# EARLY CHILDHOOD SCREENING SUMMARY

**Child’s Name: M F Birth Date:**  **Age:**

**(For office use) Interpreter: Yes\_\_\_ No\_\_\_**

**Child/Student’s MARSS ID Number: Screened in Home Language:**

**Parent/Guardian Name: Phone:**

**Address: City: Zip:**

| **Components** | **No**  **Concern** | **Re-screen** | **Refer** | **DeclinedReferral** | **Comments** |
| --- | --- | --- | --- | --- | --- |
| **Vision 1**  History | x | x | x | x | x |
| Observation | X | X | X | X | ***x*** |
| Visual acuity: R: 10/\_\_\_\_  HOTV or LEA L: 10/\_\_\_\_ | x | x | X | X | ***x*** |
| Cover Test: Near | x | x | x | x | ***x*** |
| Cover Test: Distance |  |  |  |  |  |
| Plus Lens, if age 5 and passed acuity: |  |  |  |  |  |
| Corneal Light Reflex | x | x | x | x | ***x*** |
| Corrective Lenses: \_\_Y \_\_N  Comprehensive vision exam date, if known: **3**\_\_\_\_\_ | x | x | x | x | ***x*** |
| **Hearing 1**  History |  |  |  |  |  |
| External inspection |  |  |  |  |  |
| Pure tone Audiometry:  500 (25) 1000 (20) 2000 (20) 4000 (20)  R: \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_  L: \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ | x | x | x | x | *Pass = Mark box for each response*  *Missed = Circle all that apply* |
| **Development 1,2 *Circle Observational tool***  Brigance III MPSI-R Bayley III  ESI-R DIAL 4 BDI-2/NU | x | x | x | x | Development **1,2***optional, circle parent report tool*  ASQ-3 PEDS |
| Speech/Language | x | x | x | x | x |
| Cognitive | x | x | x | x | x |
| Fine/Gross Motor | x | x | x | x | x |
| **Social/Emotional/Behavior1,2 *Circle Parent Report***  PSC ASQ-SE-2 | x | x | x | x | x |
| **Physical Growth 1  Height: \_\_\_\_\_ Weight: \_\_\_\_\_\_** | x | x | x | x | x |
| **Immunization Review 1** *(up to date or need now)*  ***Circle the shots that are needed*** | x | x | x | x | DTaP Polio MMR Hep A  Varicella HIB Hep B |
| **Health care coverage** 1 | x | x | x | x | x |
| **Factors which may impact learning** 1 ***Circle tool***  Child Health/ Developmental History Other | x | x | x | x |  |
| Well Child Exam | x | x | x | x | Recommended annually |
| Dental Exam | x | x | x | x | Recommended every 6 months |

**Early Education Opportunities Discussed / Referred:**

\_\_ School Readiness/ Pre-kindergarten \_\_ Early Childhood Family Ed (ECFE) \_\_ Community Pre-kindergarten Program \_\_ Head Start

\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Early Learning Scholarships for Child Care \_\_ Home Visiting (Public Health)

\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date Screening Provider Signature Date

1 Minimum requirements for the Early Childhood Screening program. (Minnesota Statutes, section 121A.17, subdivision 3).

2 The developmental screening program must include both a parent report of the child’s history in skill development, emotional status, and behavior status and a direct observation of child’s functioning using standardized developmental screening instruments approved by the MDE for Early Childhood Screening program (Minnesota Rule 3530, 3400 Subpart 3.) 3 Effective July 1, 2015, Early Childhood Screening Programs are required to record the date of the child’s most recent comprehensive vision exam, if the child received one. The vision exam is performed by an optometrist or ophthalmologist.