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 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 and B***

____***Screening described above except:*** _____

Parent/Guardian Signature _____ Date _____ Relationship to Child _____

REV: 03/2019

Buffalo Hanover Montrose
BHM SCHOOLS

School Census and Early Childhood Contact Information

Please complete the information below, so that your family can be added to the school district database. This will ensure that you will receive pertinent school district mailings and kindergarten registration information when your child becomes eligible for kindergarten.

Head(s) of Household

Parent/ Guardian #1

Last Name: _____ First Name: _____
Address: Street _____
City _____ State _____ Zip _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Home email: _____

Parent/ Guardian #2

Last Name: _____ First Name: _____
Address: Street _____
City _____ State _____ Zip _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Home email: _____

Children Living in Household (Birth to 5 years only):

Last Name _____ First Name _____
Full Middle Name: _____ Date of Birth: _____ Gender: M F

Last Name _____ First Name _____
Full Middle Name: _____ Date of Birth: _____ Gender: M F

Last Name _____ First Name _____
Full Middle Name: _____ Date of Birth: _____ Gender: M F

Last Name _____ First Name _____
Full Middle Name: _____ Date of Birth: _____ Gender: M F

Data provided on this registration form will be used by personnel in the Buffalo-Hanover-Montrose Schools to identify the student and family for school placement, open enrollment, and transportation.

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: #877 Buffalo Hanover Montrose

Screening Date: _____ Screening District Name: Buffalo Hanover Montrose

Child's Resident District Name: Buffalo

Resident Screening District Number and Type: #877

MARSS ID Number: _____

Check type of screening child received – STATE AID CATEGORY (SAC)
(To be completed by the Early Childhood Screening Coordinator)

X 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.

Jennifer Diemang _____
School District Early Childhood Screening Coordinator Signature Date

DEPARTMENT OF EDUCATION

2019-20 Ethnic and Racial Demographic Designation Form

Student's First Name: _____ Middle Name/Initial: _____ Last Name: _____

Date of Birth: _____ District: _____ School: _____

Schools are required to report ethnicity and race to the state and to the U.S. Department of Education. Because of recent changes to Minnesota state law, Minnesota disaggregates each category into detailed groups to further represent our student populations. Parents or guardians are not required to answer the federal questions **(in bold)** for their children. If you choose not to answer the federal questions **(in bold)**, federal law requires schools to choose for you. This is a last resort—we prefer if parents or guardians complete the form. State questions are labeled as "Optional" and schools will not fill in this information for you.

This information helps improve teaching and learning for everyone and helps us accurately identify and advocate for students currently underserved. The information this form collects is considered private information. You can review the privacy notice to learn more about the purpose of collecting this information, how it will be used and not used, and how the detailed groups were identified. The privacy notice can be found in our *Frequently Asked Questions: Ethnic and Racial Designation Form.*

Is the student Hispanic/Latino as defined by the federal government? The federal definition includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.[1]

[You must select "yes" or "no" to this question.]

○ **Yes** *[If yes, go to Question A.]* ○ **No** *[If no, go to Question 1.]*

Optional Question A: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Guatemalan	☐ Salvadoran	☐ Other Hispanic/Latino
☐ Colombian	☐ Mexican	☐ Spaniard/Spanish/ Spanish-American	☐ Unknown
☐ Ecuadorian	☐ Puerto Rican		

Go to Question 1.

[Select "yes" to at least one of the Questions (1-6) below.]

Question 1: Does the student identify as American Indian or Alaska Native as defined by the state of Minnesota? The state of Minnesota definition includes persons having origins in any of the original peoples of North America who maintain cultural identification through tribal affiliation or community recognition. [This question is needed to calculate state aid/funding.]

○ **Yes** *[If yes, go to Question 1a.]* ○ **No** *[If no, go to Question 2.]*

Optional Question 1a: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Cherokee	☐ Other North American Indian Tribal Affiliation
☐ Anishinaabe/Ojibwe	☐ Dakota/Lakota	☐ Unknown

Go to Question 2.

[1]Federal Register, Vol. 72, No. 202/Friday, October 19, 2007/Notices/59274

Question 2. Is the student American Indian from South or Central America?

