

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

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 blood pressure
- Head-to-toe physical exam
- Check of your child's teeth, gums, and mouth
- Check for risk of tuberculosis
- 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
- Complete screening as described above in A and B
- Screening described above except: _____

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: ISD #877 Buffalo Hanover Montrose Schools

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)

41 - Screening by District

44 - Private Provider

42 - Child and Teen Checkups/EPSTD

43 - Head Start

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 Release of Information

Child's Name: _____ Birthdate: _____

(For office use only)

MARSS other ID: Parent/Guardian Name(s): _____

ISD #877 BuffaloHanover Montrose Schools (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)
- School Readiness
- Other (regionally specific programs)

_____ Understand Information _____ Authorize release of information

Parent/Guardian Signature: _____ Date: _____ Relationship to Child: _____ REV:



Student Registration Form

For Office Use Only	
School Name:	Teacher:
Student#:	Effective Date:
Transportation: <input type="checkbox"/> W <input type="checkbox"/> R <input type="checkbox"/> E <input type="checkbox"/> OE Bus#:	

Student Legal LAST Name	Student Legal FIRST Name	Student Legal MIDDLE Name	DOB (mm/dd/yyyy)
Has this child ever attended school in our district? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, When:			
Military Connected Youth? <input type="checkbox"/> Yes <input type="checkbox"/> No		Legal Gender <input type="checkbox"/> M <input type="checkbox"/> F	Grade Enrolling in
Student Cell Phone			
Does the student receive any other services? <input type="checkbox"/> Special Ed <input type="checkbox"/> EL/ESL/ELD <input type="checkbox"/> 504 Plan <input type="checkbox"/> Title 1 <input type="checkbox"/> Gifted			
Please Explain:			
Schools are required to complete bus safety training annually. Please check this box if your child DID NOT receive training this year: <input type="checkbox"/>			

STUDENT'S PRIMARY Household

Note: Please notify the school office and provide legal documentation if there is a custodial issue.

Address	City	State	Zip	Home Phone
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Student lives with (check ALL that apply):

Parent Guardian Step-Parent Foster Parent Relative/Other (Please List):

Primary Household Parent/Guardian 1		Primary Household Parent/Guardian 2	
Name (Last, First, MI)		Name (Last, First, MI)	
Email		Email	
Cell Phone		Cell Phone	
Work Phone		Work Phone	

Please list all additional members of the Primary Household (adults and children)

Full Legal Name (Last, First, Middle)	DOB (mm/dd/yyyy)	Relationship to Student	Grade	School (If Attending)

STUDENT'S SECONDARY Household

Note: Legal documentation is required if school information should NOT be sent to this household.

Address	City	State	Zip	Home Phone
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Student lives with (check ALL that apply):

Parent Guardian Step-Parent Foster Parent Relative/Other (Please List):

Secondary Household Parent/Guardian 1		Secondary Household Parent/Guardian 2	
Name (Last, First, MI)		Name (Last, First, MI)	
Email		Email	
Cell Phone		Cell Phone	
Work Phone		Work Phone	

Please list all additional members of the Secondary Household (adults and children)

Full Legal Name (Last, First, Middle)	DOB (mm/dd/yyyy)	Relationship to Student	Grade	School (If Attending)

Please Complete Both Sides →

Student's Previous School Enrollments (list the most recent first)

*Name of School	City and State	Grade(s)	School Phone, Email or Fax (if known)
*If student is enrolling in grades 9-12, please make sure to list ALL high schools for credit purposes.			

Student's Ethnicity

Due to differences in State and Federal reporting guidelines, it is necessary to make selection(s) in all three sections below.

