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: _____

Screening Date: _____ Screening 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
___ 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

Early Childhood Special Education Program
Harley Hopkins Family Center
125 South Monroe Avenue
Hopkins, MN 55343
Lori Abel RN, LSN school nurse
952-988-5034 lori.abel@hopkinsschools.org

PHYSICAL EXAMINATION

NAME_____M_____F_____
(Last) (First) (Middle)
Date of Birth_____Grade_____School_____

Parent/Guardian_____

Address_____Phone_____

PHYSICIAN'S FINDINGS AND RECOMMENDATIONS

Height_____Weight_____
Eyes: Right 20/_____ Left: 20/_____
Glasses Worn: Yes_____ No_____
Ears: Right_____ Left: _____
Nose_____
Throat_____
Glands_____
Heart_____
Lungs_____
Blood Pressure_____
Orthopedic_____
Scoliosis Screening _____
Nervous System_____
Skin_____
Posture_____
Nutrition_____
Hemoglobin_____
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)

Early Childhood Special Education Program
Harley Hopkins Family Center
125 South Monroe Avenue
Hopkins, MN 55343
Lori Abel RN, LSN school nurse
952-988-5034 lori.abel@hopkinsschools.org

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:_____
street city zip

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)

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.

*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.

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.

Type of Vaccine DO NOT USE (✓) or (×)	**1st Dose Mo/Day/Yr**	**2nd Dose Mo/Day/Yr**	**3rd Dose Mo/Day/Yr**	**4th Dose Mo/Day/Yr**	**5th Dose Mo/Day/Yr**
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.)					
Diphtheria, Tetanus, and Pertussis (DTaP, DTP) • 3 doses during 1st year *(at 2-month intervals)* • 4th dose at 12-18 months • 5th dose at 4-6 years *Indicate vaccine type: DTaP or DTP*					5th dose not required if 4th dose was given on or after the 4th birthday
Polio (IPV, OPV) • 2 doses in the first year • 3rd dose by 18 months • 4th dose at 4-6 years			4th dose not required if 3rd dose was given on or after the 4th birthday		
Measles, Mumps, and Rubella (MMR) • Required for children 15 months and older • 1st dose on or after 1st birthday • 2nd dose at 4-6 years					
***Haemophilus influenzae* type b (Hib)** • 2-3 doses in the first year • 1 dose required after 12 months or older • For unvaccinated children 15-59 months, 1 dose is required • Not required for children 5 years or older					
Varicella (chickenpox) • Required for children 15 months and older • 1st dose on or after 1st birthday • 2nd dose at 4-6 years					
Pneumococcal Conjugate Vaccine (PCV) • Required for children age 2 - 24 months • 3 doses in the first year • 4th dose after 12 months • At least 1 dose is recommended for children age 24-59 months in child care					
Hepatitis B (hep B) • 2-3 doses in the first year • 3rd dose (final dose) by 18 months					
Hepatitis A (hep A) • 2 doses separated by 6 months for children 12 months and older					
Recommended					
Rotavirus (2-3 doses between 2 and 6 months)					
Influenza (annually for children 6 months or older)					

Name _____

Instructions, please complete:

Box 1 to certify the child's immunization status

Box 2 to file an exemption (medical or concientious)

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.

_____

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

_____ Date

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:

_____

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

_____ Date

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 occured 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

HOPKINS
PUBLIC SCHOOLS

EARLY CHILDHOOD SCREENING-parent consent

Child's name_____ Birth Date_____ Parent/Guardian_____

Early Childhood Screening includes;

- Review of immunizations
- Growth check (height and weight)
- Screening for vision and eye health
- Screening for hearing
- Screening of general development
- Information about health care and insurance
- Review of factors that influence health, growth and development
- Health and development history from parent/ guardian
- Discussion of resources in your school and community based on screening information.

(This screening does not replace on-going care from your health care provider/ dentist/ vision care provider)

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 you child's entry into the public school kindergarten or first grade. This requirement is met if your child has participated in a screening through Head Start, Child and Tee checkups or equivalent screening through another provider within the past year. The screening summary results must be given to our child's school district.
3. Screening is not required if you are a conscientious objector to screening.
4. You have the right to refuse any of this screening for your child and still receive any of the other screening parts.
5. You have the right to refuse referral for 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 Early Childhood Screening for _____(child's name)
____Complete screening as described above ____Screening described above except:_____
Parent/ Guardian Signature_____ Date_____ Relationship to child_____

Consent to Release Information

Hopkins Early Childhood Screening uses Screening information 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. 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.

Information may be used for the following purposes:

1. To obtain follow-up services for your child after the screening.
2. To arrange for further evaluation or assessment of your child's health, growth, development or learning.
3. To fulfill the requirements for your child's entrance into public school.
4. To evaluate screening programs by the Minnesota Department of Health, Minnesota Department of Education and/ or the Department of Human Services. Your child's name will not be identified in any evaluation results.

I hereby authorize release of my child's screening information to the following checked programs or services for the purpose of evaluation, assessment, diagnosis, treatment, follow-up, and/ or programming.

____ Early Childhood Family Education, Early Childhood Special Education, School Readiness

____School District

____Other:_____

Parent/ Guardian Signature_____ Date_____ Relationship to child_____

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