SOUTHERN ILLINOIS LearnGrowGo

Southern Illinois Screening Collaborative

Permission to Screen and Enter Results into Database

Today's Date: _____ Location: _____

Child's Name: _____ Male ☐ Female ☐

Birth Date: _____ If your child was premature, how many weeks? _____

Parent's/Guardian's Name: _____

Address: _____

Street City Zip

Phone Home _____ Cell _____ School District: _____

Email address: _____

Primary Home Language: _____ Secondary Home Language: _____

Do you have any concerns about your child? (Please explain) _____

_____

Has your child ever been screened before? No ____ Don't know ____ Yes ____ If so, where and when? _____

_____

Has your child attended any program or received any services? No ____ Yes ____

If yes, what program/services? _____

The Purpose of the Collaborative is to develop and implement a system, that includes policies, procedures and protocols that ensure all children ages birth to 5 are screened for developmental delays and receive the necessary services and supports that promote positive growth and development.

- I give my permission to the participating agencies* of the *Southern Illinois Screening Collaborative* to assess my child's speech, vision, hearing, and overall development **and** to enter the information into their secure regional database.
- I understand that the tools used are nationally known and valid in assessing the developmental status of children. The screening is implemented in a "game-like" format of activities and results may be reviewed by participating agencies*. I understand that the results will be reviewed with the parents or guardian.
- Your child's results are confidential and will not be shared outside of the Southern Illinois Screening Collaborative. Demographic information will be used for reporting purposes but all identifying information will be removed.
- I am willing for this information to be shared for potential enrollment into high quality early childhood programs and determining if additional educational services are needed and available.
- I understand that referrals for further evaluation will be made for children as required by law if results indicate a potential delay. Information will be shared between referral agencies.
- I understand that I can revoke this ***Permission to Screen*** in writing at any time. Until then, this permission is valid.

_____ _____

Parent/Guardian Signature *Date*

***Participating agencies may include:** CCR&R at JALC, Child and Family Connections, Early Head Start and Head Start Programs, Early Intervention Programs and Prevention Initiatives, Preschool Programs, Local Education Agencies, Licensed Child Care Centers and Family Child Care Homes, Health Departments and Physicians

For office use only:

☐ Developmental Screening

☐ Social Emotional Screening

Recommendations: _____