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: 0192 Farmington Public School District

Screening Date: _____ Screening District Name: Farmington Public School District

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
___ 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 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. 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:*** _____

Parent/Guardian Signature: Type your full name _____Date: _____Relationship to Child: _____

Updated May 2020

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) ISD 192
__ School Readiness _____
__ Other (regionally specific programs) _____

✓ **Understand Information** ✓ **Authorize release of information**

Parent/Guardian Signature: Type your full name _____ Date: _____ Relationship to Child: _____

REV: 11/2016

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.

☐ Has difficulty falling/staying asleep

☐ Takes a nap: from ____to____

☐ Gets 60 minutes or more of exercise each day

☐ Is NOT able to/does NOT get 60 minutes of exercise

_____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

☐ Has trouble speaking or hard to understand

☐ Has trouble being understood by others

☐ Seems clumsy when using hands

☐ understands other people

☐ Able to follow directions

☐ Plays in a variety of ways

☐ Walks or runs poorly (falls)

Dear Farmington School District Resident,

Farmington is a growing community and it is critical that the district's decision makers have accurate household information to best serve the needs of the district's residents and students. We also use this information to notify parents and residents of programs available through the District. We value your opinion, so please feel free to comment or ask questions.

Please help us in our effort to gather census data by providing us with the information requested. This information is for educational purposes only and the release of this information is governed by State and Federal laws as well as School Board policy. Your address and phone number are considered private data. Once completed, please return to: 20655 Flagstaff Ave Farmington, MN 55024 Attn: Census Dept.

(Please Print)

Parent(s) Names _____Phone #._____

Address _____City_____

Email Address: _____

Number of Household Members in Each Age Group

_____ 0 – 4 _____ 5 – 10 _____ 11 – 15 _____ 16 – 18
_____ 19 – 25 _____ 26 – 35 _____ 36 – 50 _____ 51 – 60 _____ 61 +

School Aged Children:

Name _____Birth Date _____School _____GR____

Name _____Birth Date _____School _____GR____

Name _____Birth Date _____School _____GR____

Name _____Birth Date _____School _____GR____

Pre-School Aged Children 0-5:

Name _____BirthDate_____

Name _____BirthDate_____

Name _____BirthDate_____

We appreciate your comments and questions

_____

_____

_____

Thank you for helping make District 192 an excellent and innovative school district.

Rev Feb2023