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

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)

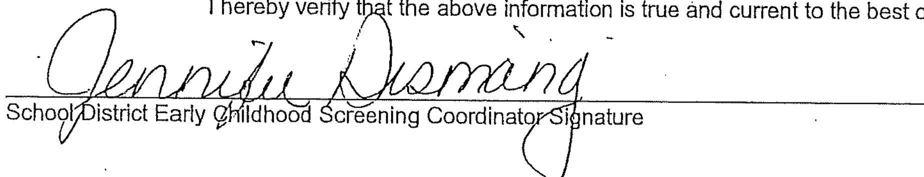
X 41 - Screening by District
___ 42 - Child and Teen Checkups/EPSDT
___ 43 - Head Start
___ 44 - Private Provider
___ 45 - Conscientious Objector, no screening

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.



School District Early Childhood Screening Coordinator Signature ____________ Date

Use after 7/1/18

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

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
- ☐ Anishinaabe/Ojibwe
- ☐ Cherokee
- ☐ Dakota/Lakota
- ☐ Other North American Indian Tribal Affiliation
- ☐ Unknown

Go to Question 2.

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[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?**

O **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]

O **Yes** *[If yes, go to Question 3a.]*   O **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
- ☐ Asian Indian
- ☐ Burmese
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Karen
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Unknown

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]

O **Yes** *[If yes, go to Question 4a.]*   O **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
- ☐ African-American
- ☐ Ethiopian-Oromo
- ☐ Ethiopian-Other
- ☐ Liberian
- ☐ Nigerian
- ☐ Somali
- ☐ Other black
- ☐ 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]

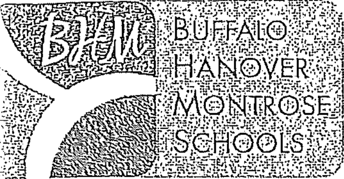
O **Yes** *[Go to Question 6.]*   O **No** *[Go to Question 6.]*

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]

O **Yes**   O **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 ______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

______Has trouble speaking or hard to understand

______Has trouble being understood by others

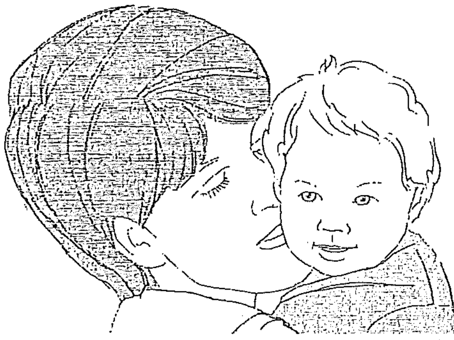
______Seems clumsy when using hands

______ understands other people

______ Able to follow directions

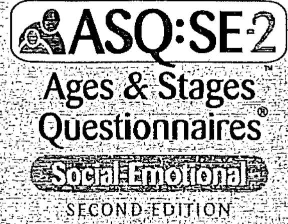
______ Plays in a variety of ways

______ Walks or runs poorly (falls)



60 Month Questionnaire

54 months 0 days through 72 months 0 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: ______________________

P201600000

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60 Month Questionnaire *54 months 0 days through 72 months 0 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?	☐ z	☐ v	☐ x	○ v	____
2. Does your child cling to you more than you expect?	☐ x	☐ v	☐ z	○ v	____
3. Does your child like to be hugged or cuddled?	☐ z	☐ v	☐ x	○ v	____
4. Does your child talk or play with adults he knows well?	☐ z	☐ v	☐ x	○ 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	____
8. Does your child seem happy?	☐ z	☐ v	☐ x	○ v	____

TOTAL POINTS ON PAGE ____

P201600100

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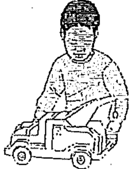
Check the box ☑ that best describes your child's behavior. Also, check the circle ✓ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
9. Does your child cry, scream, or have tantrums for long periods of time?	☐ x	☐ v	☐ z	○ v	____
10. Is your child interested in things around him, such as people, toys, and foods? 	☐ z	☐ v	☐ x	○ v	____
11. Does your child go to the bathroom by herself? (Reminders and help with wiping are okay.)	☐ z	☐ v	☐ x	○ v	____
12. 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	____
13. Does your child stay with activities she enjoys for at least 15 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 do what you ask him to do? For example, does he wash his hands or wait to take a turn when asked?	☐ z	☐ v	☐ x	○ v	____
16. Does your child seem more active than other children her age?	☐ x	☐ v	☐ z	○ v	____
17. Does your child sleep at least 8 hours in a 24-hour period?	☐ z	☐ v	☐ x	○ v	____
18. Does your child use words to tell you what he wants or needs?	☐ z	☐ v	☐ x	○ v	____

TOTAL POINTS ON PAGE ____

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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	
19. 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	____
20. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	☐ z	☐ v	☐ x	◯ v	____
21. Does your child explore new places, such as a park or a friend's home?	☐ z	☐ v	☐ x	◯ v	____
22. Does your child do things over and over and get upset when you try to stop him? For example, does he rock, flap his hands, spin, or ________? (Please describe.) ______________________________ ______________________________	☐ x	☐ v	☐ z	◯ v	____
23. Does your child hurt herself on purpose?	☐ x	☐ v	☐ z	◯ v	____
24. Does your child follow rules at home or at child care?	☐ z	☐ v	☐ x	◯ v	____
25. Does your child destroy or damage things on purpose?	☐ x	☐ v	☐ z	◯ v	____
26. Does your child stay away from dangerous things, such as fire and moving cars?	☐ z	☐ v	☐ x	◯ v	____
27. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt?	☐ z	☐ v	☐ x	◯ v	____
28. Do *other* children like to play with your child?	☐ z	☐ v	☐ x	◯ v	____

TOTAL POINTS ON PAGE ____

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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	
29. Does *your child* like to play with other children?	☐ z	☐ v	☐ x	○ v	___
30. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	☐ x	☐ v	☐ z	○ v	___
31. Does your child take turns and share when playing with other children?	☐ z	☐ v	☐ x	○ v	___
32. Does your child show an unusual interest in or knowledge of sexual language and activity?	☐ x	☐ v	☐ z	○ 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. Does your child have simple back-and-forth conversations with you? For example: Parent: "It's raining!" Child: "And cold outside." Parent: "Let's get your coat." Child: "I got it!"	☐ z	☐ v	☐ x	○ v	___
36. 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 ___

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OVERALL Use the space below for additional comments.

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

___

___

___

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

___

___

___

39. What do you enjoy about your child?

___

___

___

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