Suggested Preparation for Early Childhood Screening

- Screening is a snapshot of your child engaging in a variety of activities. Talk to your child about the screening before your appointment. Let your child know ahead of time that he/she will be playing games and talking with a teacher and/or nurse, and that you will be with them while they play.
- Complete the attached paperwork and bring it with you to the appointment if you are screening in-person. For virtual screening appointments, email, drop off or mail ALL of your paperwork prior to your appointment (see contact information below).
- Please bring (or send) a copy of your child's birth certificate or a passport/visa or an official US court/government document indicating the child's full legal name and birthdate. This copy will stay with the district.
- Please do not bring any siblings to the screening.
- The entire process takes approximately 1 to 1 ½ hours. Please arrive (log on) 5-10 minutes early to complete additional paperwork.

Edina Early Childhood Screening
Edina Public Schools
5701 Normandale Road, Room 165
Edina, MN 55424

Email: ECScreening@edinaschools.org

Phone: 952-848-3985 – Affey Sigat, School Readiness Coordinator

Registration for Early Childhood Screening

GENERAL INFORMATION AND INSTRUCTIONS: Page 1 of the registration form must be completed by the child's parent/guardian. Page 3 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 Names (First, Middle, Last): _____

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

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 question below. You may choose more than one answer in Part B. See top of page 3 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

PREVIOUS HEALTH AND DEVELOPMENTAL SCREENING INFORMATION

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

☐ 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 Services 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**

Minnesota Language Survey

Minnesota is home to speakers of more than 100 different languages. The ability to speak and understand multiple languages is valued. The information you provide will be used by the school district to see if your student is multilingual. In Minnesota, students who are multilingual may qualify for a Multilingual Seal upon further assessment. Additionally, the information you provide will determine if your student should take an English proficiency test. Based upon the results of the test, your student may be entitled to English language development instruction. **Access to instruction is required by federal and state law. As a parent or guardian, you have the right to decline English Learner instruction at any time. Every enrolling student must be provided with the Minnesota Language Survey during enrollment.** Information requested on this form is important to us to be able to serve your student. Your assistance in completing the Minnesota Language Survey is greatly appreciated.

Student Information	
Student's Full Name: (Last, First, Middle)	Birthdate or Student ID:

	Check the phrase that best describes your student:	**Indicate the language(s) other than English in space provided:**
1. My student first learned:	☐ language(s) other than English. ☐ English and language(s) other than English. ☐ only English.	
2. My student speaks:	☐ language(s) other than English. ☐ English and language(s) other than English. ☐ only English.	
3. My student understands:	☐ language(s) other than English. ☐ English and language(s) other than English. ☐ only English.	
4. My student has consistent interaction in:	☐ language(s) other than English. ☐ English and language(s) other than English. ☐ only English.	

Language use alone does not identify your student as an English learner. If a language other than English is indicated, your student will be screened for English language proficiency.

Parent/Guardian Information	
Parent/Guardian Name (Printed):	
Parent/Guardian Signature:	Date:

* All data on this form is private. It will only be shared with district staff who need the information to best serve your student and for legally required reporting about home language and service eligibility to the Minnesota Department of Education. At the district and at the Minnesota Department of Education, this information will not be shared with other individuals or entities, except if they are authorized by state or federal law to access the information. Compliance with this request for information is voluntary.

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: 273

Screening Date: _____ Screening District Name: Edina Public Schools

Child's Resident District Name: _____

Resident Screening District Number and Type: _____

MARSS ID Number: 0273- _____

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

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 ____ p.m. Wakes up at ____ a.m. ☐ 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 of fruits/vegetables: oranges, apples, bananas, mangos, berries, spinach, corn, peas

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

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

☐ 3 or more servings of 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 ◯ Doubled up with friends or family ◯ Hotel or motel

◯ Emergency shelter/transitional housing ◯ Unsheltered (cars, parks and campgrounds, temporary)

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

☐ 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 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 ongoing care from your health care provider or dentist. Screening data collected is private so it may only be shared with anyone listed on the release of information; school district staff with a legitimate educational need to know; by court order; or with others as required by law, including the state or legislative auditor.

A. This screening includes:

- Review of your child's immunization record
- Check of your child's growth, such as height and weight
- Check for possible hearing problems
- Check for eye health, including how well your child can see
- Review of 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 including emotional and behavioral status
- 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 blood pressure
- Head-to-toe physical exam
- Check of your child's teeth, gums, and mouth
- Check for risk of tuberculosis
- 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 an 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**
- ☐ **Complete screening as described above in A and B**
- ☐ **Screening described above except:** _____

Parent/Guardian Signature: _____Date:_____Relationship to Child:_____

Early Childhood 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 do 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 the release of my child's screening information to the following check 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:_____

Early Childhood Hearing and Vision Screening Questionnaire

Name _____ DOB _____ Age (Yr/Mo)_____ Today's Date _____

Hearing History	No	Yes
1. Is there a concern that child has a hearing problem?	☐	☐
2. Are there any childhood hearing problems in the family of either the child's mother/father?	☐	☐
3. Does child have history of middle ear disease and/or tubes?	☐	☐
4. Has child had head trauma with concussion, skull fracture or loss of consciousness?	☐	☐
5. Has child been hospitalized with a serious illness (i.e. kidney or meningitis)?	☐	☐

Vision History and Questions	No	Yes
1. Has your child ever had a complete eye exam by an eye doctor?	☐	☐
2. Do you suspect anything is wrong with your child's eyes/vision?	☐	☐
3. Have the child's siblings, parents, grandparents, aunts, uncles or first cousins had eye/vision problems that require treatment before entering school?	☐	☐
4. Was your child born prematurely before 32 weeks of gestation?	☐	☐
5. Have you observed any problems or change in the whites, pupils, lids, lashes or the area around the eyes?	☐	☐
6. Have you noticed an abnormal sensitivity to light, nausea or dizziness or signs/complaints of headaches?	☐	☐
7. Have you noticed any of the following:		
a. Turning of one eye (in, out, up or down)?	☐	☐
b. Poking at the eyes or frequent rubbing?	☐	☐
c. Poor eye contact?	☐	☐
d. Covering or closing an eye when looking at an item of interest?	☐	☐
e. Abnormal head posture?	☐	☐
f. Squinting?	☐	☐
g. Moving the head forward, backward or horizontal while looking at an item?	☐	☐
h. Tilting head to one side?	☐	☐
i. Placing head close to item of interest?	☐	☐
j. Excessive blinking?	☐	☐
k. Inaccurate in reaching for item of interest?	☐	☐
l. Unusual tearing?	☐	☐