MINNEAPOLIS PUBLIC SCHOOLS
Urban Education. Global Citizens.

Please complete & bring with you to screening!

Early Childhood Screening
HEALTH AND FAMILY INFORMATION

*Screening and immunizations are **REQUIRED** before entering Kindergarten*

NOTE TO PARENT/GUARDIAN: Early Childhood Screening is required by the State of Minnesota for your child to enroll in public school kindergarten or first grade, unless you are a conscientious objector to screening. If your child had a screening at Head Start or your health care provider in the last 365 days, your child does not need to be screened through the district screening program. You may choose to decline any part of the screening services and still receive all of the other parts of the services. *You may decline to answer questions about your child's health and family circumstances. Declining any portion of the screening does not prevent your child from being enrolled in school.*

GENERAL INFORMATION

Child's Name:	Date of Birth: ___/___/___ Month Date Year	Sex: ☐ Boy ☐ Girl
Street Address:		
City:	Zip Code:	
Home Phone:	Work/Other Phone:	
Parent/Guardian Name (and address if different):	Home Language:	
Parent/Guardian Name (and address if different):	Home Language:	
Email:	Language(s) spoken by child:	
Form Completed By:		

CHILD'S HEALTH CARE PROVIDER INFORMATION

Health Care Provider: _____ (Clinic Name)

Date of child's last well child exam (complete physical):_____

Dentist:_____

Date of child's last dental check up: _____

Does your child have health care insurance? ☐ Yes ☐ No Eye Exam by Optometrist or Ophthalmologist: ☐ Yes ☐ No

If your child DOES have health care insurance, please indicate the type below:

☐ Medical Assistance ☐ HealthPartners ☐ Minnesota Care ☐ Blue Cross ☐ U Care ☐ Medica ☐ MHP ☐ Other

EARLY CHILDHOOD EXPERIENCE

Please check the service(s) that you or your child use:

- ☐ Early Childhood Family Education (ECFE)
- ☐ Learning Readiness
- ☐ Child and Teen checkups
- ☐ Follow Along Program
- ☐ Food shelves
- ☐ Parenting education
- ☐ Way to Grow
- ☐ WIC

Is your child in any of the following:

- ☐ Head Start (location) _____
- ☐ Day care center (name) _____
- ☐ In-home day care_____
- ☐ Preschool (name) _____
- ☐ Services for children with special needs
- ☐ Recreational programs
- ☐ Foster care
- ☐ Other (please list)_____

PRENATAL CARE, PREGNANCY & BIRTH INFORMATION

☐ ***My child is adopted – prenatal care, pregnancy and birth information is unknown.***

Prenatal Care:

Age of mother during pregnancy_____ Regular prenatal care? _____ Month prenatal care began (1-9)_____

Please check the box that applies to your child and explain as needed:

☐ My child was born at term (37-42 weeks gestation) ☐ My child was born early or late. at _____ weeks gestation.

He/she weighed _____ pounds _____ ounces at birth.

Is it possible that before the mother knew she was pregnant, she: (Please check the box(es) that apply.)

☐ Drank alcohol ☐ Were exposed to toxic chemicals (e.g. lead, mercury, PCBs, dioxin, fertilizers/pesticides)
☐ Used street drugs ☐ Took prescription medication (list) _____
☐ Smoked cigarettes ☐ None of the items listed

If the mother drank alcohol, took drugs or was exposed to chemicals/toxins, when was it?

☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐ while breastfeeding ☐ N/A

Did the mother have any problems during pregnancy? ☐ **Yes** ☐ **No** (Please check the box(es) that apply.)

☐ Bleeding or spotting ☐ High blood pressure/toxemia/preeclampsia ☐ Diabetes
☐ Bed rest ☐ Amniocentesis ☐ Depression
☐ Preterm labor ☐ Infections (measles/CMV/chicken pox, 5th disease) ☐ Accident or injury

Were there any problems during labor and delivery? ☐ **Yes** ☐ **No** (Please check the box(es) that apply.)

☐ Breech ☐ C-Section ☐ Forceps delivery ☐ Vacuum extraction ☐ Baby stressed or problems with heart rate

Did your child need medical care following birth? ☐ **Yes** ☐ **No (Please check the box(es) that apply.)**

☐ NICU or LEVEL II ☐ Ventilator ☐ Heart/Apnea monitor ☐ Medications: _____
☐ IV or tube feeding ☐ Treatment for jaundice ☐ Blood Transfusion ☐ Other: _____

CHILD HEALTH HISTORY

Immunization Status: ***(Please bring shot record to screening appointment.)***

☐ My child is up to date. ☐ My child is **not** up to date. ☐ I don't know if my child needs immunizations.
☐ I am a conscientious objector.

Health History - My Child (check applicable boxes/list when necessary):

☐ Has allergies: ☐ foods _____ ☐ medicine _____ ☐ animals/insects _____
☐ environment (e.g. dust,mold) _____ ☐ other _____
☐ Has a health condition: ☐ diabetes ☐ seizures ☐ heart problems ☐ other _____
☐ Has asthma, reactive airway disease, or other breathing problems
☐ Allergic rhinitis
☐ Dietary Restrictions_____
☐ Activity limitations_____
☐ Has eczema
☐ Takes medicines, herbs, vitamins, home remedies (please list)_____
☐ Has had visits to medical specialists_____
☐ Has had serious illnesses/injuries/head injuries_____
☐ Has had emergency department visits (reason & date) _____
☐ Has had hospital stays and/or surgeries (reason & date) _____
☐ Has vision concerns or eyes that cross or wander
☐ Has frequent ear infections ☐ Problems with wax build up in ears ☐ Trouble hearing ☐ PE tubes (date) _____
☐ Dental concerns/tooth decay _____
☐ Walking or balance concerns ☐ Weakness in body ☐ Falls down more than other children
☐ Walks with toes in or out ☐ Wears corrective devices on feet/legs
☐ Behavior/attention/mental health concerns or diagnosis_____

