For Office Use Only:	*For Office Use Only:*	*For Office Use Only:*
Center Name: ☐ EHS ☐ HS/ABC	☐ 1st Year Student ☐ 2nd Year Student ☐ 3rd Year Student	Application Date: Enrollment Date: Dropped Date: PIR Age: Transferred to:

HILD/Household Information

For Office Use Only	**Child's Name:**	**Student Data #**
☐Automatic Eligibility AE ☐Income Eligible ☐Over-Income	Last: First: Middle:	**Family # 63-** **Classroom Teacher Assigned: 63-** **Health Disabilities Concerns ?** ☐ Yes ☐ No
Gender: ☐Male ☐Female	**Date of Birth:**	**Age at time of enrollment:**

Physical (911) Address:	**City:** **County:**	**State:**	**Zip Code:**

Child's Social Security #	**Home Phone:**	**Cell Phone:**

Mailing Address **(If different from physical address listed above)**	**Primary language spoken in the home:** ☐English ☐Spanish ☐Other School District:	**Race:** ☐White ☐African American ☐Pacific Islander/Native Hawaiian ☐Bi-Racial/Multi-Racial ☐Other: **Ethnicity:** ☐Hispanic/Latino
Name of person enrolling child:	**Relationship to Child:**	**Parents/Guardians in the home:** ☐One Parent ☐Two Parents
EHS Only: If you are pregnant: **Due Date:**	**EHS Only:** **If so are you are receiving prenatal care ?** ☐Yes ☐No	**Name of person having legal guardianship of the child:**
Does the child or family member living with and supported by you receive Supplemental Security Income Benefits (SSI) ? ☐Yes ☐No	**Is the child living with a relative or friend due to incarceration or abandonment ?** **(Excluding foster children)** ☐Yes ☐No	**Does the child's mother/father/legal guardian receive TANF ?** ☐Yes ☐No
Is the child in Foster/Child Protective Services ? ☐Yes ☐No If yes, please answer and list the following: DHS Caseworkers name: DHS Caseworker Phone # How long has child been in foster care ?	**Is your current address a temporary living arrangement ?** ☐Yes ☐No **Is the child regularly cared for by anyone other than the parent/guardian ? If so, please list name below.**	**If your current address is temporary please check one of the following arrangements.** ☐Hotel/Motel ☐Shelter ☐With more than one family in a house or apt ☐Moving from place to place ☐Non ordinary sleeping accommodations such as a car/park/campsite ☐Other
Are your living arrangements due to a loss of , economic hardship or similar situation with the past year ? ☐Yes ☐No	**Do you have a primary fixed nighttime residence ?** ☐Yes ☐No	**Total # of people living in the household (including you) for who provide financial support:** Income:

List all family members (including yourself) living in the household for whom you are responsible for the care and welfare of:

First Name	Last Name	Birth Date	Is this person related to the child's parent(s) ?	Is this person supported by the parent's income ?

Mother/Guardian Information

Last Name	First Name	
Address (if different from child)	Age of Mother: Email Address: Home Phone Number: Cell Phone Number:	
Lives with Child ? ☐ Yes ☐ No	Legal Custody ☐ Full custody ☐ Joint Custody	Has Income ☐ Yes ☐ No
Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed	Race If separated/divorced, do you child support ? Amount:	Highest level of education ☐ Less than High School ☐ Some College or AA/AS ☐ High School Grad or GED ☐ Bachelor's or Advanced Degree
Employment Status ☐ Employed ☐ Unemployed		Employer Name
Employer Phone Number		Work Hours To
Are you in school or training ? ☐ Yes ☐ No	School Name	School Phone Number

Father/Guardian Information

Last Name	First Name	
Address (if different from child)	Age of Father: Email Address: Home Phone Number: Cell Phone Number:	
Lives with Child ? ☐ Yes ☐ No	Legal Custody ☐ Full custody ☐ Joint Custody	Has Income ☐ Yes ☐ No
Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed	Race If separated/divorced, do you child support ? Amount:	Highest level of education ☐ Less than High School ☐ Some College or AA/AS ☐ High School Grad or GED ☐ Bachelor's or Advanced Degree
Employment Status ☐ Employed ☐ Unemployed		Employer Name
Employer Phone Number		Work Hours To
Are you in school or training ? ☐ Yes ☐ No	School Name	School Phone Number

For Office Use Only:

Verification of Age Eligibility Was Made By Reviewing One Of The Following Documents

Copy of Birth Certificate	☐ Yes	☐ No	Birth Certificate Number
Copy of Hospital Record	☐ Yes	☐ No	Hospital Record Number

Was a Birth Certificate Application given to the parent/guardian to complete if the child did not already have a Birth Certificate at the time of enrollment ?

