationship): ☐ foster parent ☐ guardian _____	Email address: Primary language spoken in home:		

Early Childhood Screening is <u>required</u> for your child to start public school kindergarten or first grade, unless you are a conscientious objector to screening. It can help a school district identify children who may benefit from district and community resources. If your child had a full screening through Head Start, Child & Teen Check-ups, or another provider within twelve months, the school will need evidence with the screening date and results. The screening does not replace regular ongoing health care by your child's health care provider. It includes a vision screening that helps detect potential eye problems, but is not a substitute for a full eye exam. The screening standards are the same regardless of race, income, color, creed, national origin, political belief or sex.

1. WHAT INFORMATION WILL BE COLLECTED AT THE SCREENING?

- Developmental check
- Immunization record review
- Insurance and Health Care
- Vision and hearing check (***Screened at a future date***)
- Review of anything that might get in the way of your child's health, growth, development or learning
- Information about community resources
- Your report on how your child is doing

2. IF I CONSENT TO RELEASE SCREENING INFORMATION, HOW WILL IT BE USED?

- To arrange for further evaluation or assessment of your child's health, growth, development or learning through MPS ECSE/Speech Services.
- To get follow-up for further services for your child after the screening.
- To transmit helpful information to another health, education, or social services provider if a referral is made for further evaluation.
- To fulfill the requirements for your child's entrance into public school, or other early learning programs.
- To evaluate screening programs by the Minneapolis Public Schools, Minnesota Department of Health, Minnesota Department of Education, and/or the Minnesota Department of Human Services. Your child's name will not be identified in any evaluation results.
- To provide access to and accountability for government funds paid to the local school district for providing the required ECS services.
- To plan for early childhood programs and school entry.

3. IF I DO NOT CONSENT TO RELEASE SCREENING INFORMATION, WHAT WILL HAPPEN?

- You have the right to refuse any part of the screening and still be eligible for any other part/s.
- You have the right to refuse referral for assessment, diagnosis, and/or possible treatment for your child.
- Your child's medical assistance eligibility or eligibility for any other health, education or social service program/s will not be affected if you refuse this screening or any of its parts.
- Information obtained in this screening is private and cannot be discussed or released to anyone except as allowed by state and federal privacy law. You are not required to consent to release this information.

Your signature indicates that you have read, understand and agree that the information can be used as stated above. I give my consent for:

☐ Complete screening for my child as described above.

☐ Screening as described above, except the following part/s: _____

I authorize release of my child's screening to the following checked entities for the purposes described above in #2 (attach name and address if available

☐ School District
☐ Way to Grow
☐ Dentist
☐ Mental Health Provider
☐ Head Start
☐ ECFE
☐ Public Health Agency/Home Care
☐ Child Care Provice/Daycare
☐ Physician/Physician's Asst./Nurse Practitioner
☐ School/Learning Readiness Programs
☐ MPS ECSE/Speech Services
☐ Other_____

X_____ _____

Verbal Consent of parent or guardian (Type full name) **Date**

Student ID #:

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:** MN **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 or Other (specify) _____

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

Which language does your child usually speak? ☐ English or 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 (Type Full name) **Date**

Early Childhood Screening

HEALTH AND FAMILY INFORMATION

You may decline to answer questions about your child's health and family circumstances. Declining any portion of the screening does not prevent your child from being enrolled in school

GENERAL INFORMATION

Child's Name: _____ Student ID: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Preschool Experience: ☐ Head Start ☐ Day care center ☐ Preschool ☐ Recreational programs ☐ Other

CHILD'S HEALTH CARE PROVIDER INFORMATION

Clinic Name: _____ Has the child been seen in the last 12 months ☐ Yes ☐ No

Dentist: _____ Has the child been seen in the last 12 months ☐ Yes ☐ No

Eye exam by Optometrist or Ophthalmologist ☐ Yes ☐ No

Does your child have health insurance ☐ Yes ☐ No

PRENATAL CARE, PREGNANCY AND BIRTH INFORMATION

Is you child adopted? ☐ Yes ☐ No

Were there any problems requiring special care during your pregnancy? _____

Born at term? ☐ Yes ☐ No If preterm, birth weight _____

Were there any chemical exposures during the pregnancy? (drugs, alcohol or cigarettes) If yes, please explain

_____

Did the baby stay in the hospital or did the baby come home with you? _____

CHILD HEALTH HISTORY

Immunization Status: ☐ Up To Date ☐ Not Up To Date ☐ Unknown ☐ Conscientious Objector

Does your child have a health condition/medical diagnosis? ☐ Yes ☐ No If yes, please explain

_____

Has your child been hospitalized, had a head injury, any allergies, vision or hearing concerns, or does your child currently take medications regularly? If yes, please explain

_____

Do you have any concerns with your child's sleep?

Do you have any concerns with your child's eating/nutrition? _____

HOME SAFETY/FAMILY FACTORS

Has your child ever had an elevated lead level? ☐ Yes ☐ No If yes, please explain _____

Do you have concerns that your child is exposed to violence, abuse, street drugs, cigarette smoke or other? If yes, please explain ☐ Yes ☐ No _____

Do you have any other concerns about your child that you would like to discuss

_____

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

ENGLISH

DO YOU KNOW YOUR CHILD MAY HAVE THESE RIGHTS?

- To immediately enroll in school.
- To continue at the same school if transportation is feasible.
- To attend special programs and afterschool activities.
- To automatically qualify for free lunch at school.
- To have free school supplies.
- To receive needed services as all other students.

If you or your family lives in one of the situations listed below, your student meets the McKinney Vento definition of being homeless or highly mobile because of lacking a fixed, regular and adequate nighttime residence.

Do you or your family live in any of these situations? (Check all that apply.)

- ○ In a shelter or transitional housing program_____(name)
- ○ In a motel, hotel, or weekly rate housing
- ○ Doubled up with friends or relatives because you cannot find or afford housing
- ○ In an abandoned building, public space, car or other inadequate accommodation
- ○ In emergency foster care
- ○ ***NONE OF THESE SITUATIONS APPLY***

Yes, I/we are currently living in one of these situations. The child(ren) named below should be given the rights listed above.

Student Name	ID# (staff will complete)	Date of Birth
Student Name	ID# (staff will complete)	Date of Birth
Student Name	ID# (staff will complete)	Date of Birth

Parent/Guardian or Student Signature _____ Phone _____ Date _____

This information is confidential.

Staff Only: Email to amber.lampron@rpsmn.or call 612-243-3047 _____

Submitted by: School Name: _____