RISK FACTORS ***to be completed by staff***

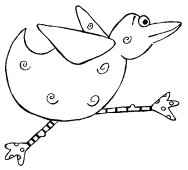
DEVELOPMENTAL
☐ Suspected hearing loss
☐ Atypical or delayed development
☐ Suspected speech delay
☐ Suspected visual impairment
☐ Other developmental risk(s) _____
Notes:

ENVIRONMENTAL
DIFFICULTY MEETING BASIC NEEDS
☐ Lack of safe, stable place to live
☐ Not enough money to buy nutritious food or necessary clothing
☐ Other difficulty meeting basic needs
FAMILY STRESS CONDITIONS
☐ Unreliable means of transportation
☐ Inability to pay medical bills
☐ Family without steady source of income
☐ Family member with serious physical disability
☐ Family member with serious mental health disability
☐ Social isolation
☐ Suspected abuse of alcohol or drugs (family member)
☐ Lack of familial support system
☐ Maternal Depression
☐ Other family stress condition
DIFFICULTY WITH CAREGIVING
☐ Significant inadequate hygiene
☐ Difficulty with ongoing, stable, positive relationship with child
☐ Difficulty providing care because of disabling medical condition.
☐ Difficulty providing care because of disabling mental health condition.
☐ Other difficulty with caregiving
DIFFICULTY WITH PROTECTION
☐ History of repeated or accidental injuries
☐ Concerns about physical, verbal or sexual abuse
☐ Other difficulty with protection
OTHER
☐ Exposure to secondhand smoke
☐ Exposure to:_____
☐ Blood lead levels
☐ Parental education (specify final grade level)
☐ Absence of regular professional health supervision
☐ Positive newborn hearing screen with no follow-up
☐ Other environmental risk _____
☐ Other environmental risk _____
Notes:

PRENATAL/MATERNAL
☐ Family history of vision impairment
☐ Pregnancy induced hypertension
☐ Prenatal care (3 or less visits starting in the 2nd trimester)
☐ History of alcohol use during pregnancy
☐ History of other drug use during pregnancy (Specify Usage)
☐ History of communicable disease during pregnancy
☐ Maternal metabolic disorders
☐ Family history of permanent hearing loss(Child or Youth Onset)
☐ Prenatal maternal smoking
☐ Maternal age under 18(specify age)_____
☐ Maternal age over 35 (specify age)_____
☐ Gestational Diabetes
☐ Other prenatal/maternal risk(s) _____
Notes:

SOCIAL EMOTIONAL
(Many of the other FAP risks are also SE risk factors)
FAMILY FACTORS
☐ Parental Delinquent behaviors
☐ Large Family
☐ Poor Parenting practices/ disagreements over child-rearing
☐ Marital status/single/divorced /separated/reconstituted (Blended)
☐ Sibship size
☐ Parent criminality
NEIGHBORHOOD FACTORS
☐ Overcrowding
☐ Low-Income, high rise dwelling
CHILD FACTORS
☐ Difficult to handle/Tempermental Difficulties
☐ Aggressive
☐ Withdrawn
☐ Fidgeting/hyperactive
☐ Exposure to traumatic effect
☐ Maternal ratings of infant difficulties
☐ Behavior Problems
☐ Excessive crying

MEDICAL
☐ Birthweight < 2500 grams (5lbs. 8ozs.)
☐ Apgar score-six or less at 5 minutes
☐ Neonatal seizures any type
☐ Chronic illness
☐ Retinopathy of prematurity
☐ Microcephaly-head circumference < 3rd percentile
☐ Macrocephaly-head circumference > 97th percentile
☐ Recurrent/persistent otitis media with effusion for at least 3 mos.
☐ Serious congenital or acquired infection
☐ Significant respiratory distress
☐ Clinical impression of possible neurological abnormality
☐ Central nervous system insult
☐ Major congenital anomalies or possible syndromes
☐ Familial disorder with developmental implication
☐ Evidence of growth deficiency, nutritional problems, anemia, failure to thrive
☐ Gestational age less than or equal to 36 weeks
☐ Hyperbilirubinemia
☐ Hypoglycemia
☐ Intracranial Hemmorhage
☐ Ototoxic medications (Aminoglycosides alone/or with loop diuretics
☐ Abnormal Newborn Metabolic Screening
☐ Head trauma
☐ FAS/FAE
☐ Hypoglycemia
☐ Other medical risk(s) _____
Notes:



FOLLOW ALONG PROGRAM
Identification Data Form (to be completed by families)
DEMOGRAPHICS AND ENROLLMENT DATA

(first) (middle) (last)

Name: _____

Birth Date: _____ / _____ / _____ **Gestational Age:** _____ (weeks) **Sex:** ❒ male ❒ female

Birth weight: _____ pounds _____ ounces

Physician: _____ **Birth Hospital:** _____

Was baby in a NICU? ❒ no ❒ yes - where? _____

County: _____ **School district:** _____

Child's race (check all that apply):	
❒ American Indian, Alaska Native	❒ Native Hawaiian, Pacific Islander
❒ Asian	❒ White
❒ Black, African-American	❒ Unknown
❒ Hispanic, Latino	

Child's insurance (check all that apply):
❒ HMO
❒ Insurance
❒ Medical Assistance (MA)
❒ Minnesota Care
❒ None of the above (self-pay)

Primary Guardian: ❒ both parents ❒ mother ❒ father ❒ other _____

	MOTHER	FATHER
NAME	(first, middle, last)	(first, middle, last)
		⇩ if different from mother or child ⇩
Home phone		
Work phone		
Home language		
Written language		
Mailing address		
Mailing address		
City		
State		
Zip		
E-mail		
Send information to this person?	❒ yes ❒ no	❒ yes ❒ no

Newborn Hearing Screening Status:

Was your child's hearing screened at birth? ❒ no/unknown ❒ yes, dates if known: _____

Results of screening: ❒ pass ❒ fail

The Follow Along Program wants to support families in caring for their children. Sometimes families need or want services to help them do this. Please tell us what services your child is currently using and those you would like to receive more information about.

