



Child Screening Program
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For Office Use:

CHILD CARE:

Date of Admission:

☐ 0-3 ☐ 3-6

County: _____

☐ Typical

☐ Referral: _____

☐ Rescreen ___/___/___ ☐ ASQ +SE ☐ ITC

Rescreen Results: _____

PERMISSION TO SCREEN

Goodwill Easter Seals Miami Valley (GESMV) Child Screening Team has permission to perform an onsite developmental screening on my child and/or review my child's parent-completed Ages and Stages Questionnaires (ASQ). My child's early childhood program has permission to submit a screening for my child into the secure GESMV ASQ Online Enterprise System for review and follow-up on screening results. GESMV may release screening results and exchange information with my child's early childhood program. In the event of a suspected delay or concern, GESMV has permission to make a referral and exchange information with Help Me Grow (applicable to children 0-36 months only), your child's home school district (children ages 3-5 years), and/or your child's physician (if physician contact information is listed below). Intervention services are voluntary programs and parents may accept or refuse participation once a Help Me Grow or school district professional contacts the family If concerns are present on your child's screening, GESMV will attempt to contact you by phone or email to discuss these assessment options and gather additional developmental information. Goodwill Easter Seals Miami Valley also offers the services of our Early Childhood Support Consultant at no cost to families and early childhood learning programs to support your child's success in the classroom and beyond. The Early Childhood Support Consultant has permission to observe my child in the classroom, provide supports for the teacher and address concerns we have regarding our child's social-emotional development. At times, GESMV may run general data reports to share with community stakeholders to determine the effectiveness and scope of the online screening partnership. This shared data will **NOT** include identifiable child information including names or family contact information.

Male / Female (please circle)

Child's Name (First) (Middle) (Last)

Date of Birth ___/___/___ Number of Weeks Premature ___ (if under 2 yr.)

LANGUAGES OTHER THAN ENGLISH SPOKEN IN THE HOME: _____

Signature of Legal Guardian

Phone (Best)

Legal Guardian's Name (Please Print)

Email

Relationship to Child

Ethnicity/Race (optional)

Address

City

State

Zip Code

County

Home School District

In the event of a suspected developmental concern, a copy can be sent to your child's doctor/clinic:

Child's Doctor/Clinic Name

Street Name (Doctor)

YES NO (please circle) Does your child receive any current intervention services?

YES NO (please circle) Does your child have a current IFSP (Help Me Grow)?

YES NO (please circle) Does your child have a current IEP for special needs preschool (school district)?

YES NO (please circle) Does your child receive private therapy?