



# Early Childhood Screening Release of Information

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

(For office use only) MARSS other ID: \_\_\_\_\_

Shakopee Schools 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 \_\_\_\_\_
- Early Childhood Family Education (ECFE) \_\_\_\_\_
- Early Childhood Special Education \_\_\_\_\_
- Follow Along Program \_\_\_\_\_
- Head Start \_\_\_\_\_
- Health Care Provider (Medical Clinic) \_\_\_\_\_
- Interagency Early Intervention Committee (IEIC) \_\_\_\_\_
- Mental Health Agency \_\_\_\_\_
- Public Health Agency (WIC) \_\_\_\_\_
- School District  Shakopee Public Schools \_\_\_\_\_
- School Readiness \_\_\_\_\_
- Other (regionally specific programs) \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_



## 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

\_\_\_\_\_ 61- Referral to special education *(\*School Readiness, Head Start, Early Childhood Family Education, Family literacy)*

\_\_\_\_\_ 62 - Referral to health care provider

\_\_\_\_\_ 63 - Referral to special education AND health care provider

\_\_\_\_\_ 64 - Referral to early childhood program

\_\_\_\_\_ 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: \_\_\_\_\_

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.

### This Screening includes:

- Review of your child's immunization record
- Check 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 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 belief.
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 to complete screening for (Child's Name)

\_\_\_\_\_

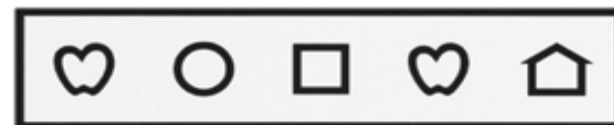
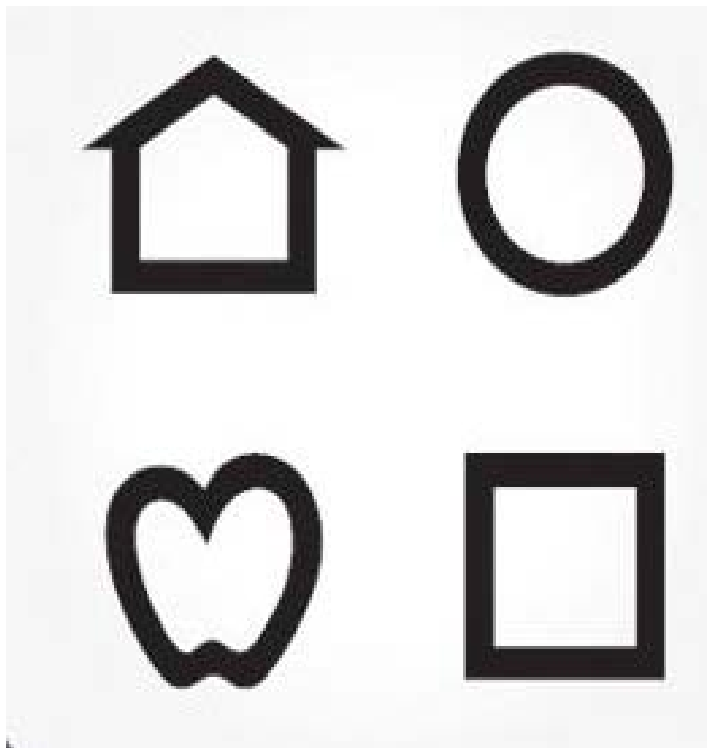
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

# Lea Prescreening Practice Sheet

In order for us to check your child's vision he/she must be able to play a matching game.

1. Cut the paper along the dotted lines.
  2. Place the four large letters (Chart 1) in front of your child.
  3. Point to a letter on Chart 2 and have your child touch the letter that looks the same on Chart 1. Start with the larger letters and move downward to the smaller.
  4. Play the game until your child responds correctly and consistently.
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Maternal and Child Health Section  
85 East 7<sup>th</sup> Place  
St. Paul, MN 55101  
(651) 201-3760



## Child Health and Developmental History

Child's Name: \_\_\_\_\_ MARSS ID (office use only): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Female \_\_\_\_\_ Male

Parent/Guardian Name (s): \_\_\_\_\_

Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_

### **Pregnancy and Birth Information:**

At how many weeks gestation was your child born? \_\_\_\_\_ Birth weight: \_\_\_\_\_

Any problems during pregnancy or birth? \_\_\_\_\_

Is your child adopted? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, at what age? \_\_\_\_\_

### **Child Health History:**

Please check all that apply to your child and describe:

- Medical Diagnosis: \_\_\_\_\_
- Daily/Routine Medications: \_\_\_\_\_
- Emergency Medications: \_\_\_\_\_
- Allergies (food, environment, medication, seasonal): \_\_\_\_\_
- Follows with specialists: \_\_\_\_\_
- Surgical History: \_\_\_\_\_
- Recent Hospitalizations: \_\_\_\_\_
- Vision Problems: \_\_\_\_\_ Glasses: \_\_\_\_\_ Yes \_\_\_\_\_ No
- Hearing Problems: \_\_\_\_\_ Frequent Ear Infections: \_\_\_\_\_ Yes \_\_\_\_\_ No
- Behavior Concerns: \_\_\_\_\_
- Significant Immediate Family History: \_\_\_\_\_

### **Please check any areas that you have concerns or questions about your child:**

\_\_\_\_\_ Health \_\_\_\_\_ Learning \_\_\_\_\_ Behavior \_\_\_\_\_ Development \_\_\_\_\_ Speech/talking

\_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_ Social \_\_\_\_\_ Obtaining Access to Health Care

### **Family Information:**

Has there been any unusual stress in your family within the past year or more that might have an impact on your child?

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Do you have any questions about resources/services available to you through the school district or the community?

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