Scott County Follow Along Program Enrollment Form

Please be sure to complete all of the following information to enroll. The boxes that are outlined in red are required to be filled in order for your child to be enrolled. Thank you.

Child's Full Name: _____

Date of Birth: _____ ☐ **Female** ☐ **Male**

Birth Weight: _____

Race (optional) *Please select all that apply*: ☐ Asian ☐ Am. Indian or AK Native ☐ Black or African Am. ☐ Hispanic or Latino ☐ White

Language preferred: ☐ English ☐ Spanish

How many weeks were you pregnant when baby was born? _____

Was your infant's hearing tested in the hospital? ☐ **No** ☐ **Yes**

- what were the hearing test results? ☐ **Pass** ☐ **Fail**

Birth Hospital _____ **NICU graduate** ☐ **No** ☐ **Yes**

Do you have any health concerns about your infant? ☐ **No** ☐ **Yes**

If yes, please state:

Did you have any health concerns while you were pregnant? ☐ **No** ☐ **Yes**

If yes, please state:

What services are you currently using? _____

Do you have needs that you would like information/resources for?

PARENT(S) NAME: _____

ADDRESS: _____

CITY/STATE: _____ **ZIP:** _____

PHONE # 1: _____ **PHONE # 2:** _____

Where did you get this enrollment form from? ☐ **Mail** ☐ **ECFE/ECSE** ☐ **Public Health Nurse**

☐ **Online** ☐ **Other** - Please explain: _____

Please be sure to sign "PERMISSION FOR ENROLLMENT" on the back of this form. *Thank you!*

Please print the enrollment form and fill out by hand or fill it in here, then print. Either mail, or fax, the completed form to:

Scott County Public Health
Marschall Road Transit
Station 1615 Weston Court
Shakopee, MN 55379

- OR -

Fax to:
(952) 496-8072

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 bow 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 _____ , _____ , Follow Along Program.
(Child's name) *(Birth Date: mm/dd/yy)*

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 services available in my community.
- ✓ I will complete questionnaires that ask about my child's growth and development at different ages such at 4, 8, 12, 16, 20, 24, 30, and 36 months of age. I will return them to the Managing Agency. (I understand that I may be asked to complete some of the questionnaires after my child reaches a certain age if my child was born prematurely).

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 obtained 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 Dr. _____ *(Name of child's physician)*, the Managing Agency, and early intervention services through the *(Name of education district)* _____ education 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 identifiable 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)* _____

IC# 140-0562 *If you ask, we will provide this information in another form such as Braille, large print or audiotape.*