Registration for Early Childhood Screening

GENERAL INFORMATION AND INSTRUCTIONS: Page one of the registration form must be completed by the child’s parent/guardian. The back side (page two) is completed by school district personnel only. Please print.

Child’s Legal Name: (First, Middle, Last): ____________________________

Child’s Nickname or Other Name (First, Middle, Last): ____________________________

Child’s Birth Date: ______________ Gender: Male ______ Female ______

Address: __________________________

City: __________________________ State: ________ Zip: ______________

Race/Ethnicity (choose ONLY one)

_____ 1 - American Indian

_____ 2 - Asian or Pacific Islander

_____ 3 - Hispanic

_____ 4 - Black, not of Hispanic Origin

_____ 5 - White, not of Hispanic Origin

Please complete the federal race/ethnicity questions below. You may choose more than one answer in Part B.

*Part A – Is the child Hispanic/Latino? (choose ONE)

_____ NO, not Hispanic/Latino

_____ YES, Hispanic/Latino

*Part B – What is your child’s race? (mark all that apply)

_____ American Indian/Alaska Native

_____ Native Hawaiian/Pacific Islander

_____ Asian

_____ Black/African American

_____ 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) __________________________

In what country was your child born? __________________________

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 ______________

Please print name __________________________ Relationship to child __________________________
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 people 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, Japan, Korea, Malaysia, Pakistan, the Philippines Island, Thailand and Vietnam.

Black or African American – Person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander - Person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

White - Person having origins in any of the original peoples of Europe, the Middle East or North Africa.

TO BE COMPLETED BY SCHOOL DISTRICT PERSONNEL ONLY

Screening District Number and Type: __________________________________________

Screening Date: ________________________ Screen District Name: __________________

Child’s Resident District Name: ________________________________________________

Resident Screening District Number and Type: ___________________________________

MARSS ID Number: __________________________________________________________

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

— 41 - Screening by District
— 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
☐ 65 Referral, parent declined

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 ________________
PHYSICAL EXAMINATION

NAME__________________________ M ______ F ________
(Last) (First) (Middle)
Date of Birth____________________ Grade_________ School________________
Parent/Guardian__________________________________________
Address____________________________________ Phone________________

PHYSICIAN’S FINDINGS AND RECOMMENDATIONS

Height_________ Weight_________ Blood Pressure____________________
Eyes: Right 20/_____ Left: 20/______ Orthopedic____________________
Glasses Worn: Yes____ No_______ Scoliosis Screening ______________
Ears: Right_____ Left: ________ Nervous System________________
Nose___________________________________ Skin__________________
Throat_________________________________ Posture________________
Glands_________________________________ Nutrition________________
Heart__________________________________ Hemoglobin________________
Lungs_________________________________ Urinalysis________________
Allergies______________________________________________
Chickenpox: Date of Disease__________/ Date of Immunization__________
Medical Diagnosis__________________________
Current Medication/ Dosage________________________

Kindergarten Dev. Screening Completed by Physician ________
Yes____ No________
Tool Used________ Pass_______ Fail________ Date of Screening__________
Comments________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Is there any reason why the above student should not participate in inter-scholastic athletics?   Yes_______ No _______ If yes, please specify ____________________

Physician__________________________ Date________________________
Telephone________________________
Clinic Name/Address__________________________
Physical Exam Date:__________________________

Please Return This Form to Your Early Childhood Screening Nurse
(Please attach immunization record from clinic)

Serving the communities of: Eden Prairie · Edina · Golden Valley · Hopkins · Minnetonka · Plymouth · St. Louis Park

An equal opportunity/affirmative action educator and employer.
Child Health and Developmental History (3-5 Years)

Date of Screening____________

Child’s Full Name:________________________ Date of Birth:______ Male____ Female____
Parent/ Guardian Name:________________________ Phone Number:________________
Address:___________________________________________________________________________

Who lives with your child? _____________________________________________________________
Language(s) spoken in the home? __________________________________________________________