Significant Family History of :

☐ Allergies_____ ☐ Asthma_____
☐ Diabetes_____ ☐ ADD/ADHD _____
☐ Mental health issues_____ ☐ Social or behavior concerns_____
☐ Learning problems_____ ☐ Other_____

BEHAVIORAL AND SOCIAL INFORMATION

Please check the following concerns you have about your child:

Thinking
- ☐ Does not seem to understand; is slow to "catch on"
- ☐ Unable to follow directions
- ☐ Has trouble paying attention
- ☐ Poor listener
- ☐ Anxious/worries a lot
- ☐ Fearful
- ☐ Often seems unhappy
- ☐ Overly sensitive; feelings easily hurt
- ☐ Has not learned to do things at the same age as other kids

Physical Problems
- ☐ Breathing problems
- ☐ Frequent headaches
- ☐ Frequent stomach aches or poor appetite
- ☐ Speech/language is difficult to understand
- ☐ Bowel/bladder problem; not toilet trained
- ☐ Daytime/nighttime toileting accidents
- ☐ Feeding concerns

Behavior
- ☐ Overly quiet
- ☐ Highly active
- ☐ Unable to control own behavior
- ☐ Seems unhappy; overly cries/whines
- ☐ Refuses to comply with rules
- ☐ Angers easily
- ☐ Destructive
- ☐ Takes things that don't belong to him
- ☐ Immature; acts younger than age
- ☐ Temper tantrums
- ☐ Easily frustrated
- ☐ Sensory issues: overreacts to loud sounds, dirty hands, touch, pain or bright lights

Social Interactions
- ☐ Seldom plays with other children
- ☐ Aggressive behavior; threatens or harms others
- ☐ Seems overly shy
- ☐ Seems overly friendly

CHILD'S DAILY ROUTINES

Please answer the following questions about your child's habits and routines:

Sleep Pattern
- ☐ Goes to sleep easily
- ☐ Has difficulty falling asleep or staying asleep
- ☐ Goes to bed at _____ PM
- ☐ Wakes up at _____ AM
- ☐ Takes a nap from _____ PM to _____ PM
- ☐ No longer takes naps

TV Viewing/Screen Time
- ☐ Watches TV ____ hours per day
- ☐ Plays video games ____ hours per day
- ☐ Is on the computer /internet ____ hours per day

Nutrition
- ☐ Eats 3 or more servings of whole grains per day (whole wheat bread or pasta, brown rice, quinoa, whole oats, millet)
- ☐ Eats 5-9 servings of fruits and vegetables per day
- ☐ Eats 2-3 servings of iron-rich foods per day (legumes, fish, meat, eggs)
- ☐ Eats 3 servings of calcium-rich foods per day
- ☐ Eats more than 1 serving of sweets or junk food per day

Exercise
- ☐ Gets 60 minutes or more of vigorous exercise per day
- ☐ Is NOT able to/does NOT get 60 minutes of exercise per day

HOME SAFETY INFORMATION

Please check all of the boxes that apply:

Does your child live or play in a home or building:
- ☐ Built before 1950 (If yes, has the child's blood lead level ever been checked? _____ Results:_____)
- ☐ Built before 1978
- ☐ Remodeled within the last 5 years

Does anyone in your home or who cares for your child:
☐ Use tobacco ☐ Use alcohol ☐ Have a gun/weapon

Do you have concerns that your child is exposed to:
☐ Violence ☐ Abuse ☐ Street drugs ☐ Unsafe conditions ☐ Cigarette smoke ☐ Other_____

Do you and/or your child use/have the following:
☐ Seat belts ☐ Car seats ☐ Helmets & safety equipment ☐ Smoke detectors ☐ Carbon monoxide detectors

MORE INFORMATION . . .

Would you like information about…?:

- ☐ Seat belts/car seats
- ☐ Bike helmet/safety
- ☐ Gun safety
- ☐ Toy/playground safety
- ☐ Discipline
- ☐ Parenting groups (ECFE)
- ☐ Child development
- ☐ Nutrition
- ☐ Lead poisoning
- ☐ Stranger safety
- ☐ TV watching
- ☐ Carbon monoxide detector
- ☐ Smoke detector
- ☐ Health or dental care
- ☐ Asthma
- ☐ Recreational programs
- ☐ Emergency/hotline phone numbers
- ☐ Food/clothing
- ☐ Adult education/English classes
- ☐ Other:_____

_____

_____

FAMILY FACTORS

Please list all family members. Include adults, children and any other person(s) living in your home:

_____

_____

_____

As you think about your child growing up in your family, please tell us something that will help us better understand and plan for your child.

- What are some of your family's strengths?

  _____

  _____

- Has there been any unusual stress in your family that might affect your child? (examples: new brother or sister, divorce, death of friend or family member, moving, financial problems, not enough food for the family, etc.)

  _____

  _____

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

  _____

- Please list any concerns you have about your child. We can talk about them at your child's screening appointment.

  _____

- Is there anything else that would help us better understand your child?

  _____

  _____

YOUR CHILD'S HEALTH HISTORY AND FAMILY INFORMATION WILL BE REVIEWED AT THE SCREENING APPOINTMENT.