Early Childhood Screening Consent

Child's Name: _____

Birthdate: _____ 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 healthcare provider or dentist.

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

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 for the child indicated above:

Check One:

____ ***Complete screening as described above***

____ ***Screening described above except:*** _____

____ ***I grant permission for my child to be screened without a parent/guardian present***

Parent/Guardian Signature _____ Date _____

Relationship to Child _____

REV: 02/2020

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): _____

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: Alexandria Public Schools District 206

Screening Date: _____ _____ Screening District Name: SD 206

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

DEPARTMENT OF HEALTH

Initial Child & Family Health History

Patient Information

Last Name: _____ **First Name:** _____ **Middle Initial:** _____ **Birth Date** (MM/DD/YY): _____

GENERAL

Do you consider your child to be in good health?
□ Yes □ No □ Don't know
Explain:

Does your child have any special health care needs?
□ Yes □ No □ Don't know
Explain:

SOCIAL HISTORY

Who does the child live with?
Relationships/Names:

Does the child attend day care, Head Start, or school on a regular basis? □ No □ Yes:

Has your child received any special services or accommodations?
□ No □ Yes:

ALLERGIES (food/drugs/seasonal/environmental):	DESCRIBE REACTION

CURRENT MEDICATIONS (Name)	DOSE	USED FOR (prescription/over the counter/herbal):

Birth History – *ONLY Complete if Child is 3 years old or younger*

Complications during pregnancy: □ Yes □ No Explain:

Delivery (mark all that apply):
□ On time □ Premature □ Late
□ Normal Vaginal □ Induced □ Prolonged Labor
□ Breech □ C-Section □ Forceps □ Other:

Newborn Health (mark all that apply):
□ Birth Defects □ Infection □ Breathing Problems □ Jaundice
□ Transfusion □ Congenital Disease □ Metabolic Disorder
□ Circumcised □ Other:

Newborn Screening Results

Newborn hearing	□ Normal	□ Abnormal/Follow up
Newborn blood spot	□ Normal	□ Abnormal/Follow up
Critical congenital heart disease (pulse ox)	□ Normal	□ Abnormal/Follow up

Complete the remainder of the form for ALL children

HOSPITALIZATIONS OR SURGERIES (Date Month/Year, Reason):

Name: _____ **DOB:** _____

SERIOUS INJURY OR FRACTURE OR BURNS (Date Month/Year, Reason):

MEDICAL AND DENTAL PROVIDERS (List Provider or Clinic Name): **Release of information is still required to share info.*

Past Medical History (circle conditions the child or family has had):	Child	Family	Comments
Eye infections, vision problems, cataracts			
Hearing problems, frequent ear infections			
Frequent sore throats or colds, snoring, dental cavities, mouth problems			
Asthma, wheezing, bronchitis, pneumonia, tuberculosis			
Food intolerances, underweight, overweight			
Heart disease, high blood pressure, high cholesterol, stroke			
Stomach pain, constipation, reflux, diarrhea, liver disease, digestive problems, celiac disease			
Bladder or kidney infections, kidney disease, bedwetting (after age 5 years)			
Abnormal breast development, undescended testicle, hernia, early or late puberty			
Bone, joint, muscle, coordination problems, arthritis, toe-walking, frequent falls			
Anemia, bruises easily, sickle cell trait or disease, elevated lead levels			
Headaches, numbness, tingling, chronic pain, seizures, epilepsy, concussion, fainting			
Eczema, psoriasis, impetigo, rashes, acne, birth marks			
Diabetes, thyroid disorder, metabolic or endocrine disorders			
Birth defects or congenital anomalies			
Recurrent fevers, fatigue, loss of appetite, unintentional weight loss or gain:			
Cancer, bone marrow or organ transplant			
Depression, anxiety, bipolar disorder, other mental health issues			
ADHD/ADD, behavioral concerns			
Developmental delay (speech, motor, cognitive) or learning difficulties			
Substance use (tobacco, vaping, alcohol, drugs)			
Death in the 1st year of life or sudden death at any age from any cause			

Other medical, social or developmental problems or concerns

I have answered these questions to the best of my knowledge so that my child's health care providers have complete and accurate information in order to best care for my child. I understand that incorrect or incomplete information may affect the provider's ability to effectively care for my child.

Parent/Guardian Signature: _____ **Date:** _____