1. For Federal reporting, check ONE	2. For Federal reporting, check all responses that apply. (Must check ONE)
Is the student Hispanic or Latino? <input type="checkbox"/> Yes (please select all that apply) <input type="checkbox"/> Decline to indicate <input type="checkbox"/> Colombian <input type="checkbox"/> Ecuadorian <input type="checkbox"/> Guatemalan <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Salvadoran <input type="checkbox"/> Spaniard/Spanish/Spanish-American <input type="checkbox"/> Other Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African America <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White

3. For State reporting, select YES to at least ONE of the following:		
Is the student American Indian or Alaska Native? <input type="checkbox"/> Yes (please select all that apply) <input type="checkbox"/> Decline to indicate <input type="checkbox"/> Cherokee <input type="checkbox"/> Other North American Indian Tribal Affiliation <input type="checkbox"/> Anishinaabe/Ojibwe <input type="checkbox"/> Dakota/Lakota <input type="checkbox"/> Unknown <input type="checkbox"/> No	Is the student Asian? <input type="checkbox"/> Yes (please select all that apply) <input type="checkbox"/> Decline to indicate <input type="checkbox"/> Asian Indian <input type="checkbox"/> Burmese <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Hmong <input type="checkbox"/> Karen <input type="checkbox"/> Korean <input type="checkbox"/> Other Asian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Unknown <input type="checkbox"/> No	Is the student black or African American? <input type="checkbox"/> Yes (please select all that apply) <input type="checkbox"/> Decline to indicate <input type="checkbox"/> African-American <input type="checkbox"/> Ethiopian-Other <input type="checkbox"/> Ethiopian-Oromo <input type="checkbox"/> Liberian <input type="checkbox"/> Nigerian <input type="checkbox"/> Other black <input type="checkbox"/> Somali <input type="checkbox"/> Unknown <input type="checkbox"/> No
Is the student American Indian from South or Central America? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the student Native Hawaiian or Other Pacific Islander? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the student white? <input type="checkbox"/> Yes <input type="checkbox"/> No

Home Language Questionnaire

	Check the phrase that best describes your student:	Indicate the language(s) other than English:
My student first learned:	<input type="checkbox"/> Language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> Only English.	
My student speaks:	<input type="checkbox"/> Language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> Only English.	
My student understands:	<input type="checkbox"/> Language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> Only English.	
My student has meaningful and consistent exposure to:	<input type="checkbox"/> Language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> Only English.	

Parent/Guardian Signature

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. You are not required to respond to all requests for information on this form; however, be advised that incomplete information may limit the ability of the Buffalo Hanover Montrose Schools to fully provide education services.

I certify the information given above is true and complete to the best of my knowledge.

Parent/Guardian Signature

Parent/Guardian PRINTED Name

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Early Childhood Family Education | <input type="checkbox"/> Child & Teen Check-ups | <input type="checkbox"/> Child care center |
| <input type="checkbox"/> Early Childhood Special Education | <input type="checkbox"/> School-based pre-K | <input type="checkbox"/> Family/neighbor care |
| <input type="checkbox"/> Follow Along program | <input type="checkbox"/> Private preschool | <input type="checkbox"/> Library |
| <input type="checkbox"/> Parenting Education | <input type="checkbox"/> Head Start | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Parks and Recreation programs | <input type="checkbox"/> Foster Care | <input type="checkbox"/> 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):

- | | | |
|---|---|--|
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Growth Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Health Disorders | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Deafness/Hearing | <input type="checkbox"/> Sickle Cell Anemia/Trait | <input type="checkbox"/> Other health problems |

CHILD'S DAILY ROUTINES

- _____ Sleeps at ___ pm. Wakes up at ___ am. Gets 60 minutes or more of exercise each day
- Has difficulty falling/staying asleep Is NOT able to/does NOT get 60 minutes of exercise
- Takes a nap: from _____ to _____ _____ 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:

- | | |
|---|---|
| <input type="checkbox"/> Says numbers 1 to 10 | <input type="checkbox"/> understands other people |
| <input type="checkbox"/> Has trouble speaking or hard to understand | <input type="checkbox"/> Able to follow directions |
| <input type="checkbox"/> Has trouble being understood by others | <input type="checkbox"/> Plays in a variety of ways |
| <input type="checkbox"/> Seems clumsy when using hands | <input type="checkbox"/> Walks or runs poorly (falls) |