CADC EHS/HS/ABC Enrollment Application (1)

FOR OFFICE USE ONLY:

Center Name:

_____

- ☐ EHS
- ☐ HS/ABC

FOR OFFICE USE ONLY:

- ☐ 1st Year Student
- ☐ 2nd Year Student
- ☐ 3rd Year Student

FOR OFFICE USE ONLY

APPLICATION DATE: _____

ENROLLMENT DATE: _____

DROPPED DATE: _____TRANSFERRED TO:_____
(CENTER NAME)

PIR AGE: _____

CHILD/HOUSEHOLD INFORMATION

FOR OFFICE USE ONLY:

- ☐ Automatic Eligibility **AE**
- ☐ Income Eligible
- ☐ Over-Income

Child's Name:

LAST: _____

FIRST: _____

MIDDLE: _____

Student Data #

_____

Family #

_____

Classroom Teacher Assigned

_____

Health/Disabilities Concerns

- ☐ Yes
- ☐ No

Gender:

- ☐ Male
- ☐ Female

Date of Birth: _____/_____/_____

Age at the time of enrollment: _____

Physical (911) Address:

City:
County:

State:

Zip Code:

Child's Social Security Number:

Home Phone:
( )_____-_____

Cell Phone:
( )_____-_____

Mailing Address: (If different from physical address)

_____

_____

_____

Primary language spoken in the home:

- ☐ English
- ☐ Spanish
- ☐ Other: _____

School District:

_____

Race:

- ☐ White
- ☐ Black/African American
- ☐ American Indian
- ☐ Pacific Islander/Native Hawaiian
- ☐ Bi-Racial/Multi-Racial
- ☐ Other: _____

Ethnicity:

- ☐ Hispanic/Latino

Name of Person Enrolling Child:

Relationship to the child:

Parents/Guardians in the Home

- ☐ One Parent
- ☐ Two Parents

EHS only:

If you are pregnant:
Due Date (month/year) _____/_____

EHS only:

If so are you 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 child's mother/father/legal guardian receive TANF?

- ☐ Yes
- ☐ No

Is the child in Foster Care/Child Protective Services?

- ☐ Yes
- ☐ No

If yes, please answer and list the following:
DHS Caseworker's Name:
_____
DHS Caseworker Phone #:
_____
How long has the 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 their 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 an apartment
- ☐ Moving from place to place
- ☐ Non-ordinary sleeping accommodations such as a car, park, or campsite
- ☐ OTHER: _____

Is your living arrangements due to a loss of housing, economic hardship or similar situation with the past year?

- ☐ Yes
- ☐ No

Do you have a primary fixed nighttime residence?

- ☐ Yes
- ☐ No

Total number of people living in the household (including you) for whom you provide financial support:

_____

Income

CADC EHS/HS/ABC Enrollment Application (2)

LIST ALL FAMILY MEMBERS (INCLUDING YOU) 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?
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No

MOTHER/GUARDIAN INFORMATION

Last Name	First Name
Address (if different than child) _____ _____	Age of Mother:_____ Email Address:_____ Home Phone Number: _____ Cell Phone Number: _____

Lives with child	Legal Custody	Has Income
☐ Yes ☐ No	☐ Full Custody ☐ Joint Custody	☐ Yes ☐ No

Marital Status		Highest Level of Education
☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed	Race _____ If separated/divorced, do you receive child support? _____ Amount	☐ Less than High School ☐ Some College or AA/AS ☐ High School Grad or GED ☐ Bachelor's or Advanced Degree

Employment Status	Employer Name
☐ Employed ☐ Unemployed	
Employer Phone Number	Work Hours _____ TO _____

Are you in School or Training	School Name	School Phone Number
☐ Yes ☐ No		

FATHER/GUARDIAN INFORMATION

Last Name	First Name
Address (if different than child) _____ _____	Age of Father: _____ Email Address: _____ Home Phone Number: _____ Cell Phone Number: _____

Lives with child	Legal Custody	Has Income
☐ Yes ☐ No	☐ Full Custody ☐ Joint Custody	☐ Yes ☐ No

Marital Status		Highest Level of Education
☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed	Race _____ If separated/divorced, do you receive child support? _____ Amount	☐ Less than High School ☐ Some College or AA/AS ☐ High School Grad or GED ☐ Bachelor's or Advanced Degree

Employment Status	Employer Name
☐ Employed ☐ Unemployed	
Employer Phone Number	Work Hours _____ TO _____

Are you in School or Training	School Name	School Phone Number
☐ Yes ☐ No		

CADC EHS/HS/ABC Enrollment Application (3)

FOR OFFICE USE ONLY	
VERFICATION OF AGE ELGIBILITY 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 at Birth Certificate at the time of enrollment? ☐ Yes ☐ No	
Verified by:_____ Date:_____ *Signature of CADC EHS/HS/ABC Staff*	

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

A 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 maybe 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 examination 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 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 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 Insurance 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 advertisements ☐ Flyers/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	

CADC EHS/HS/ABC Enrollment Application (4)

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, Please 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 (Circle Yes or No)

Asthma	Yes	No
Anemia	Yes	No
Diabetes	Yes	No
Overweight	Yes	No
Lead Levels	Yes	No
Other Special Health Needs	Yes	No

If yes, please list: _____

BIRTH HISTORY (Circle Yes or No)

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

EARS AND EYES (Circle Yes or No)

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

If yes, to any of the above, please explain:

SOCIAL-EMOTIONAL DEVELOPMENT (Circle Yes or No)

Does your child have problems getting along with other children their same age?	Yes	No
Does your child have problems getting along with other family members?	Yes	No
Does your child have problems sleeping?	Yes	No
Does your child have temper tantrums?	Yes	No
Does your child have severe fears?	Yes	No
Does your child have aggressive behavior?	Yes	No
Does your child have extreme shyness?	Yes	No
Does your child have problems separating from parent/guardian?	Yes	No
Is your child currently receiving mental health services?	Yes	No

If yes, please list agency:_____

Do you have any other concerns about your child's behavior? Yes No

If yes, please discuss:_____

_____

CADC EHS/HS/ABC Enrollment Application (5)

DISABILITIES (Circle Yes or No)

Has your child been diagnosed by a Professional with a disability?	Yes	No
Does your child have an Individualized Education Plan (IEP)?	Yes	No
Does your child have an Individual Family Service Plan (IFSP)?	Yes	No
Is your child currently receiving services from another agency? If yes, please list agency: _____	Yes	No

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 classroom/learning 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/Guardian's Signature: _____ Date: _____

Witnessed By: _____ Date: _____
CADC EHS/HS/ABC Staff Person's Signature

All proof of income must be verified by CADC EHS/HS/ABC Staff, please see the next page titled HEAD START ELGIBILITY VERIFICATION for this information.

AN INCOMPLETE APPLICATION WILL DELAY ENROLLMENT

(Revised 2/12, 6/12, 2/13, 6/13, 6/14,5/15)