Minnesota Department of Education

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** _____

Address: _____

City: _____ **State:** _____ **Zip**: _____

Race/Ethnicity (choose ONLY one)

_____ 1 - American Indian _____ 3 - Hispanic _____ 5 - White, not of Hispanic Origin

_____ 2.- Asian or Pacific Islander _____ 4 - Black, not of Hispanic Origin

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 people 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, Japan, Korea, Malaysia, Pakistan, the Philippines Island, Thailand and Vietnam.

Black or African American – Person having origins in any of the black racial groups of Africa.

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
- ☐ 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, parent declined

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

Parent Consent
Child Health & Developmental Screening

Child's Name:	Birth Date:	*(For office use)* *Child's MARSS ID or Record No.*
Parent's Name		

A. This screening includes:

- Review of your child's immunization record
- Check of your child's growth, such as height & 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 on 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 Checkups, 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 tests for possible problems
- Blood test for anemia
- Blood test for lead
- Other: _____

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. Screening is not required for your child's entry into kindergarten or first grade if you are a conscientious objector to screening.
4. You have the right to refuse any of this screening for your child and still receive any of the other screening parts.
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 & Developmental Screening checked below for_____
(Child's Name)

Check one (√)

☐ Complete screening as described above in A & B above.

☐ Screening described above except: _____

Parent/Guardian Signature	Date	Relationship to child

MINNESOTA MDH DEPARTMENT OF HEALTH Minnesota Department of Education Minnesota Department of Human Services

Revised 8/2006

INFORMATION COLLECTION, USE AND RELEASE CONSENT
CHILD HEALTH & DEVELOPMENT SCREENING

Child's Name	Birth Date	(For office use) Child's MARSS ID or Record No.
Parent/Guardian's Name		

_____(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. 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.

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 (v) 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 (Medicare Clinic)
	Interagency Early Intervention Committee (IEIC)
	Mental Health Agency
	Public Health Agency/WIC
	School District (Name)
	School Readiness
	Other (regionally specific programs)

☐Understand Information ☐Authorize release of information

Parent/Guardian Signature	Date	Relationship to Child

MINNESOTA MDH DEPARTMENT OF HEALTH Minnesota Department of Education

Revised 08/17/06

Child Information Form

Early Childhood Screening is a chance to learn about your child's health and development and get community resources before kindergarten. Completion of this form is voluntary. Declining to answer any questions will not prevent your child from enrolling in kindergarten. Please complete all forms before your screening appointment and bring them with you. Thank you!

Child's Full Name_____ Date of Birth _____ ☐ Male ☐ Female

Parent's Name _____ Phone (home) _____

Phone (cell) _____ Phone (work) _____

Address _____ Language(s) spoken in the home _____

City & Zip _____ _____

Please list persons living in the home, including adults and children:

First and Last Name	Relationship to Child	Birthdate	Male or Female

Have there been recent situational or environmental changes in your child's life? Please check all that apply.

☐ Divorce/separation ☐ New baby ☐ Moved to new residence ☐ Change in guardianship ☐ Other_____

Please detail any information that you want screening staff to know about your family's cultural background and heritage (language, traditions) that might make a difference in the assessment of learning and/or behavior. _____

_____

Check the boxes if you or your child use:

☐ Early Childhood Family Education
☐ Preschool - Location: _____
☐ Childcare _____
☐ Head Start
☐ WIC
☐ Child and Teen Checkups
☐ Other (list)
_____

Describe your child's strengths:_____

What are your main concerns for your child? Please check all that apply.

☐ Gross Motor (balance, coordination, running , walking)
☐ Fine Motor (writing, cutting, stacking blocks)
☐ Adapting to changes in routine/environment
☐ Behavior (tantrums, aggression)
☐ Other_____
☐ Pre-Academics (counting, naming colors/shapes/letters)
☐ Attention/Hyperactivity
☐ Social Interactions
☐ Self Help (eating, dressing, toileting)

Check the boxes if you have questions, concerns, or want information about:

☐ nutrition/eating habits
☐ discipline
☐ sleeping
☐ toilet training
☐ car seats/seat belt safety
☐ emergency/hotline numbers
☐ bike/sports helmets
☐ stranger safety
☐ kindergarten/school
☐ child care
☐ media use/TV watching
☐ lead poisoning
☐ Other questions or concerns: _____

Turn Page

Check all boxes that describe your child:

- ☐ Says numbers from 1 to 10
- ☐ Copies a circle or other shapes
- ☐ Follows two-step verbal directions
- ☐ Prints first name or part of it
- ☐ Understands "one", gives you just one when asked
- ☐ Can feed self independently, using utensils
- ☐ Plays in a variety of ways
- ☐ Knows how many fingers are on each hand
- ☐ Compares things, for example, says "This one is bigger, etc."
- ☐ Can hold and use markers, pencils, scissors
- ☐ Has balance and control when walking, hopping, running
- ☐ Has trouble sitting still
- ☐ Seems quiet/withdrawn
- ☐ Has unusual fear of _____
- ☐ Has difficulty forming good relationships with peers/adults
- ☐ Acts much younger than age
- ☐ Seldom plays with other children
- ☐ Seems unhappy, cries, whines
- ☐ Seems more active than other children his/her age
- ☐ Seems bothered by certain textures; e.g. food, clothing

Check the frequency that best descibes your child in the areas below:

Hits or takes toys from others
☐ seldom/never ☐ sometimes ☐ usually/always

Has trouble paying attention
☐ seldom/never ☐ sometimes ☐ usually/always

Seems overly aggressive
☐ seldom/never ☐ sometimes ☐ usually/always

Clings or gets very upset when leaving parent/caregiver
☐ seldom/never ☐ sometimes ☐ usually/always

Prefers to play alone rather than with other children
☐ seldom/never ☐ sometimes ☐ usually/always

Has difficulty in switching activities or places
☐ seldom/never ☐ sometimes ☐ usually/always

Only likes certain foods; e.g. picky eater, unusual combinations
☐ seldom/never ☐ sometimes ☐ usually/always

Uses toys in unusual ways; e.g. lines up toys rather than playing with them
☐ seldom/never ☐ sometimes ☐ usually/always

Destroys or damages things on purpose
☐ seldom/never ☐ sometimes ☐ usually/always

Has specific interest or behavior that preoccupies or is unusual in its intensity
☐ seldom/never ☐ sometimes ☐ usually/always

When your child becomes very frustrated or upset, what does he/she do?

☐ Cries ☐ Screams ☐ Hits others ☐ Hits self ☐ Pushes ☐ Other _____

Length of outbursts: ☐ Less than 15 minutes ☐ 15 to 45 minutes ☐ 45 minutes or longer

Frequency of outbursts: ☐ Daily ☐ Weekly ☐ Monthly

I have concerns about my child's speech or language development. ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Estimated percentage of child's language you can understand: _____ % Comments: _____

I have been and/or am currently concerned about my child's development. ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Child Safety Issues:

When traveling in a car/vehicle, how often is your child in a car or booster seat? ☐ Never ☐ Sometimes ☐ Usually ☐ Always

Does your child wear a safety helmet when biking ? ☐ Yes ☐ No ☐ My child does not ride a bicycle or tricycle

Do you have any guns in your home? ☐ Yes ☐ No If Yes, are the guns locked? ☐ Yes ☐ No

Is your child exposed to: ☐ Second-hand smoke ☐ Violence ☐ Street drugs ☐ Unsafe conditions

This Child Information Form can be part of my child's school record: ☐ **Yes** ☐ **No**

Signature of Parent/Guardian: _____ **Date:** _____

Medical Health History Form

The following information is helpful for the Health Care Specialist to provide improved medical services to the students of Spring Lake Park School District. The health information provided will be confidentially shared with staff to assist in educational planning. It will be kept on file in your child's health record. Completion of this form is voluntary.

Child's Full Name:_____ Date of Birth: _____

HEALTH INSURANCE/HEALTH CARE INFORMATION

Do you have health insurance for your child? ☐ Yes ☐ No Insurance plan name: _____

Is your child on Medical Assistance? ☐ Yes ☐ No

Would you like information about MN Care insurance.? ☐ Yes ☐ No

How often does your child see: a healthcare provider? _____ a dentist? _____

Last well-child check up: _____ Last dental visit: _____

Indicate which of the following your child has had or has at present. Check all boxes that apply:

☐ Allergies
☐ Asthma
☐ Autism/ASD
☐ Bleeding Disorder
☐ Bowel/Bladder Concerns
☐ Cancer
☐ Diabetes
☐ Headaches
☐ Heart Condition
☐ Hearing/Ear Concerns
☐ Hyperactivity/Attention Deficit Disorder
☐ Learning Disability
☐ Mental Illness
☐ Seizures
☐ Skin Conditions
☐ Vision/Eye Concerns
☐ Other (list) _____

Please explain all checked conditions:: _____

My child is allergic to _____ Is an Epi pen required? ☐ Yes ☐ No

List all medications your child is currently taking: _____

Has your child had a severe reaction requiring emergency medical attention? Please explain: _____

Please indicate any other significant past history and/or illnesses (e.g. injuries, surgeries, hospitalizations): _____

Does your child have any physical limitations that may affect his/her performance in school? ☐ Yes ☐ No

If yes, please explain: _____

I understand the information that I have given is correct to the best of my knowledge and it is my responsibility to inform the Health Care Specialist of any changes in my child's medical status.

