

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: _____

Screening Date: _____ Screening District Name: _____

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)

41 - Screening by District

44 - Private Provider

42 - Child and Teen Checkups/EPSTD

45 - Conscientious Objector, no screening

43 - Head Start

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

64 - Referral to early childhood programs*

61 - Referral to special education

*(*School Readiness, Head Start, Early Childhood Family Education, family literacy)*

62 - Referral to health care provider

65 - Referral offered, parent declined

63 - Referral to special education AND health care provider

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 does not replace on-going care
from your health care provider or dentist.**

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. 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:
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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

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 ____ pm. Wakes up at ____ am.

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 fruits/vegetables: oranges, apples, bananas, mangos, berries, spinach, corn, peas

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

2-3 serving iron rich foods: fish, poultry, meat, beans, legumes, eggs

3 or more servings: 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

understands other people

Has trouble speaking or hard to understand

Able to follow directions

Has trouble being understood by others

Plays in a variety of ways

Seems clumsy when using hands

Walks or runs poorly (falls)