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: ISD 622

Screening Date: _____ Screening District Name: North St. Paul Maplewood Oakdale

Child's Resident District Name: North St. Paul Maplewood Oakdale

Resident Screening District Number and Type: ISD 622

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

Early Childhood Screening
Parent Consent to Screen and
Consent to Release Information

This screening includes:

1. Review of your child's immunization record
2. Check of your child's growth, such as height & weight
3. Tests for possible hearing problems
4. Tests for eye health, including how well your child can see
5. Review of any other factors that might interfere with your child's health, growth, development, or learning
6. Check of your child's development
7. Your report on your child's growth and learning
8. Information about your child's health care and insurance
9. Information about community resources and programs based on your child's or family's needs

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. 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.
4. Screening is not required for your child's entry into kindergarten or first grade if you are a conscientious objector to screening.
5. You have the right to refuse any of this screening for your child and still receive any of the other screening parts.
6. You have the right to refuse referral for assessment, diagnosis, and possible treatment for your child.
7. 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.

Signature required on back

Early Childhood Screening
Parent Consent to Screen and
Information Collection, Use and Release Consent
Page 2

Child's Name:	**Birth Date:**

CONSENT TO SCREEN

I give permission for the complete Early Childhood Screening, with the exception of the following component(s):

Parent/Guardian Signature	**Relationship to Child**	**Date**

CONSENT TO RELEASE INFORMATION

The North St. Paul, Maplewood, Oakdale Independent School District 622 uses information from the Early Childhood 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.

I hereby authorize release of my child's screening information to the appropriate school district for the purpose of evaluation, assessment, diagnosis, follow-up, and/or programming.

Parent/Guardian Signature	**Relationship to Child**	**Date**

Early Childhood Screening Resource & Health History Form

Today's Date: _____

Child's Name: _____

Date of Birth:_____

Height:_____ Weight:_____

Please enter dates of:

Last Well Child Exam: _____

Last Dental Exam: _____

Last Exam by Vision Specialist: _____

Resources

Is your child attending: ☐ Day Care, ☐ Head Start, ☐ ECFE, ☐ Preschool, ☐ Other _____

Where? _____ How often? _____

I am interested in information about: ☐ Early Childhood Family Education ☐ Preschool
☐ English Language Learning ☐ Kindergarten Enrollment

Do you want information or have questions about:

☐ Child Care ☐ Food ☐ Early Childhood Workshops/Activities
☐ Transportation ☐ Clothing ☐ Recreational programs
☐ Housing ☐ Lead poisoning ☐ Adult reading programs, (GED, ESL)
☐ Other _____

Do you have health insurance? ☐ Yes ☐ No If no, would you like us to fax your info to Portico? ☐ Yes ☐ No

Portico Healthnet helps people navigate health care systems and insurances with one on one assistance that best fit each families unique needs. www.porticohealthnet.org 651-603-5100

Where did your child receive their immunizations?

Clinic Name: _____

City, State: _____

Please bring a copy of your child's immunization for this appointment.
Clinics can fax them to 651-702-8452. ATTN: Early Childhood Screening

***These areas offers valuable insights for their school experience, though all parts are optional.

Home

Is your family in a temporary living situation due to loss of housing or economic hardship? ☐ Yes ☐ No

Does your child live or play in a building built:
Before 1950? ☐ Yes ☐ No Before 1978? ☐ Yes ☐ No Is it being remodeled? ☐ Yes ☐ No

Do you have concerns about anyone in your home or anyone who cares for your child using tobacco, alcohol or drugs?: ☐ Yes ☐ No

If your home has a firearm, is it safely locked? ☐ Yes ☐ No ☐ N/A

Do you have... Smoke detectors? ☐ Yes ☐ No (test soon!) Carbon Monoxide detectors? ☐ Yes ☐ No
Use safe car seats? ☐ Yes ☐ No Have Poison Control number? ☐ Yes ☐ No

Things about raising my child that are challenging:

When I need help with my family, I usually:

Has any member of your family witnessed or experienced family or neighborhood violence?
☐ Yes ☐ No If **YES**, explain:

Has there been unusual stress in your family that might affect your child?
(Examples - new sibling, move, divorce, death, financial problems, not enough food, etc.)

Please List All Family/Household Members Including Adults and Children:

Name	Relationship to Child	Birth Date	Gender	Lives at Home
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Health

Please check the box(es) that apply to your child and explain:

☐ Allergies to foods and/or medicines_____

☐ Asthma _____

☐ Takes medicines, herbs, and/or vitamins_____

☐ Visits to health specialists or therapists_____

☐ Serious illnesses_____

☐ Serious injuries or loss of consciousness_____

☐ Hospital stays and/or surgeries_____

☐ Problems during pregnancy_____

☐ At birth, was hospital stay longer for the baby?_____

☐ Was adopted. (What age and from what country?) _____

Evaluated for or received therapy for learning, speech or developmental concerns

_____

Members of the same family sometimes have similar conditions or concerns.
Check if the parents, brothers, or sisters of child have:

☐ Vision impairment	Who: _____
☐ Hearing impairment	Who: _____
☐ Mental illness (depression, anxiety, etc.)	Who: _____
☐ Learning problems	Who: _____
☐ Behavioral Issues	Who: _____

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

☐ nutrition	☐ headache	☐ skin/bruising, rashes	☐ activity level
☐ health	☐ eyes/vision	☐ breathing/coughing	☐ behavior
☐ growth	☐ ears/hearing	☐ walking/balance	☐ social - friends
☐ development	☐ throat	☐ toileting	☐ feelings/moods
☐ general appearance	☐ teeth	☐ speech	☐ learning

☐ other or comments: _____