Parent Signature: _____

Date: _____

Reviewed by: _____

Pupil Immunization Record

FOR SCHOOL USE ONLY
( ) Complete; booster required in _____
( ) In process; 8 mos. Expires _____
( ) Medical exemption for _____
( ) Conscientious objection for _____

Name_____ Birthdate _____ Student Number _____

Minnesota Statutes Section 121A.15 requires children enrolled in a Minnesota school to be immunized against certain diseases, allowing for specified exceptions. This form is designed to provide the school with information required by the law.

Enter the MONTH, DAY, and YEAR for all vaccines the pupil received. DO NOT USE (✓) or (✗).
Vaccines/doses in shaded boxes are recommended but not required by law.

Type of Vaccine	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
Diphtheria, Tetanus, and Pertussis (DTaP, DTP)					
Diphtheria and Tetanus (DT) – formulation for <7 yrs					
Tetanus and Diphtheria (Td, Tdap) – formulation for ≥7 yrs					
Polio (IPV, OPV)					
Measles, Mumps, and Rubella (MMR) (minimum age: on or after 1st birthday)					
Hepatitis B (hep B)*					
Varicella (chickenpox)** (minimum age: on or after 1st birthday)					
Pneumococcal Conjugate (PCV)***					
Haemophilus influenzae* type b** (Hib)					
Meningococcal (MPSV, MCV)					
Human Papillomavirus (HPV)					
Hepatitis A (hep A)					
Rotavirus					

* Hepatitis B is required for kindergarten and 7th grade.
** Varicella vaccine or disease history is required for kindergarten and 7th grade.
*** PCV and Hib vaccines are recommended only for children through age 4 years.

Note for school personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTaP+Hib, Hib+HBV) in each applicable space.

Indicate immunization status and source of above information by choosing one of the following:

I certify that this student has received all immunizations required by law.

_____
Signature of parent/guardian or physician/public clinic Date

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B (K + 7th), varicella (K + 7th), measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B, and/or polio vaccine series within the next 8 months. The dates on which the remaining doses are to be given are:

_____

_____
Signature of physician/public clinic Date

Medical exemption: No student is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a student to receive a medical exemption, a physician must sign this statement:

*I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed. **(For varicella disease see ** below)***

Exempted immunization(s):

_____

_____
Signature of physician/nurse practitioner/physician assistant Date

****History of varicella disease only.** In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in _____.
Year

_____
Signature of physician/nurse practitioner/physician assistant

Conscientious exemption: No student is required to have an immunization which is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the student or others they come in contact with. To receive this exemption, a parent or legal guardian must complete and sign the following statement and have it notarized:

I certify by notarization that immunization for my child is contrary to my conscientiously held beliefs.
Indicate vaccine(s):

_____

_____
Signature of parent or legal guardian Date

Subscribed and sworn to before me this _____ day of _____ 20_____

_____
Signature of notary

Additional exemptions

- **Children less than 7 years of age:** The 5th dose of DTaP/DTP/DT (similarly, the 4th dose of polio vaccine) is not necessary if the 4th DTaP/DTP/DT (3rd dose of polio) was administered after the 4th birthday.
- **Children 7 years of age and older:** A history of 3 doses of DTaP/DTP/DT/Td/Tdap and 3 doses of polio vaccine meets the minimum requirements of the law.
- **Students in grades 7-12:** A Td or Tdap booster at age 11 years or later is not required for students in grades 7-12 whose most recent Td was given after their 7th birthday but before their 11th birthday. Instead, it will be required 10 years after the date of the most recent dose.
- **Students 11-15 years of age:** A 3rd dose of hepatitis B vaccine is not required for those students who provide documentation of the alternative 2-dose schedule.
- **Students 10 years or older:** May receive Tdap to fulfill the Td requirement for students in grades 7-12
- **Students 18 years of age or older:** Do not need polio vaccine.

Immunization Program
P.O. Box 6497
St. Paul, MN 55164-097
651-201-5503 or 1-800-657-397
www.health.state.mn.us/immuniz
(4/2010) IC#140-015