Anoka-Hennepin School District #11

EARLY CHILDHOOD SCREENING INFORMATION FORM

Sandburg Education Center
1902 2nd Avenue
Anoka, MN 55303

SCREENING OFFICE: (763) 506-2400

I. IDENTIFYING INFORMATION

Date Completed: _____

Child's Name: _____
Last First Middle Initial 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

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.

PREGNANCY/ BIRTH HISTORY	❑ There were problems during the pregnancy or birth _____ ❑ The baby stayed in the hospital longer than the mother _____
SPECIAL HEALTH CARE	The child: ❑ Has had some chronic health problems ❑ Has physical restrictions ❑ Has been seen by a specialist ❑ Takes medications regularly Explain any of the above: _____
HOSPITALI-ZATIONS/ OPERATIONS	Has the child been hospitalized? ❑ NO ❑ YES - If yes, list dates, hospital and reason: _____ _____ Has the child had any operations? ❑ NO ❑ YES - If yes, list dates and operations: _____ _____

ILLNESSES

The child has had the following illnesses:

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

ALLERGIES

The child has had the following conditions:

- ❑ 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

Check the box if the child:

- ❑ Has had any serious accidents or injuries
- ❑ Has accidently 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:

_____

RESPIRATORY	Has the child been diagnosed with asthma? ❑ NO ❑ YES Has the child had problems with wheezing or shortness of breath? ❑ NO ❑ YES - If yes, explain below: _____ Has the child been exposed to tuberculosis? ❑ NO ❑ YES Has the child had 6 or more colds in a year? ❑ NO ❑ YES
CARDIO-VASCULAR	Has the child been diagnosed with a heart problem? ❑ NO ❑ YES
GASTRO-INTESTINAL	Check the box if the child has problems with any of the following: ❑ Weight loss in the past year ❑ Frequent diarrhea ❑ Eating habits ❑ Frequent constipation ❑ Frequent stomach aches ❑ Frequent vomiting
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: _____
NEURO-MUSCULAR	The child: ❑ Has unusual staring spells ❑ Has some unexplained movements or jerks ❑ Has a weakness in his/her body ❑ Falls down more than other children and/or is clumsy or awkward ❑ Has had convulsions or seizures
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
- ❑ Bad dreams, disturbed sleep
- ❑ Biting nails, thumbsucking
- ❑ Overly cautious, fearful, shy
- ❑ Breath holding
- ❑ Seems withdrawn
- ❑ Too much, or too little energy
- ❑ Seems overly aggressive
- ❑ Temper tantrums
- ❑ Unable to share, disobedient, destroys things
- ❑ Cruel to animals or other children
- ❑ 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
- ❑ Child development
- ❑ Adult education
- ❑ Help with personal/family issues
- ❑ Child's eating habits
- ❑ Food/clothing
- ❑ Recreational programs
- ❑ Child care/preschool
- ❑ Health or dental care
- ❑ Housing
- ❑ Jobs
- ❑ Other: _____

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

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

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

- ❑ Unsafe conditions
- ❑ Violence
- ❑ Abuse
- ❑ Street drugs
- ❑ Other exposures: _____