○ Yes *[Go to Question 3.]* No *[Go to Question 3.]*

Question 3. Is the student Asian as defined by the federal government? The federal definition includes persons 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.[1]

○ Yes *[If yes, go to Question 3a.]* ○ No *[If no, go to Question 4.]*

Optional Question 3a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Chinese	☐ Karen	☐ Other Asian
☐ Asian Indian	☐ Filipino	☐ Korean	☐ Unknown
☐ Burmese	☐ Hmong	☐ Vietnamese	

Go to Question 4.

Question 4. Is the student black or African American as defined by the federal government? The federal definition includes persons having origins in any of the black racial groups of Africa.[1]

○ Yes *[If yes, go to Question 4a.]* ○ No *[If no, go to Question 5.]*

Optional Question 4a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Ethiopian-Other	☐ Somali
☐ African-American	☐ Liberian	☐ Other black
☐ Ethiopian-Oromo	☐ Nigerian	☐ Unknown

Go to Question 5.

Question 5. Is the student Native Hawaiian or Other Pacific Islander as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.[1]

○ Yes *[Go to Question 6.]* ○ No *[Go to Question 6.]*

Question 6. Is the student white as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Europe, the Middle East, or North Africa.[1]

○ Yes ○ No

Parent(s)/Guardian Name _____ Date _____

Parent(s)/Guardian Signature _____

Buffalo-Hanover-Montrose
Early Childhood Screening
301 NE 2nd Avenue
Buffalo, MN 55313
(763) 682-8408
bhmschools.org

Dear Parents,

State law in Minnesota requires that every child must complete and Early Childhood Health and Developmental Screening (ECS) before entering kindergarten. This screening may be done through the public schools free of charge, or at a public health care provider. To consent to this screening by ISD #877 Buffalo Hanover Montrose Schools, please fill out this letter and bring it with you to your child's scheduled screening.

My signature provides consent for _____(child's name) to receive ECS as well as the following (check all that apply):

_____ ISD #877 may share the results of this screening with appropriate district personnel as needed for follow-up.
_____ Screening results may become a part of my child's school record through elementary school.
_____ Screening results may be transferred to another school district, should we move, or shared with Health Care Providers, Early childhood Teachers, Specialists, or Social Services upon my request.

_____ _____
Parent/guardian signature date

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 safe 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)

36 Month Questionnaire

33 months 0 days through 41 months 30 days

ASQ:SE-2 Ages & Stages Questionnaires® Social-Emotional SECOND EDITION

Date ASQ:SE-2 completed: _____

Child's information

Child's first name: _____ Child's middle initial: _____ Child's last name: _____

Child's date of birth: _____

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

City: _____ State/province: _____ ZIP/postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Other: _____
◯ Grandparent/other relative ◯ Foster parent ◯ Child care provider

People assisting in questionnaire completion: _____

Program information

(For program use only.)

Child's ID #: _____ Age at administration in months and days: _____

Program ID #: _____

Program name: _____

P201360000

36 Month Questionnaire *33 months 0 days through 41 months 30 days*

ASQ:SE-2

Questions about behaviors children may have are listed on the following pages. Please read each question carefully and check the box ☑ that best describes your child's behavior. Also, check the circle ⓥ if the behavior is a concern.

Important Points to Remember:

- ☐ Answer questions based on what you know about your child's behavior.
- ☐ Answer questions based on your child's *usual* behavior, not behavior when your child is sick, very tired, or hungry.
- ☐ Caregivers who know the child well and spend more than 15–20 hours per week with the child should complete ASQ:SE-2.
- ☐ Please return this questionnaire by: _____
- ☐ If you have any questions or concerns about your child or about this questionnaire, contact: _____
- ☐ Thank you and please look forward to filling out another ASQ:SE-2 in _____ months.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
1. Does your child look at you when you talk to her?	☐ z	☐ v	☐ x	◯ v	____
2. Does your child like to be hugged or cuddled? 	☐ z	☐ v	☐ x	◯ v	____
3. Does your child talk or play with adults he knows well?	☐ z	☐ v	☐ x	◯ v	____
4. Does your child cling to you more than you expect? 	☐ x	☐ v	☐ z	◯ v	____
5. When upset, can your child calm down within 15 minutes?	☐ z	☐ v	☐ x	◯ v	____
6. Does your child seem too friendly with strangers?	☐ x	☐ v	☐ z	◯ v	____
7. Does your child settle herself down after exciting activities?	☐ z	☐ v	☐ x	◯ v	____

