

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 #191 BES

Screening Date: _____ Screening District Name: ISD #191

Child's Resident District Name: ISD #191

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
- 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.

Laurie Mewissen
 School District Early Childhood Screening Coordinator Signature

Date

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 on-going care from your health care provider or dentist.

A. This Screening includes:

- Review of your child's immunization record
- Check of your child's growth, such as height and weight
- Tests for possible hearing problems
- Tests for eye health, including how well your child can see
- Review of any other 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
- 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 pulse, respirations and blood pressure
- Unclothed physical screening of your child's skin, head, eyes, ears, nose, throat, mouth, neck, chest, heart, lungs, abdomen, genitals, arms, legs, spine, and muscles
- Check of your child's teeth, gums, and mouth
- Test for exposure to tuberculosis
- Urine test for possible problems
- 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 referral for 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** and **B**
 Screening described above except: _____

Parent/Guardian Signature _____ Date _____ Relationship to Child _____

Early Childhood Screening 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 does 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 release of my child's screening information to the following checked 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) 191 _____
- School Readiness _____
- Other (regionally specific programs) _____

Understand Information

Authorize release of information

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

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Early Childhood Family Education | <input type="checkbox"/> Child & Teen Check-ups | <input type="checkbox"/> Child care center |
| <input type="checkbox"/> Early Childhood Special Education | <input type="checkbox"/> School-based pre-K | <input type="checkbox"/> Family/neighbor care |
| <input type="checkbox"/> Follow Along program | <input type="checkbox"/> Private preschool | <input type="checkbox"/> Library |
| <input type="checkbox"/> Parenting Education | <input type="checkbox"/> Head Start | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Parks and Recreation programs | <input type="checkbox"/> Foster Care | <input type="checkbox"/> 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):

- | | | |
|---|---|--|
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Growth Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Health Disorders | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Deafness/Hearing | <input type="checkbox"/> Sickle Cell Anemia/Trait | <input type="checkbox"/> 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 with friends or family hotel or motel
 emergency shelter/transitional housing

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

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

Other: _____

Please check any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Says numbers 1 to 10 | <input type="checkbox"/> understands other people |
| <input type="checkbox"/> Has trouble speaking or hard to understand | <input type="checkbox"/> Able to follow directions |
| <input type="checkbox"/> Has trouble being understood by others | <input type="checkbox"/> Plays in a variety of ways |
| <input type="checkbox"/> Seems clumsy when using hands | <input type="checkbox"/> Walks or runs poorly (falls) |

Future Ready. Community Strong.

Independent School District 191 Enrollment & Family Information (one form per family)

Data Entry: _____

Office Use Only

Primary Household: Parent/Guardian information.

Parent/Guardian Last Name	First Name	Cell Phone	Work Phone	Relationship to student	Interpreter
1					Yes <input type="checkbox"/> No <input type="checkbox"/>
2					Yes <input type="checkbox"/> No <input type="checkbox"/>

Parent/Guardian Email Addresses	1	2
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Street Address	Apt/Lot #	City	State	Zip

Currently reside with another family, person, or other temporary housing location? No Yes

Secondary Household: (separation, co-parenting, etc.) Not applicable.

Parent/Guardian Last Name	First Name	Cell Phone	Work	Relationship to student	Interpreter
					Yes <input type="checkbox"/> No <input type="checkbox"/>
Street Address	Apt/Lot #	City	State	Zip	

List ALL CHILDREN in primary household, ages 0 through 24. Use legal name as listed on birth record.

Student Last Name	First Name	Middle Name	Birth Date	Gender	Grade	Will this student attend 191 schools?
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No, where? _____
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No, where? _____
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No, where? _____
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No, where? _____
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No, where? _____
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No, where? _____

Emergency Contact Information: List a minimum of two emergency contacts who will assume temporary care of your child if you cannot be reached

Name	Cell Phone	Work	Relationship to Student
1			
2			

Have you or your family recently moved to the United States from another country? No Yes, Month/Year _____ Country of origin _____

Have you moved to this school district for temporary or seasonal agricultural work (migrant)? No Yes

Currently, does the student(s) have a parent, guardian, sibling, or relative in the military? No Yes If yes, is this person currently deployed? No Yes

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:
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	Check the phrase that best describes your student:	Indicate the language(s) other than English in space provided:
1. My student first learned:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
2. My student speaks:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
3. My student understands:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
4. My student has consistent interaction in:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> 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.