Early Childhood Screening Consent

Child's Name: _____ Birthdate: _____

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 on-going 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 behavior 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

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***

☐ ***Screening described above except:*** _____

☐ ***I grant permission for my child to be screened without a parent/guardian present***

Parent/Guardian Signature: _____ Date: _____ Relationship to Child: _____

Updated May 2020

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: Alexandria Public Schools

Screening Date: _____ Screening District Name: APS- 206

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)

X 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

DEPARTMENT OF HEALTH

Alexandria Public Schools
Community Education
Early Education

Child's Name: _____ Age/DOB: _____

Parent/Caregiver Name: _____ Date: _____

Child and Family Hearing History and *JCIH Risk Assessment Questionnaire

Child and Family Hearing History (Circle Yes or No as it applies to child or family member)	YES	NO
Were birthmother, father, or child's siblings told they have permanent hearing loss in childhood? *	YES	NO
After the birth, was your child in the intensive care more than 5 days? *	YES	NO
Did your child have jaundice requiring a blood transfusion after birth? *	YES	NO
Were you told your child was given medicine after birth that might harm their hearing? *	YES	NO
Were you told your child had encephalopathy after birth because of low oxygen levels? *	YES	NO
Was your child on a special ventilator called ECMO after birth? *	YES	NO
Did birthmother have an infection during pregnancy: zika virus, cytomegalovirus (CMV), varicella, herpes, rubella, syphilis, or toxoplasmosis? *	YES	NO
Does your child have: Craniofacial or temporal bone anomalies, if so, what are they? *	YES	NO
Does your child have congenital microcephaly, congenital, or acquired hydrocephalus? *	YES	NO
Have you been told your child has a syndrome that could possibly cause hearing loss? *	YES	NO

Child's Postnatal History (Circle Yes or No as it applies to your child)	YES	NO
Has your child had an illness such as meningitis or encephalitis? *	YES	NO
Has your child had head trauma, concussion, skull fracture or chemotherapy? *	YES	NO
Do you have concerns about your child's ears/hearing, speech, language, or development? *	YES	NO
Does your child have history of many ear infections and /or tubes?	YES	NO

Parent/Caregiver Observations (Circle Yes or No as it applies to your child)	YES	NO
Have you seen your child...		
...Tugging at ear(s)?	YES	NO
...Complaints of pain, fullness, noise in the ears, drainage in ear, cannot hear?	YES	NO
...Is inattentive to conversation or ...asks to have things repeated?	YES	NO
...Watches speaker's lips or turns side of head towards the speaker?	YES	NO
...Shows strain when listening? ...Talks too loudly or softly? ...Or has a speech problem?	YES	NO
...Makes frequent mistakes following directions? Tends to be passive?	YES	NO

*Joint Committee on Infant Hearing (JCIH) Risk Factors, 2019: Any child with a risk factor which has not been screened by an audiologist should be referred to one.

Child and Family Vision History and Risk Assessment Questionnaire

Child and Family Vision History (Circle Yes or No as indicated)	YES	NO
Has your child ever been diagnosed with an eye condition, developmental delay, seizure disorder, syndrome, genetic, metabolic disorder, or any systemic disease associated with eye abnormalities?	YES	NO
Child's parents or siblings had eye/vision problems that required treatment at an early age (before age six years) such as amblyopia, cataracts, eye cancer or wearing glasses? **	YES	NO
Was your child born before 32 weeks of age?	YES	NO

Description: Circle Yes or No in the appropriate box as it applies to your child	YES	NO
Do caregiver or teacher have any concerns about child's eye(s) or vision? **	YES	NO

Have you noticed any of the following behaviors with your child?	YES	NO
▪ Any problems or change in the eyes: whites, pupils, lids, lashes, or the area around the eyes? ▪ Abnormal sensitivity to light? ▪ Frequent headaches? ▪ Turning of one eye in or out? ▪ Frequent eye rubbing, blinking? ▪ Unusual eye watering or discharge? ▪ Poor eye contact? ▪ Covering or closing of one eye when looking at an object? ▪ Abnormal headposture such as tilting the head to one side or moving forward or backward when viewing an item of interest? ▪ Placing the head close to an item of interest? ▪ Inaccuracy in reaching for objects?		
If yes to any of the above questions, please explain:		

** A positive family history for eye conditions before the age of six years, positive parental or caregiver concern or a newly diagnosed condition is an indication for referral to an eye care professional.

Child & Family Health & Developmental History

DEVELOPMENT	YES	NO
My child learned to do things at the same age as other children (sit, stand, walk, toilet trained, etc.) *If not, please explain:*	YES	NO
My child says numbers 1 to 10.	YES	NO
I have a difficult time understanding my child when he/she speaks.	YES	NO
Others have trouble understanding my child when he/she speaks.	YES	NO
My child seems to understand what I am telling him/her.	YES	NO
My child seems clumsy when using his/her hands.	YES	NO
My child plays in a variety of ways.	YES	NO
FAMILY HISTORY	**YES**	**NO**
Does your child or immediate family have a history of learning disability, delay, or behavior concerns? (ADHD, Dyslexia, Dyscalculia, auditory or language processing disorder, etc.)	YES	NO
Does your child or immediate family have a history of diagnosed mental health conditions? (depression, anxiety, bipolar disorder, etc.)	YES	NO
Do you consider your child to be in good health?	YES	NO
Does your child have any special health care needs? *If yes, explain:*	YES	NO

CHILD HEALTH HISTORY
Please list any medically diagnosed allergies:
Please list hospitalizations, surgeries, or serious injuries (month/year, reason)
Please name your local medical provider:
On average, my child visits their primary physician _____ times per year.
Please name your dental provider:
On average, my child visits their dental care provider _____ times per year.