TOTAL POINTS ON PAGE ____

36 Month Questionnaire

ASQ:SE-2

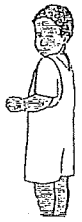
Check the box ☑ that best describes your child's behavior.
Also, check the circle ✓ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
8. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	☐ z	☐ v	☐ x	◯ v	____
9. Does your child seem happy?	☐ z	☐ v	☐ x	◯ v	____
10. Is your child interested in things around him, such as people, toys, and foods?	☐ z	☐ v	☐ x	◯ v	____
11. Does your child do what you ask her to do?	☐ z	☐ v	☐ x	◯ v	____
12. Does your child seem more active than other children his age? 	☐ x	☐ v	☐ z	◯ v	____
13. Does your child stay with activities she enjoys for at least 5 minutes (other than watching shows or videos, or playing with electronics)?	☐ z	☐ v	☐ x	◯ v	____
14. Do you and your child enjoy mealtimes together?	☐ z	☐ v	☐ x	◯ v	____
15. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.) _____ _____	☐ x	☐ v	☐ z	◯ v	____
16. Does your child sleep at least 8 hours in a 24-hour period?	☐ z	☐ v	☐ x	◯ v	____
17. Does your child use words to tell you what she wants or needs?	☐ z	☐ v	☐ x	◯ v	____

TOTAL POINTS ON PAGE ____

36 Month Questionnaire

ASQ:SE-2™ Check the box ☑ that best describes your child's behavior. Also, check the circle ⊘ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
18. Does your child follow routine directions? For example, does he come to the table or help clean up his toys when asked?	☐ z	☐ v	☐ x	◯ v	____
19. Does your child cry, scream, or have tantrums for long periods of time?	☐ x	☐ v	☐ z	◯ v	____
20. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home? 	☐ z	☐ v	☐ x	◯ v	____
21. Does your child do things over and over and get upset when you try to stop her? For example, does she rock, flap her hands, spin, or _____? (Please describe.) _____ _____	☐ x	☐ v	☐ z	◯ v	____
22. Does your child hurt himself on purpose?	☐ x	☐ v	☐ z	◯ v	____
23. Does your child stay away from dangerous things, such as fire and moving cars?	☐ z	☐ v	☐ x	◯ v	____
24. Does your child destroy or damage things on purpose?	☐ x	☐ v	☐ z	◯ v	____
25. Does your child use words to describe her feelings and the feelings of others? For example, does she say, "I'm happy," "I don't like that," or "She's sad"?	☐ z	☐ v	☐ x	◯ v	____
26. Can your child name a friend?	☐ z	☐ v	☐ x	◯ v	____

TOTAL POINTS ON PAGE ____

36 Month Questionnaire

ASQ:SE-2™

Check the box ☑ that best describes your child's behavior.
Also, check the circle ⊘ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
27. Do *other* children like to play with your child?	☐ z	☐ v	☐ x	◯ v	____
28. Does *your child* like to play with other children? 	☐ z	☐ v	☐ x	◯ v	____
29. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	☐ x	☐ v	☐ z	◯ v	____
30. Does your child show an unusual interest in or knowledge of sexual language and activity?	☐ x	☐ v	☐ z	◯ v	____
31. Does your child try to show you things by pointing at them and looking back at you?	☐ z	☐ v	☐ x	◯ v	____
32. Does your child pretend objects are something else? For example, does he pretend a banana is a phone?	☐ z	☐ v	☐ x	◯ v	____
33. Does your child wake three or more times during the night?	☐ x	☐ v	☐ z	◯ v	____
34. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____	☐ x	☐ v	☐ z	◯ v	____
35. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: _____ _____ _____	☐ x	☐ v	☐ z	◯ v	____

TOTAL POINTS ON PAGE ____

OVERALL Use the space below for additional comments.

36. Do you have concerns about your child's eating, sleeping, or toileting habits? If yes, please explain: ◯ YES ◯ NO

37. Does anything about your child worry you? If yes, please explain: ◯ YES ◯ NO

38. What do you enjoy about your child?