

SUMMARY

CHILD HEALTH & DEVELOPMENTAL SCREENING

Child's Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	Age	<i>(For office use)</i> Child/Student's MARSS ID or Record No. _____
Parent's Name		Phone (include area code)		
Address		City		Zip
√	Components	Findings		Comments/Concerns
	Vision ¹ <input type="checkbox"/> History <input type="checkbox"/> Observation/Muscle Balance Tests <input type="checkbox"/> Red Reflex <input type="checkbox"/> Visual Acuity Screen	Acuity: R 10/____ L 10/____ <input type="checkbox"/> Referral <input type="checkbox"/> Follow-up		
	Hearing ¹ <input type="checkbox"/> History, review risk factors <input type="checkbox"/> Manual Puretone Audiometry	R _____ L _____ <input type="checkbox"/> Normal <input type="checkbox"/> Rescreen <input type="checkbox"/> Referral <input type="checkbox"/> Follow-up		
	Development: ^{1,2} <input type="checkbox"/> Speech/Language <input type="checkbox"/> Fine Motor <input type="checkbox"/> Gross Motor <input type="checkbox"/> Psycho/Social	<input type="checkbox"/> No concerns <input type="checkbox"/> Referral <input type="checkbox"/> Follow-up <input type="checkbox"/> Rescreen		
	Observed Instrument ² : <input type="checkbox"/> Brigance <input type="checkbox"/> Dial 3 <input type="checkbox"/> ESI-R <input type="checkbox"/> FirstSTEP <input type="checkbox"/> ESP <input type="checkbox"/> MPSI-R	Parent Report ² : <input type="checkbox"/> ASQ <input type="checkbox"/> ASQ-SE <input type="checkbox"/> CDR <input type="checkbox"/> PEDS <input type="checkbox"/> CHDH		
	Health History	<input type="checkbox"/> Referral <input type="checkbox"/> Follow-up		
	Physical Growth ¹	Ht. _____ % Wt. _____ % <input type="checkbox"/> Referral <input type="checkbox"/> Follow-up		
	Physical Exam (complete including blood pressure)	<input type="checkbox"/> No concerns <input type="checkbox"/> Referral <input type="checkbox"/> Follow-up		
	Immunizations/review ¹	<input type="checkbox"/> Up-to-date (current) <input type="checkbox"/> Referral (needs immunizations) <input type="checkbox"/> Exemption		
	Lab Tests <input type="checkbox"/> Hgb <input type="checkbox"/> Lead <input type="checkbox"/> Urine <input type="checkbox"/> Other	<input type="checkbox"/> Normal <input type="checkbox"/> Referral <input type="checkbox"/> Follow-up		
	Family Factors/Anticipatory Guidance	<input type="checkbox"/> Referral <input type="checkbox"/> Follow-up		
	Dental last visit: ____ / ____ / ____	<input type="checkbox"/> Referral		
	Health Care Coverage ¹	<input type="checkbox"/> Covered <input type="checkbox"/> Referral		
Additional screening tools used:				
Parent/Guardian Signature		Screening Provider Signature		Screening Provider Signature
Date		Date		Date



¹ Minimum requirements for the Early Childhood Screening program (Minnesota Statutes § 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 the Early Childhood Screening program (Minnesota Rule 3530.3400, Subpart 3)