

## 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 \_\_\_\_\_



### 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)

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> 41 - Screening by District | <input type="checkbox"/> 44 - Private Provider                     |
| <input type="checkbox"/> 42 - Child and Teen Checkups/EPST     |  |
| <input type="checkbox"/> 43 - Head Start                       | <input type="checkbox"/> 45 - Conscientious Objector, no screening |

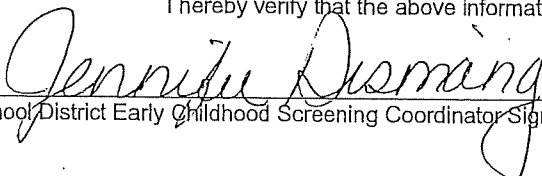
Check the **Primary** type of referral following the early childhood health and developmental screening using STATUS END CODES (SEC). Only one box may be checked. Must have a valid SEC for – STATE AID CATEGORY (SAC) 41. If unsure of referral status for SAC 42-44, use "no referral" SEC 60. (To be completed by the Early Childhood Screening Coordinator.)

**Status End Codes:**

- |  |  |
|--|--|
| <input type="checkbox"/> 60 - No referral  | <input type="checkbox"/> 64 - Referral to early childhood programs*                |
| <input type="checkbox"/> 61 - Referral to special education                          | (*School Readiness, Head Start, Early Childhood Family Education, family literacy) |
| <input type="checkbox"/> 62 - Referral to health care provider                       | <input type="checkbox"/> 65 – Referral offered, parent declined                    |
| <input type="checkbox"/> 63 - Referral to special education AND health care provider | <input type="checkbox"/> 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

## 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.<sup>1</sup>

*[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*):

- |  |                                       |  |  |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Decline to indicate | <input type="checkbox"/> Guatemalan   | <input type="checkbox"/> Salvadoran                            | <input type="checkbox"/> Other Hispanic/Latino |
| <input type="checkbox"/> Colombian           | <input type="checkbox"/> Mexican      | <input type="checkbox"/> Spaniard/Spanish/<br>Spanish-American | <input type="checkbox"/> Unknown               |
| <input type="checkbox"/> Ecuadorian          | <input type="checkbox"/> 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*):

- |  |  |   |
|--|--|---|
| <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  |

*Go to Question 2.*

<sup>1</sup>Federal Register, Vol. 72, No. 202/Friday, October 19, 2007/Notices/59274

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

Yes [Go to Question 3.]

No [Go to Question 3.]

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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.<sup>1</sup>

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.

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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.<sup>1</sup>

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.

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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.<sup>1</sup>

Yes [Go to Question 6.]

No [Go to Question 6.]

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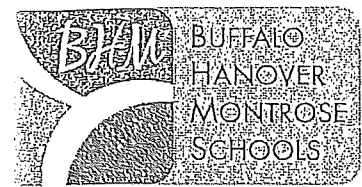
Question 6. Is the student white as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Europe, the Middle East, or North Africa.<sup>1</sup>

Yes

No

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

Parent(s)/Guardian Signature \_\_\_\_\_



## Buffalo-Hanover-Montrose Early Childhood Screening

301 NE 2<sup>nd</sup> Avenue  
Buffalo, MN 55313  
(763) 682-8408  
bhmschools.org

*Making a Difference!*

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. | _____ 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  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

understands other people

Has trouble speaking or hard to understand

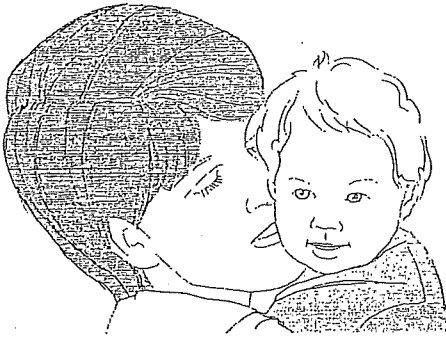
Able to follow directions

Has trouble being understood by others

Plays in a variety of ways

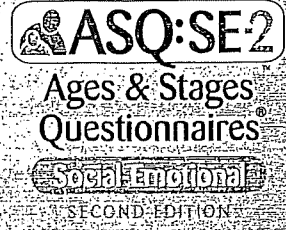
Seems clumsy when using hands

Walks or runs poorly (falls)



# 36 Month Questionnaire

33 months 0 days through 41 months 30 days



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: \_\_\_\_\_

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



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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
2. Does your child like to be hugged or cuddled?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
3. Does your child talk or play with adults he knows well?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
4. Does your child cling to you more than you expect?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
5. When upset, can your child calm down within 15 minutes?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
6. Does your child seem too friendly with strangers?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
7. Does your child settle herself down after exciting activities?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____



TOTAL POINTS ON PAGE \_\_\_\_\_

# 36 Month Questionnaire



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)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
9. Does your child seem happy?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
10. Is your child interested in things around him, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
11. Does your child do what you ask her to do?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
12. Does your child seem more active than other children his age?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> 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)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
14. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
15. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.) _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
16. Does your child sleep at least 8 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
17. Does your child use words to tell you what she wants or needs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____



TOTAL POINTS ON PAGE \_\_\_\_\_

# 36 Month Questionnaire



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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
19. Does your child cry, scream, or have tantrums for long periods of time?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> 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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> 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.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
<div data-bbox="727 632 802 856" data-label="Image"> </div>					
22. Does your child hurt himself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
23. Does your child stay away from dangerous things, such as fire and moving cars?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
24. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> 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"?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
26. Can your child name a friend?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE \_\_\_\_\_

# 36 Month Questionnaire



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 <i>other</i> children like to play with your child?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
28. Does <i>your child</i> like to play with other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
					
29. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
30. Does your child show an unusual interest in or knowledge of sexual language and activity?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
31. Does your child try to show you things by pointing at them and looking back at you?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
32. Does your child pretend objects are something else? For example, does he pretend a banana is a phone?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
33. Does your child wake three or more times during the night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
34. Is your child too worried or fearful? If "sometimes" or "often or always," please describe:	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
_____					
_____					
_____					
35. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain:	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> 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

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37. Does anything about your child worry you? If yes, please explain:

YES  NO

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38. What do you enjoy about your child?

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