Parent Consent
Child Health & Developmental Screening

Child's Name:	Birth Date:	*(For office use)* *Child's MARSS ID or Record No.*
Parent's Name		

A. This screening includes:

- Review of your child's immunization record
- Check of your child's growth, such as height & 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 on 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

B. If this screening is a Child and Teen Checkups, Head Start, or other equivalent screening it may also include:

- Check of your child's present, past, or other family health
- Check of your child's pulse, respirations and blood pressure
- Unclothed physical screening of your child's skin, head, eyes, ears, nose, throat, mouth, neck, chest, heart, lungs, abdomen, genitals, arms, legs, spine, and muscles
- Check of your child's teeth, gums, and mouth
- Test for exposure to tuberculosis
- Urine tests for possible problems
- Blood test for anemia
- Blood test for lead
- Other: _____

This screening <u>does not</u> replace on-going care from your health care provider or dentist.

<u>Child and Parent Rights, Obligations, and Assurances</u>

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. This requirement is met if your child has participated in a screening through Head Start, Child and Teen Checkups, or equivalent screening through another provider that includes all required ECS components within the past year. The screening summary results must be given 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.
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 the Child Health & Developmental Screening checked below for _____
(Child's Name)

Check one (√)

ق Complete screening as described above in A & B above.

ق Screening described above except: _____

Parent/Guardian Signature	Date	Relationship to child

MINNESOTA MDH DEPARTMENT OF HEALTH Minnesota Department of Education Minnesota Department of Human Services

INFORMATION COLLECTION, USE AND RELEASE CONSENT
CHILD HEALTH & DEVELOPMENT SCREENING

Child's Name	Birth Date	(For office use) Child's MARSS ID or Record No.
Parent/Guardian's Name		

_____(this organization) uses information from the Child Health and Developmental Screening 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.

Your signature indicates that you have read, understand, and agree that the information can be used as stated above.

CONSENT TO RELEASE INFORMATION

I hereby authorize release of my child's screening information to the following checked programs or services for the purpose of evaluation assessment, diagnosis, follow-up, and/or programming. (Please provide names and addresses where available).

Check (v) any persons/agencies that you wish to receive screening information about your child.

	Child Care Provider
	Dentist (Name)
	Early Childhood Family Education (ECFE)
	Early Childhood Special Education
	Follow Along Program
	Head Start (Name)
	Health Care Provider (Medicare Clinic)
	Interagency Early Intervention Committee (IEIC)
	Mental Health Agency
	Public Health Agency/WIC
	School District (Name)
	School Readiness
	Other (regionally specific programs)

☐Understand Information ☐Authorize release of information

Parent/Guardian Signature	Date	Relationship to Child

MINNESOTA MDH DEPARTMENT OF HEALTH Minnesota Department of Education

Revised 08/17/06