☐ Yes
☐ No

Verified by

_____

Signature of CADC EHS/HS/ABC Staff *Date:*

Immunizations

Before your child can be enrolled into CADC EHS/HS/ABC, we must be provided an authorized record of up to date immunizations or documentation of a religious or medical exemption from the Arkansas Department of Health and Human Services.

Required Physical Examination

Physical examination by a physician is required. This exam must include Hearing and Vision Screenings, Height and Weight, and a Lead Screening Test. A hemoglobin/Hematocrit (blood work) test and a TB assessment may be conducted if the child is considered to be at risk. If you do not have a copy of a current physical exam for your child, you will be asked to take your child to the doctor within 90 days of the first day of school to obtain one. It is best to do this before your child is enrolled (See Health Record: Form 3, Screenings, Physical Examination/Assessment).

Is a copy of a current Physical examination included with this application ? ☐ Yes ☐ No Date of child's last physical examination:

Required Dental Examination

A dental examiniation by a dentist is required. If you do not have a copy of a current dental exam for your child, you will be asked to take your child to the dentist within 90days of the first day of school to obtain one. It is best to do this before your child is enrolled (see Health Record: Form 5, Dental Health).

Is a copy of a current Dental examination included with this application ? ☐ Yes ☐ No Date of child's last Dental examination:

Health Information Child/Family History

Doctor's Name (Medical Home)	Phone	Address	City	Zip
Dentist's Name (Dental Home)	Phone	Address	City	Zip

Health/Dental Coverage

☐ Medicaid # _____
☐ AR KIds (CHIP)# _____
☐ Military Health (Tri-Care or CHAMPUS) # _____
☐ Non Insured at the time of enrollment

If non insured at the time of enrollment, did CADC EHS/HS/ABC Staff provide and/or assist you in completing an AR Kids Insurance Application ?

☐ Yes
☐ No

Are you receiving services from:

☐ WIC
☐ Food Stamps #_____

Does your family have a pre-existing Family Plan with another agency(DHS, Mental Health Agencies, etc).

☐ Yes
☐ No

Do you have another child(ren) applying for or enrolled in Head Start ?

☐ Yes
☐ No

If yes, what is the child(ren)'s name(s) ?

How did you hear about Head Start ?

☐ Newspaper/Television advertisement
☐ Flyer/Pamphlets
☐ Friend or Family Member
☐ Referral from outside agency or program
☐ Recruitment efforts by Head Start (Target Area Surveys, Community Assessments, Family Development,etc)
☐ Other:

Mother's Health History/Status

☐ Good
☐ Fair
☐ Poor

Father's Health History/Status

☐ Good
☐ Fair
☐ Poor

While pregnant did the mother drink alcoholic beverages that affected the development of the child ?

☐ Yes
☐ No

While pregnant did the mother take any drugs that affected the development of the child ?

☐ Yes
☐ No

If yes to any of the above, please explain:

Has the child been exposed to second hand smoke ?

☐ Yes
☐ No

Medications

List all medications that your child currently takes on a regular basis:

*Parents/Guardians please note: Your child will not be given any medication at school unless it is prescribed by a doctor.

Allergies and Special Diet

List all allergies that your child has (Food or other)

List special diets to accommodate for cultural preference or for religious reasons (indicate what specific foods are included)

Nutrition Information

Does your child experience any symptoms after eating ?

☐ Yes ☐ No

If yes, check the appropriate box(es):

- ☐ Diarrhea
- ☐ Vomiting
- ☐ Itching
- ☐ Difficulty Swallowing

Does your child eat any of the following: Please check the appropriate box(es):

- ☐ Dirt
- ☐ Laundry Starch
- ☐ Clay
- ☐ School Paste
- ☐ Paint Chips
- ☐ Pencils
- ☐ Ice Chips
- ☐ Refrigerator Frost
- ☐ Cornstarch

Special Needs/Chronic Illness

	Yes/No
Asthma	
Anemia	
Diabetes	
Overweight	
Lead Levels	
Other Special Needs If yes, please list	

Birth History

	Yes/No
Was your child premature	
Was your child exposed to cigarette smoke	
While in the hospital, did your child experience any health complications ?	

