**EARLY CHILDHOOD SCREENING INFORMATION FORM**

Anoka-Hennepin School District #11

Sandburg Education Center
1902 2nd Avenue
Anoka, MN 55303

**SCREENING OFFICE:** (763) 506-2400

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### I. IDENTIFYING INFORMATION

**Date Completed:** __________________

- **Child’s Name:** ______________________________________________________________________________________________________
- **Birthdate:** ______________________________________________________________________________________________________
- **Address:** __________________________________________________________________________________________________________
- **Number/Street Name City State Zip Code**
  - __________________________________________________________
  - __________________________________________________________
  - __________________________________________________________
- **Sex (M, F) Home Phone with Area Code School Child Will Attend**

### II. PHYSICIAN INFORMATION

- **Clinic Name or Physician’s Name:** _________________________________________________________________________________
- **Phone ( ) —**
- **Primary Physician City: State:** __________________________________________
- **Date of last complete physical exam**

- **Do you have health insurance?**  □ Yes  □ No

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**HEALTH HISTORY**

This history is used to determine your child’s specific health or developmental concerns and establish what community resources may be helpful to your family. Specific identifying information about your family is classified as private and will not be released to anyone outside the public school systems without your written consent. General statistics are released to state and local planning agencies.

**PROVIDING ANY OR ALL OF THE FOLLOWING INFORMATION IS VOLUNTARY.**

□ Please check box if you do NOT want to fill out this form.

### III. PAST HEALTH HISTORY - Please check the boxes that apply and explain.

<table>
<thead>
<tr>
<th>PREGNANCY/BIRTH HISTORY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ There were problems during the pregnancy or birth ______________________________</td>
<td></td>
</tr>
<tr>
<td>□ The baby stayed in the hospital longer than the mother ________________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SPECIAL HEALTH CARE</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>The child: □ Has had some chronic health problems □ Has been seen by a specialist □ Has physical restrictions □ Takes medications regularly</td>
<td></td>
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</tbody>
</table>

- **Explain any of the above:** _____________________________________________________________________________________

<table>
<thead>
<tr>
<th>HOSPITALIZATIONS/OPERATIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the child been hospitalized? □ NO □ YES - If yes, list dates, hospital and reason: ______________________</td>
<td></td>
</tr>
<tr>
<td>Has the child had any operations? □ NO □ YES - If yes, list dates and operations: ___________________________</td>
<td></td>
</tr>
</tbody>
</table>
### Illnesses

- Strep infections or Scarlet Fever
- "Hard" measles (Rubella)
- German or 3-day measles (Rubella)
- Chicken pox
- Chicken pox vaccine
- Mumps
- Meningitis
- Other ____________________________________________________________________________________
- RSV
- Hepatitis B
- Rheumatic Fever
- Pneumonia
- High fever (104º for longer than 2 days)
- Diabetes

### Allergies

- Food and/or medication allergy
- Eczema and/or hives
- Reaction to animal dander or dust
- Severe reactions to an immunization
- Soap, lotion, latex or adhesive allergy
- Nose or eye allergy, hayfever
- Severe reactions to insect bites/stings

### Accidents

- Has had any serious accidents or injuries
- Has accidentally become poisoned

### Dental

1. Has the child been examined by a dentist?  
   - No  
   - Yes - Date of last dental exam: ________________
2. Source of water at home:  
   - City  
   - Private well  
   - Rural water system  
   - Other ________________  
   - Don't know
3. Receives fluoride from any of the following sources:  
   - Vitamins  
   - Toothpaste  
   - Tablets/drops  
   - Mouth rinses  
   - Dental office treatment
4. Has trouble with teeth, gums, or mouth. If yes, explain: _________________________________________________
   ______________________________________________________________________________________________

### Skin

Has the child had problems with rashes, bruises or unexplained bumps?  
- No  
- Yes - If yes, explain below: __________________________________________________________________________

### Head

Has the child had any head injuries or frequent headaches?  
- No  
- Yes - If yes, explain below: __________________________________________________________________________

### Eyes

Has the child had problems with his or her eyes?  
- No  
- Yes - If yes, explain below: __________________________________________________________________________

### Ears, Nose, and Throat

Has the child had frequent ear infections, a diagnosed hearing loss, or problems with his or her throat?  
- No  
- Yes - If yes, explain below: __________________________________________________________________________

