

# 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**

<b>Child's Name:</b>	<b>Birth Date:</b>
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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**

# Early Childhood Screening Resource & Health Forms

Today's Date: \_\_\_\_\_

Child's name: \_\_\_\_\_

Birth date: \_\_\_\_\_

Male      Female

Dates:

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:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Child Care     | <input type="checkbox"/> Food           | <input type="checkbox"/> Early Childhood Workshops/Activities |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Clothing       | <input type="checkbox"/> Recreational programs                |
| <input type="checkbox"/> Housing        | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Adult reading programs, (GED, ESL)   |
| <input type="checkbox"/> 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](http://www.porticohealthnet.org) 651-603-5100

Where did your child receive his/her 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**



## 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 birth or mother's pregnancy \_\_\_\_\_
- At birth, stayed in the hospital longer than mother \_\_\_\_\_
- 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:**

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