Suggested Preparation for Early Childhood Screening

- Screening is a snapshot of your child engaging in variety of activities. Talk to your child about the screening before your appointment. Let your child know ahead of time that he/she will be playing games and talking with a teacher and/or nurse, and that you will be with them while they play with the teacher and nurse.
- **Please complete the attached paperwork and bring it with you to the appointment.**
- **Please bring a copy of your child's most recent immunizations records for the district.**
- **Please bring a copy of your child's birth certificate or a passport/visa or an official US court/government document indicating child's full legal name and birthdate. This copy will stay with the district.**
- **Please do not bring siblings to the screening.**
- The entire process takes approximately 1 to 1 ½ hours. Please arrive 10 minutes early to complete additional paperwork.

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
- ☐ Early Childhood Special Education
- ☐ Follow Along program
- ☐ Parenting Education
- ☐ Parks and Recreation programs
- ☐ Child & Teen Check-ups
- ☐ School-based pre-K
- ☐ Private preschool
- ☐ Head Start
- ☐ Foster Care
- ☐ Child care center
- ☐ Family/neighbor care
- ☐ Library
- ☐ WIC
- ☐ 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
- ○ 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:

- ☐ 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)

Early Childhood Hearing and Vision Screening Questionnaire

Name_________________________ DOB________ Age (Yr/Mo)________ Today's date________

Hearing History

		No	Yes
1.	Is there concern that child has a hearing problem?	________	________
2.	Are there any childhood hearing problems in the family of either the child's mother/father?	________	________
3.	Does child have history of middle ear disease and/or tubes?	________	________
4.	Has child had head trauma with concussion, skull fracture or loss of consciousness?	________	________
5.	Has child been hospitalized with a serious illness (i.e. kidney or meningitis)?	________	________

Vision History and Questions

		No	Yes
1.	Has your child ever had a complete eye exam by an eye doctor?	________	________
2.	Do you suspect anything is wrong with your child's eye/vision?	________	________
3.	Have the child's siblings, parents, grandparents, aunts, uncles or first cousins had eye/vision problems that require treatment before entering school?	________	________
4.	Was your child born prematurely before 32 weeks of gestation?	________	________
5.	Have you observed any problems or change in the whites, pupils, lids, lashes or the area around the eyes?	________	________
6.	Have you noticed an abnormal sensitivity to light, nausea or dizziness or signs/complaints of headaches?	________	________
7.	Have you noticed any of the following?		
a.	Turning of one eye (in, out, up or down)........	________	________
b.	Poking at the eyes or frequent rubbing?........	________	________
c.	Poor eye contact?........	________	________
d.	Covering or closing an eye when looking at an item or interest?........	________	________
e.	Abnormal head posture?........	________	________
f.	Squinting?........	________	________
g.	Moving the head forward, backward or horizontal while looking at an item?........	________	________
h.	Tilting head to one side?........	________	________
i.	Placing head close to item of interest?........	________	________
j.	Excessive blinking?........	________	________
k.	Inaccurate in reaching for item of interest?........	________	________
l.	Unusual tearing?........	________	________

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) ______________________
X School District (Name) Edina Public Schools
__ School Readiness ______________________
__ Other (regionally specific programs) ______________________

______ **Understand Information** ______ **Authorize release of information**

Parent/Guardian Signature: ______________ Date: ________ Relationship to Child: ________

REV: 11/2016

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 ____________

REV: 11/2016