Minnewaska Area Schools
District 2149

Welcome! Your child has an Early Childhood Screening appointment scheduled soon.

Please print and complete the attached Early Childhood Screening forms and bring them to your appointment. Also, bring a current copy of your child's Immunization Record.

- Please plan 1-1 ½ hours for the screening to be completed.
- Your child must be accompanied by a parent or legal guardian.
- Please bring only the child being screened so there are no distractions and the child can do their best.

In consideration of all families, if arriving 15 minutes late, you may be asked to reschedule.

Early Childhood Screening Day - What you and your child can expect

We hope your child will enjoy the various activities planned for the screening. Some of these activities may be a new experience for your child. We encourage you to discuss with your child that he/she is not expected to complete all tasks or answer all questions. It is not about being right or being the best. Rather, it is a snapshot of how each child is doing in different areas. You and your child will move through the following stations.

1. Check-in table: Paperwork, height & weight
2. Developmental assessment with Early Childhood professional*
3. Vision & Hearing check with School Nurse**
4. Family interview*** & exit summary (Parent will be given a summary of screening results)

*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.
***You may decline to answer questions or provide information about family circumstances that might affect development and identification of risk factors that may influence learning. Declining will not prevent your child from being enrolled in public school if all other screening components are met.

Children are encouraged to participate and do their best during the process without coaching or prompting from parents/guardians. Thank you!

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.

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: _____2149_____

Screening Date: _____ Screening District Name:_____Minnewaska Area School_____

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)

_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

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 healthcare 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

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
____Screening described above except:_____
____Ok to screen at school

Parent/Guardian Signature _____Date _____Relationship to Child _____

Initial Child & Family Health History

Child Information

Last name:_____ First Name:_____ Middle Initial:___Birthdate(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? □Yes □No Has your child received any special services or accommodations? □Yes □ No
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):	**Newborn Health** (mark all that apply):
□On time □Premature □Late □Normal Vaginal □Induced □ Prolonged Labor □Breech □C-Section □Forceps □ Other	□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):
HEALTH INSURANCE □Yes □No

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, bed wetting (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, birthmarks			
Diabetes, thyroid disorder, metabolic or endocrine disorders			
Birth defects, or congenital anomalies			
Recurrent fevers, fatigue, loss of appetite, unintentional weight loss or gain			
Cancer, organ or bone marrow transplant			
Depression, anxiety, bipolar disorder, other mental health issues			
ADHD/ADD, behavioral concerns			
Developmental delay (speech, motor, cognitive) or learning difficulties			
Substance abuse (tobacco, vaping, alcohol, drugs)			
Death in the first 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 healthcare 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:**_____