My child uses this service	I will contact on my own	Like more information	Name of the Service	What is it?
			Audiology	Tests to see how well your child hears.
			Child And Teen Checkups	Development and health assessment for children on medical assistance (MA) or Minnesota Care.
			Child Care Assistance	Financial assistance to help families pay for child care.
			Deaf/Hard of Hearing Service	Special services for children who are deaf or have a hearing loss.
			Dental Services	Routine dental checkup.
			Early Childhood Family Ed (ECFE)	Classes for families to help in supporting and teaching their child.
			Early Childhood Special Education	Education services provided to children with disabilities.
			Family Counseling/Therapy	Assistance for families who have mental health, social, emotional or behavior concerns.
			Food Shelf	Emergency supply of food.
			Genetic Evaluation	Determine the cause for disabilities and provides information on what treatment is helpful and what to expect in the future.
			Head Start	Education services provided to children who are from families with limited income or for children who have special needs to prepare them for school.
			Medical Assistance	Helps families pay for medical care.
			Mental Health Services	Services to help children who have social, emotional or behavior problems.
			MinnesotaCare	Insurance with premiums based on income.
			MN Children With Special Health Needs (MCSHN)	Provide information about many issues that families with children with disabilities face including financial, medical, and support services 1-800-728-5420.
			MN Family Investment Program (MFIP)	Financial assistance to families who have no income or not enough income to meet basic needs.
			Occupation Therapy (OT)	Helps children who need help to learn to play and eat.
			Physical Therapy (PT)	Helps children who need help learn to walk and get around.
			Public Health Services	Provides a variety of services for children and families.
			Public Health -Home Visiting	Help families care for and support their children.
			Respite Care	Services provided to families of children with special needs to provide a break from the special care.
			Social Security (SSDI)	Financial assistance to children whose parent died.
			Social Work	Services provided by a licensed social worker.
			Speech Therapy (ST)	Helps children learn to talk and communicate.
			SSI (Supplemental Security Income)	Financial assistance to families who have children with disabilities.
			Transportation Assistance	Help getting to medical or health appointments.
			Physician -Well Child Visit to Doctor	A visit to the doctor for a physical exam, review of development and to update shots.
			WIC	Provides formula, some nutritional food and nutritional instruction for children, pregnant women, or breastfeeding women.
			Other: Please list	

FOLLOW ALONG PROGRAM
PERMISSION FOR ENROLLMENT

The Follow Along Program, sponsored by the Minnesota Department of Health and the local agency coordinating the Follow Along Program in the county/area where I live, has been explained to me orally. I have also received a brochure that provides information about how the program works as well as information about how to contact the local agency coordinating the program; hereafter referred to as the Managing Agency. With the following conditions:

I agree to enroll _____ , _____ in the Follow Along Program.
(Child's name) (Birthdate – mm/dd/yyyy)

MY RESPONSIBILITIES

- I understand that my participation in the Follow Along Program is completely voluntary. I am not legally required to provide the requested data. However, if I do not provide the data requested, it may not be possible for me to fully participate in the program.
- I will take part in a home, office, clinic or telephone visit by a nurse or developmental specialist who will share information with me about the Follow Along Program, family health and service available in my community.
- I will complete questionnaires that ask about my child's growth and development at different ages such as 4, 8, 12, 16, 20, 24, 30 and 36 months of age. I will return them to the Managing Agency.

MY RIGHTS

- I can refuse to consent. If I do not consent, my child will not be enrolled in the Follow Along Program, but other services may still be available.
- I can withdraw my child at any time by telling the Managing Agency that I do not want to continue with the Follow Along Program.
- I will be informed of my child's questionnaire results after a questionnaire is scored. If the questionnaire results are not within the normal range, a professional will contact me to discuss the next steps.
- I will have access to all information about my family through the Follow Along Program.

MY CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

- Medical and personal information about my child and family and information from the developmental questionnaires may be shared between my child's physician, Dr. _____, the Managing Agency and early intervention services through _____ School District in order to address health and developmental concerns identified through the Follow Along Program.
- The Managing Agency may or may not request my child's social security number. I am not legally required to provide my child's social security number. However, by providing this information, it may enable the Managing Agency to track my child's records through the Follow Along Program more efficiently.
- Information from the Follow Along Program which does not include identification information such as names, addresses or phone numbers may be compiled regionally or statewide to help with the planning of early intervention services and the evaluation of the program.
- Private information about my child or family will not be shared with any person or agency without my written permission.
- If we move to a county with a Follow Along Program or similar tracking program, I agree that information may be sent to our new county without additional permission.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you request it, we will obtain this information in another form such as Braille, large print or audiotape.