Early Childhood Screening Release of Information

Child's Name: _____ Birthdate: _____
(For office use only)
MARSS other ID: _____ Parent/Guardian Name(s): _____

_____(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. This means 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. Summary data about groups of children that does not include information about individual children may be shared without consent.

Information from Your Child's Screening May be Used for the Following Purposes:

1. To obtain follow-up services for your child after the screening, if you choose to participate.
2. To arrange for further evaluation or assessment of your child's health, growth, development, or learning, if you choose to participate.
3. To fulfill the requirements for your child's entrance into public school or Early Learning Scholarship, School Readiness or Voluntary Pre-Kindergarten programs.
4. To evaluate screening programs by the Minnesota Departments of Education, Health and Human Services. Your child's name will not be identified in any evaluation results.
5. To develop appropriate educational programs to meet student needs and to design appropriate health education programs for the district.
6. To plan for early childhood programs and school entry.
7. To provide access to and accountability for government funds paid to the local school district for providing required early childhood screening services.

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 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 (Medical Clinic) _____
__ Interagency Early Intervention Committee (IEIC) _____
__ Mental Health Agency _____
__ Public Health Agency (WIC) _____
✔ School District (Name) 316 Greenway 317 Deer River 318 Grand Rapids 319 Nashwauk/Keewatin 002 Hill City
__ School Readiness _____
__ Other (regionally specific programs) _____

_____ **Understand Information** _____ **Authorize release of information**

Parent/Guardian Signature: _____ Date: _____ Relationship to Child: _____

REV: 11/2016