Do you have health insurance for your child? ______Yes _______No

Date of last preventive health care visit___________ Date of last dentist visit______________

Has your child seen an eye doctor? ______Yes _______No

Do you have any questions or concerns about your child’s health or development? We can talk about
them at your visit._____________________________________________________________________

Please check resources that you and your child use:
  ____Early Childhood Family Education ECFE)  ____Child and Teen Clinics
  ____Head Start  ____Follow Along program  ____School Readiness programs
  ____WIC  ____Adult education options/parenting programs

Does your child attend preschool or daycare? ____No    ____Yes, where?_____________________

Please check any areas that you have concerns or questions about your child’s:
  ____Health  ____Learning  ____Behavior  ____Talking  ____Growth  ____Skin  ____Eyes/Vision
  ____Nose  ____Throat  ____Teeth  ____Mouth  ____Stomach  ____Toileting  ____Activity level
  ____Walking/Balance  ____Social/Friends  ____Feelings/Moods  ____Breathing/Coughing
  ____Headaches  ____General appearance  ____Other: ________________________________

Health

Please check all that apply to your child and describe:
  ____Allergies_________________  ____Medications___________________________
  ____Medical diagnoses______________  ____Serious illness or injuries_____________
  ____Hospitalizations_________________  ____Problems in pregnancy or birth__________
  ____Family health problems_________________________________

Safety/Learning

Do you have any questions about:
  ____Safety (home environment, tobacco exposure, alcohol/other drugs, guns in the home, other)
  ____Learning (how your child communicates, how your child gets along with other adults or children,
any of your child’s behaviors, your child’s activity levels, access to preschool experiences, other)
  ____Self-care skills (eating, dressing, sleeping, toileting)


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Early Childhood Immunization Form

Must be on file before a child attends any early childhood programs*

| Name _______________________________________________ |
| Birthdate __________________________________________ |
| Date of Enrollment ________________________________ |

Minnesota law requires children enrolled in early education programs to be immunized against certain diseases or file a legal medical or conscientious exemption.

**Parent/Guardian:**
You may attach a copy of the child’s immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian’s conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

Additionally, if a parent or guardian would like to give permission to the early education program to share their child’s immunization record with Minnesota’s immunization information system, they may sign section 3 (optional).

For updated copies of your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

<table>
<thead>
<tr>
<th>Type of Vaccine</th>
<th>DO NOT USE (✓) or (✗)</th>
<th>1st Dose Mo/Day/Yr</th>
<th>2nd Dose Mo/Day/Yr</th>
<th>3rd Dose Mo/Day/Yr</th>
<th>4th Dose Mo/Day/Yr</th>
<th>5th Dose Mo/Day/Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)</td>
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<tr>
<td>Diphtheria, Tetanus, and Pertussis (DTaP, DTP)</td>
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<td>• 3 doses during 1st year (at 2-month intervals)</td>
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<td>• 4th dose at 12-18 months</td>
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<tr>
<td>• 5th dose at 4-6 years</td>
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<tr>
<td>Indicate vaccine type: DTaP or DTP</td>
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<td>Polio (IPV, OPV)</td>
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<td>• 2 doses in the first year</td>
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<tr>
<td>• 3rd dose by 18 months</td>
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<tr>
<td>• 4th dose at 4-6 years</td>
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<tr>
<td>Measles, Mumps, and Rubella (MMR)</td>
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<td>• Required for children 15 months and older</td>
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<tr>
<td>• 1st dose on or after 1st birthday</td>
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<td>• 2nd dose at 4-6 years</td>
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<tr>
<td>Haemophilus influenzae type b (Hib)</td>
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<td>• 2-3 doses in the first year</td>
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<td>• 1 dose required after 12 months or older</td>
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<td>• For unvaccinated children 15-59 months, 1 dose is required</td>
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<td>• Not required for children 5 years or older</td>
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<tr>
<td>Varicella (chickenpox)</td>
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<td>• Required for children 15 months and older</td>
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<td>• 1st dose on or after 1st birthday</td>
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<td>• 2nd dose at 4-6 years</td>
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<td>Pneumococcal Conjugate Vaccine (PCV)</td>
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<td>• Required for children age 2 - 24 months</td>
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<td>• 3 doses in the first year</td>
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<td>• 4th dose after 12 months</td>
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<td>• At least 1 dose is recommended for children age 24-59 months in child care</td>
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<td>Hepatitis B (hep B)</td>
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<td>• 2-3 doses in the first year</td>
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<td>• 3rd dose (final dose) by 18 months</td>
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<td>Hepatitis A (hep A)</td>
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<td>• 2 doses separated by 6 months for children 12 months and older</td>
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<td>Recommended</td>
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<td>Rotavirus (2-3 doses between 2 and 6 months)</td>
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<td>Influenza (annually for children 6 months or older)</td>
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</table>

