



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

Date _____

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

Birth Date _____ Gestational Age _____
 (mm/dd/yyyy) (weeks pregnant at delivery)

Gender male female

Birth Weight ___ lbs. ___ ozs

Physician _____

Hospital (birth hospital) _____

Was your child in an NICU? Yes No Where? _____

County _____

School District _____

Your Child's race (Check all that apply)	
<input type="checkbox"/>	American Indian or Alaska Native
<input type="checkbox"/>	Asian
<input type="checkbox"/>	Black or African-American
<input type="checkbox"/>	Hispanic or Latino
<input type="checkbox"/>	Native Hawaiian or Pacific Islander
<input type="checkbox"/>	White
<input type="checkbox"/>	Unknown

Do your child have? (Check all that apply)	
<input type="checkbox"/>	HMO
<input type="checkbox"/>	Insurance
<input type="checkbox"/>	Medical Assistance (MA)
<input type="checkbox"/>	Minnesota Care
<input type="checkbox"/>	None of the above (Self Pay)

Who referred you to the program?		
<input type="checkbox"/>	Family member or friend	<input type="checkbox"/> Child Care provider
<input type="checkbox"/>	Head start	<input type="checkbox"/> ECFE (Early Childhood Family Education)
<input type="checkbox"/>	ESCE (Early Childhood Special Education)	<input type="checkbox"/> Hospital
<input type="checkbox"/>	Physician (Name _____)	<input type="checkbox"/> MCSHN (MN Children With Special Health Needs)
<input type="checkbox"/>	NICU (Name _____)	<input type="checkbox"/> Newborn Metabolic Screening
<input type="checkbox"/>	Social Services	<input type="checkbox"/> Public Health
<input type="checkbox"/>	WIC	<input type="checkbox"/> CTC (Child and Teen Checkup)
<input type="checkbox"/>	Other	

Why do they want your child enrolled in the program? _____

Office Use	Agency Chart # _____
Entered Software Date _____	Referral Source _____
FAP Provider Name _____	Permission Date _____ Initials _____

GUARDIANS/ADDRESSES

Primary Guardian <input type="checkbox"/> both parents <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> other _____			
	CHILD	FATHER	MOTHER
NAME		First, Middle, Last	First, Middle, Last
		If different than child's ↓	If different than child or father ↓
Home Phone			
Work Phone			
Home Language			
Written language			
Mailing Address			
Mailing Address			
City			
State			
Zip			
Email			
Do you wish information sent to this person?		_____ YES _____ NO	_____ YES _____ NO

NEWBORN HEARING SCREENING STATUS

Was your child's hearing screened at birth?"

- NO/unknown
 YES (Include dates if known) _____

Results of screening.

- Pass Fail

Please mail forms into:

**Carver County Public Health
 Government Center Administration Building
 600 East Fourth Street
 Chaska, MN 55318**

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	