

## CADC EHS/HS/ABC Enrollment Application (1)

<p><i>FOR OFFICE USE ONLY:</i></p> <p>Center Name: _____</p> <p><input type="checkbox"/> EHS <input type="checkbox"/> HS/ABC</p>	<p><i>FOR OFFICE USE ONLY:</i></p> <p><input type="checkbox"/> 1<sup>st</sup> Year Student <input type="checkbox"/> 2<sup>nd</sup> Year Student <input type="checkbox"/> 3<sup>rd</sup> Year Student</p>	<p><i>FOR OFFICE USE ONLY:</i></p> <p>ENROLLMENT DATE: _____</p> <p>DROPPED DATE: _____</p> <p>TRANSFERRED TO: _____ <span style="font-size: small;">(CENTER NAME)</span></p>
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### CHILD/HOUSEHOLD INFORMATION

<p><i>FOR OFFICE USE ONLY:</i></p> <p><input type="checkbox"/> Automatic Eligibility AE <input type="checkbox"/> Income Eligible <input type="checkbox"/> Over-Income</p>	<p><b>Child's Name:</b></p> <p><b>LAST:</b> _____</p> <p><b>FIRST:</b> _____</p> <p><b>MIDDLE:</b> _____</p>	<p>Student Data # _____</p> <p>Family # _____</p> <p>Classroom Teacher Assigned _____</p> <p>Health/Disabilities Concerns <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>Date of Birth: _____/_____/_____</p>	<p>Age at the time of enrollment: _____</p>	
<p>Physical (911) Address: _____</p>	<p>City: _____</p>	<p>State: _____</p>	<p>Zip Code: _____</p>
<p>Child's Social Security Number: _____</p>	<p>Home Phone: ( ) _____ - _____</p>	<p>Cell Phone: ( ) _____ - _____</p>	
<p>Mailing Address: (If different from physical address) _____ _____ _____</p>	<p>Primary language spoken in the home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____</p>	<p>Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Bi-Racial/Multi-Racial <input type="checkbox"/> Other: _____</p>	
<p>Name of Person Enrolling Child: _____</p>	<p>Relationship to the child: _____</p>	<p>Parents/Guardians in the Home <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parents</p>	
<p><i>EHS only:</i> If you are pregnant: Due Date (month/year) ____/____</p>	<p><i>EHS only:</i> If so are you receiving prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Name of Person Having Legal Custody of the child: _____</p>	
<p>Is the child in Foster Care/Child Protective Services? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Is the child living with a relative or friend due to incarceration or abandonment? (excluding foster children) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Does child's mother/father/legal guardian receive TANF? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Does the child or family member living with and supported by you receive Supplemental Security Income Benefits (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Is your current address a temporary living arrangement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If your current address is temporary please check one of the following arrangements: <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Shelter <input type="checkbox"/> With more than one family in a house or an apartment <input type="checkbox"/> Moving from place to place <input type="checkbox"/> Non-ordinary sleeping accommodations such as a car, park, or campsite <input type="checkbox"/> OTHER: _____</p>	
<p>Is your living arrangements due to a loss of housing, economic hardship or similar situation with the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you have a primary fixed nighttime residence? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Total number of people living in the household (including you) for whom you provide financial support: _____</p>	

## 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?
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

### MOTHER/GUARDIAN INFORMATION

Last Name		First Name		
Address (if different than child) _____		Email Address		
Lives with child <input type="checkbox"/> Yes <input type="checkbox"/> No	Legal Custody <input type="checkbox"/> Yes <input type="checkbox"/> No	Has Income <input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital Status <input type="checkbox"/> Married                      Race: _____ <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Highest Level of Education <input type="checkbox"/> Less than High School <input type="checkbox"/> Some College or AA/AS <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> Bachelor's or Advanced Degree		
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed		Employer Name		
Employer Phone Number		Work Hours _____ TO _____		
Are you in School or Training <input type="checkbox"/> Yes <input type="checkbox"/> No		School Name		School Phone Number

### FATHER/GUARDIAN INFORMATION

Last Name		First Name		
Address (if different than child) _____		Email Address		
Lives with child <input type="checkbox"/> Yes <input type="checkbox"/> No	Legal Custody <input type="checkbox"/> Yes <input type="checkbox"/> No	Has Income <input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital Status <input type="checkbox"/> Married                      Race: _____ <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Highest Level of Education <input type="checkbox"/> Less than High School <input type="checkbox"/> Some College or AA/AS <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> Bachelor's or Advanced Degree		
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed		Employer Name		
Employer Phone Number		Work Hours _____ TO _____		
Are you in School or Training <input type="checkbox"/> Yes <input type="checkbox"/> No		School Name		School Phone Number

## CADC EHS/HS/ABC Enrollment Application (3)

<b>FOR OFFICE USE ONLY</b>	
<b>VERIFICATION OF AGE ELGIBILITY WAS MADE BY REVIEWING ONE OF THE FOLLOWING DOCUMENTS:</b>	
Copy of Birth Certificate: <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Certificate Number
Copy of Hospital Record: <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Verified by: _____ Date: _____ <i>Signature of CADC EHS/HS/ABC Staff</i>	

### 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: <input type="checkbox"/> Medicaid # _____ <input type="checkbox"/> AR Kids (CHIP) # _____ <input type="checkbox"/> Military Health (Tri-Care or CHAMPUS) # _____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No  Are you receiving services from: <input type="checkbox"/> WIC <input type="checkbox"/> Food Stamps # _____		Do you have another child (ren) applying for or enrolled in Head Start? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, what is the child (ren)'s name(s)? _____  How did you hear about Head Start? <input type="checkbox"/> Newspaper/Television advertisements <input type="checkbox"/> Flyers/Pamphlets <input type="checkbox"/> Friend or family member <input type="checkbox"/> Referral from outside agency or program <input type="checkbox"/> Recruitment efforts by Head Start (Target Area Surveys, Community Assessments, Family development, etc.) <input type="checkbox"/> Other: _____		
Mother's Health History/Status <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		Father's Health History/Status <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
While pregnant did the mother drink alcoholic beverages that affected the development of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No		While pregnant did the mother take any drugs that affected the Development of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, to any of the above, please explain:				
Has the child been exposed to second hand smoke? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	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?	Yes	No
If yes, please list agency: _____		
Additional information about your child's disability or other developmental concerns. Please explain if yes circled above:		

### 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.***