Ears and Eyes

	Yes/No
Does child have any trouble hearing ?	
Does child use a hearing device ?	
Does child have any trouble with his/her eyes ?	
Has your child ever worn glasses ?	

If yes to any of the above, please explain:

Social/Emotional Development

	Yes/No
Does your child have problems getting along with other children their same age ?	Yes
Does your child have problems getting along with other family members ?	Yes
Does your child have problems sleeping ?	
Does your child have temper tantrums ?	
Does your child have severe fears ?	
Does your child have aggressive behavior ?	
Does your child have extreme shyness ?	
Does your child have problems separating from parent/guardian ?	
Is your child currently receiving mental health services ? If yes, please list agency: Do you have any other concerns about your child's behavior ? If yes, please discuss:	

Disabilities

Has your child been diagnosed by a Professional with a disability ?	
Does your child have an individualized Education Plan (IEP) ?	
Does your child have an Individual Family Service Plan (IFSP) ?	
Is your child currently receiving services from another agency ? If yes, please list agency:	
Additional information about your child's disability or other developmental concerns. Please explain:	Does your child's disability create any special needs for siblings/family members ? If yes, what are they ?

Parental Consents

CADC EHS/HS/ABC Emergency Medical/Dental Treatment Consent

I hereby give my consent for emergency medical or dental treatment of my child by any emergency medical personnel, licensed physician, or dentist while under the care of EHS/HS/ABC and for the transport of my child to and from the source of emergency treatment. This care may include examinations and tests which in the opinion of the physician or dentist are deemed necessary or advisable. This does not include the right to perform surgical operations without consent from the parent/legal guardian. The purpose of this consent has been explained to me and an opportunity to ask further questions was provided. This consent is valid the date my child is enrolled into the EHS/HS/ABC program to the end of the current program year.

☐ Parent/Guardian has read and AGREES to this consent

☐ Parent/Guardian has read and DISAGREES to this consent

CADC EHS/HS/ABC Consent for Screenings/Assessments

I hereby give my consent for my child to receive all necessary screenings required by the EHS/HS/ABC program. I understand these screenings shall include, but are not limited to: Vision, Hearing, Speech, Social-Emotional, and Developmental Screenings/Assessments.

The purpose of this consent has been explained to me and an opportunity to ask further questions was provided. This consent is valid the date my child is enrolled into the EHS/HS/ABC program to the end of the current program year.

☐ Parent/Guardian has read and AGREES to this consent

☐ Parent/Guardian has read and DISAGREES to this consent

CADC EHS/HS/ABC Consent for Classroom Observation

All EHS/HS/ABC students maybe observed in the classroom setting by a Mental Health Professional to ensure that each classroom is safe, nurturing, and conducive to good mental health.

I hereby give consent for my child's behavior and/or classroom environment to be observed by a Mental Health Professional.

The purpose of this consent has been explained to me and an opportunity to ask further questions was provided. This consent is valid the date my child is enrolled into the EHS/HS/ABC program to the end of the current program year.

☐ Parent/Guardian has read and AGREES to this consent

☐ Parent/Guardian has read and DISAGREES to this consent

Emergency Contact Information

CADC EHS/HS/ABC staff will first attempt to contact the parent/guardian in case of an emergency, but if we are unable to reach you please list below other family members or friends that we may contact:

Name	Phone Number	Relationship to Child
Name	Phone Number	Relationship to Child
Name	Phone Number	Relationship to Child

PLEASE READ CAREFULLY AND SIGN THAT YOU UNDERSTAND AND ACCEPT THIS INFORMATION.

I certify that the information in this application is true and complete to the best of my knowledge. I understand that failure to report correct information may be grounds for rejection of this application. I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing childcare services. I also certify that I have read and understood all the Parental Consents and therefore give my consent.

Parent's/Guardian's Signature: _____ Date: _____

Witnessed By: _____ Date: _____

CADC EHS/HS/ABC Staff Person's Signature

5 ***All proof of income must be verified by CADC EHS/HS/ABC Staff, please see the next page titled Head Start Eligibility Verification for this information.***

An Incomplete Application Will Delay Enrollment (Revised 2/12, 6/12, 2/13, 6/13, 6/14, 5/15, 7/16)