Has the child had tubes placed in ears?  
- No  
- Yes - If yes, explain below: __________________________________________________________________________
<table>
<thead>
<tr>
<th>RESPIRATORY</th>
<th>Has the child been diagnosed with asthma?</th>
<th>☑ NO</th>
<th>☑ YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Has the child had problems with wheezing or shortness of breath?</td>
<td>☑ NO</td>
<td>☑ YES - If yes, explain below:</td>
</tr>
<tr>
<td></td>
<td>Has the child been exposed to tuberculosis?</td>
<td>☑ NO</td>
<td>☑ YES</td>
</tr>
<tr>
<td></td>
<td>Has the child had 6 or more colds in a year?</td>
<td>☑ NO</td>
<td>☑ YES</td>
</tr>
<tr>
<td>CARDIOVASCULAR</td>
<td>Has the child been diagnosed with a heart problem?</td>
<td>☑ NO</td>
<td>☑ YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GASTRO-INTESTINAL</th>
<th>Check the box if the child has problems with any of the following:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>☑ Weight loss in the past year</td>
</tr>
<tr>
<td></td>
<td>☑ Frequent diarrhea</td>
</tr>
<tr>
<td></td>
<td>☑ Eating habits</td>
</tr>
<tr>
<td></td>
<td>☑ Frequent constipation</td>
</tr>
<tr>
<td></td>
<td>☑ Frequent stomach aches</td>
</tr>
<tr>
<td></td>
<td>☑ Frequent vomiting</td>
</tr>
</tbody>
</table>

| URINARY                     | Has the child had any urinary problems, such as frequent or painful urination or urinary tract infections? | ☑ NO  | ☑ YES - If yes, explain below: |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------|
|                             | Does the child wet during the day or night?                                                                      | ☑ NO  | ☑ YES |

| SKELETAL                    | Has the child had any broken bones, or complains of pain in legs, arms, back or joints? | ☑ NO  | ☑ YES - If yes, explain below: |

<table>
<thead>
<tr>
<th>NEUROMUSCULAR</th>
<th>The child:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☑ Has unusual staring spells</td>
</tr>
<tr>
<td></td>
<td>☑ Has some unexplained movements or jerks</td>
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<tr>
<td></td>
<td>☑ Has a weakness in his/her body</td>
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<tr>
<td></td>
<td>☑ Falls down more than other children and/or is clumsy or awkward</td>
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<tr>
<td></td>
<td>☑ Has had convulsions or seizures</td>
</tr>
</tbody>
</table>

| LEAD EXPOSURE               | Has the child’s blood lead level ever been checked?                                                | ☑ NO  | ☑ YES - If yes, when: |
|-----------------------------|--------------------------------------------------------------------------------------------------|
|                             | It is recommended that every child from the age of 12 months to 6 years be tested for lead poisoning. |
|                             | Check with your child’s health care provider if your child has not been tested.                   |

Considering that all children have a wide range of normal behavior, is there a concern about the child in any of the following areas?

- ☑ Irritability, easily upset, angers easily
- ☑ Too much, or too little energy
- ☑ Bad dreams, disturbed sleep
- ☑ Seems overly aggressive
- ☑ Biting nails, thumbsucking
- ☑ Temper tantrums
- ☑ Overly cautious, fearful, shy
- ☑ Unable to share, disobedient, destroys things
- ☑ Breath holding
- ☑ Cruel to animals or other children
- ☑ Seems withdrawn
- ☑ Gets into trouble a lot

1. Do you have any other concerns about the child’s behavior?

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
2. Has anything happened in your family that may be affecting the child?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. Would you like information about any of the following?

- Parenting/parenting groups
- Help with personal/family issues
- Recreational programs
- Housing
- Child development
- Child’s eating habits
- Child care/preschool
- Jobs
- Adult education
- Food/clothing
- Health or dental care
- Other: _________________________________________________________________________________________________

4. Would you like information about any of the following safety issues?

- Smoke detectors
- Gun safety
- Carbon monoxide detectors
- Stranger safety
- Car seat/seat belt use
- Bike safety
- Other:
________________________________________________________________________

5. Do you have concerns that the child is exposed to:

- Unsafe conditions
- Abuse
- Other exposures:
- Violence
- Street drugs
- Other exposures: _________________________________________________________________________________________________