*Early childhood programs are defined as programs that provide instructional or other services to support children’s learning and development and:
• Serve children from birth to kindergarten.
• Meet at least once a week for at least six weeks or more during the year.

This includes but not limited to early childhood family education (ECFE), early childhood special education (ECSE), school readiness programs, and other public and private preschool and pre-kindergarten programs.
Instructions, please complete:
Box 1 to certify the child’s immunization status
Box 2 to file an exemption (medical or conscientious)
Box 3 to provide consent to share immunization information (optional)

1. Certify Immunization Status. Complete A or B to indicate child’s immunization status.

A. Children who are 15 months or older:
For children who are 15 months or older and who have received all the immunizations required by law for early childhood programs:
I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.

______ Date

Signature of Parent / Guardian OR Physician / Nurse Practitioner / Physician Assistant / Public Clinic

B. Children who are younger than 15 months:
For children who are younger than 15 months OR have not received all required immunizations:
I certify that the above-named child has received the immunizations indicated. In order to remain enrolled this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:

______ Date

Signature of Physician / Nurse Practitioner / Physician Assistant / Public Clinic

2. Exemptions to Immunization Law. Complete A and/or B to indicate type of exemption.

A. Medical exemption:
No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:
I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

Signature of physician/nurse practitioner/physician assistant

______ Date

*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in ___________ (year)

Signature of physician/nurse practitioner/physician assistant (If disease occurred before September 2010, a parent can sign.)

B. Conscientious exemption:
No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:
I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):

Signature of parent or legal guardian

______ Date

Subscribed and sworn to before me this:
_______ day of ______________________ 20______

Signature of notary (A copy of the notarized statement will be forwarded to the commissioner of health.)

3. Parental/Guardian Consent to Share Immunization Information (optional):
Your child’s early childhood program is asking your permission to share your child’s immunization documentation with MIIC, Minnesota’s immunization information system, to help better protect children from disease and allow easier access for you to retrieve your child’s immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.
I agree to allow early childhood program personnel to share my child’s immunization documentation with Minnesota’s immunization information system:

Signature of parent or legal guardian

Date
Family Information

This form is optional, however it can be helpful to know more about family factors that may affect a child’s learning readiness. There may be district resources available to you that could be identified by answering the questions below. You have the option of sharing this information with the Early Childhood Screening staff, but not sharing it in any other way and you can indicate your preference on the back of this form.

Family History: Are there significant illnesses within your family and what effect does this have on your family?

What do you see as the strengths of your family?

Has there been any unusual stress in your family within the past year or more that might have an impact on your child? (Examples: new family member, divorce, moving, financial stress, etc.)

Do you have a support system (friends/relatives/other) that helps you with your family?

Behavior: What are the things you most enjoy about parenting your child?

Are there also some things that make parenting challenging?

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

I do___ do not___ give my permission to include this as part of my child’s Early Childhood Screening record_____________________________________/date___________

Parent signature

revised 9/2016