BLOOMINGTON, EDINA AND RICHFIELD
FOLLOW ALONG PROGRAM ENROLLMENT FORM

The information collected on this form will be used to link you with the local public health staff in your county that provide the Follow Along Program. All of the information on this form is confidential and will only be used for Follow Along Program participation. You may also complete this enrollment form online at **blm.mn/followalong** (available in English and Spanish).

(* signifies a required field)

CHILD INFORMATION

First * _____ Middle Initial _____

Last * _____

Child's Gender * _____Male _____Female

Hispanic or Latino _____No _____Yes

Race/Ethnicity (Check all that apply)*

_____ White
_____ Asian
_____ Native Hawaiian & Other Pacific Islander
_____Black or African American
_____ American Indian and Alaska Native
_____ Other

Insurance (Check all that apply)

_____ Medical Assistance (current or pending)
_____ None
_____ MNCare
_____ Private Insurance/HMO
_____ Other

Child's Birthdate * _____

Was your baby born prematurely? _____ No _____ Yes

How many weeks/days before your due date?* _____

How much did your baby weigh at birth? (lbs./oz. or grams) * _____

Were there any pregnancy concerns? _____ No _____ Yes

If yes, explain briefly *

Was your baby in the NICU (Neonatal Intensive Care Unit)? _____ No _____ Yes

Does your child have any health conditions or diagnoses? _____ No _____ Yes

If yes, explain Child Health Condition *

At birth, was your baby's hearing tested in the hospital?* _____ No _____ Yes

Date of test (if known) _____

Were there any concerns? _____ No _____ Yes

If yes, explain briefly *

Child's Primary Health Care Provider:_____

Clinic Name:_____

Clinic City:_____

School district your child lives in? (if known):_____

Do you have concerns about your child's development? _____ No _____ Yes

If yes, explain briefly *

GUARDIAN INFORMATION

Primary Guardian's First Name *_____

Primary Guardian's Last Name * _____

Primary Phone * _____ Other Phone _____

Email Address * _____

Primary Spoken Language * _____

Interpreter Needed? _____ No _____ Yes

Primary Written Language *_____

ADDRESS INFORMATION

Mailing Street * _____

Apt/Unit # _____

City * _____ Zip Code * _____

How did you hear about the Follow Along Program? (Check all that apply)

_____ Hospital/Clinic/Health Care Provider _____ WIC Clinic

_____ Home Visit/Public Health Nurse _____ School District

_____ Help Me Grow/ECSE _____ Other

I would like information about the following Public Health Services:

___ Immunizations

___ Women, Infants and Children (WIC) Supplemental Nutrition Program – nutrition education and food benefits

___ Help in finding local resources, such as health insurance, mental health support, help with food, etc.

___ Other: _____

FOLLOW ALONG PROGRAM
PERMISSION FOR ENROLLMENT

The Follow Along Program is sponsored by the Minnesota Department of Health (MDH) and the local public health agency coordinating the program in the county or area where I live (Managing Agency).

With the following conditions,

I am enrolling _____, _____, in the Follow Along Program.
Child's name Birth date (MM/DD/YYYY)

MY RESPONSIBILITIES

- I will complete and return questionnaires from the Managing Agency that ask about my child's growth and development at different ages every 4-6 months. (If my child was born prematurely, I may be asked to complete some of the questionnaires after my child reaches a certain age).

MY RIGHTS

- My participation in the Follow Along Program is voluntary. I am not legally required to provide information to the program. If I do not provide the data requested, however, I may not be able to fully participate in the program.
- The Managing Agency will not share private information about my child or my family with any person or agency outside of the program without my written permission, except as allowed by law or required by a court.
- I can withdraw my child from the Follow Along Program at any time by telling the Managing Agency that I don't want to continue with the program. If I withdraw, other services may still be available to me.
- Someone from the program will score my child's questionnaire and inform me of the results. If the results show any areas of concern, a public health provider will contact me to talk about next steps.
- I will have access to all of the information about my family that I provide to the Follow Along Program.

MY CONSENT

✓ I authorize the Managing Agency to collect medical and personal information about my child and family, along with questionnaire results, for the purpose of evaluating, assessing, and supporting my child's health, learning, and ongoing development for the duration of the program.

✓ I authorize the Managing Agency to share information collected as part of the program with my child's medical providers, my child's school district, early childhood behavioral health services, and other services as appropriate for the duration of the program.

✓ If I move to another county with a Follow Along Program or similar tracking program, I authorize the Managing Agency to send my information to the new county to help make sure that my child's enrollment is not interrupted.

Parent/Guardian signature_____(Date) _____

ID# 52591