

CADC EHS/HS/ABC Enrollment Application (1)

<p><u>FOR OFFICE USE ONLY:</u></p> <p>Center Name: _____</p> <p><input type="checkbox"/> EHS <input type="checkbox"/> HS/ABC</p>	<p><u>FOR OFFICE USE ONLY:</u></p> <p><input type="checkbox"/> 1st Year Student <input type="checkbox"/> 2nd Year Student <input type="checkbox"/> 3rd Year Student</p>	<p><u>FOR OFFICE USE ONLY:</u></p> <p>APPLICATION DATE: _____</p> <p>ENROLLMENT DATE: _____</p> <p>DROPPED DATE: _____</p> <p>PIR AGE: _____ (Age as of August 1st)</p> <p>TRANSFERRED TO: _____</p>
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Child Data Sheet/General Information

<p><u>FOR OFFICE USE ONLY:</u></p> <p><input type="checkbox"/> Automatic Eligibility (AE)</p> <p><input type="checkbox"/> Income Eligible (100% or Below)</p> <p><input type="checkbox"/> Income Eligible _____ % (Between 101%-130%)</p> <p><input type="checkbox"/> Over-Income _____ % (Over 130 %)</p> <p>Income: \$ _____</p>	<p>Child's Name:</p> <p>LAST: _____</p> <p>FIRST: _____</p> <p>MIDDLE: _____</p>	<p>Classroom Teacher Assigned</p> <p>_____</p> <p>Health/Disabilities Concerns</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what are the concerns?</p> <p>_____ _____</p>	
<p>Gender:</p> <p><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: _____ County: _____</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>_____ _____ _____</p>	<p>Primary language:</p> <p><input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____</p> <p>Speaks English at home:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>English Skills:</p> <p><input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not At All</p>	<p>Race:</p> <p><input type="checkbox"/> White <input type="checkbox"/> Black/African American <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>Ethnicity:</p> <p><input type="checkbox"/> Hispanic/Latino</p> <p>US Citizen</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>School District: _____</p>	<p>Name of Person Enrolling Child: _____</p>	<p>Relationship to the child: _____</p>	<p>Parents/Guardians/Authorized Caregivers in the Home</p> <p><input type="checkbox"/> One Parent <input type="checkbox"/> Two Parents</p>
<p>EHS only:</p> <p>If you are pregnant: Due Date (month/year) ____/____</p>	<p>EHS only:</p> <p>If so are you receiving prenatal care?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Name of Person Having Legal Guardianship of the child: _____</p>	
<p>Does the child or family member living with and supported by you receive Supplemental Security Income Benefits (SSI)?</p> <p><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)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Does the child's mother/father/guardian/authorized caregiver receive TANF?</p> <p><input type="checkbox"/> Yes If Yes, TANF # _____ <input type="checkbox"/> No</p>	
<p>Is the child in Foster Care/Child Protective Services?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please answer and list the following: DHS Caseworker's Name: _____ DHS Caseworker Phone #: _____ How long has the child been in foster care? _____</p>	<p>Is your current address a temporary living arrangement?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the child regularly cared for by anyone other than the parent/guardian/authorized caregiver? If so, please list their name below: _____</p>	<p>If your current address is temporary please check one of the following arrangements:</p> <p><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>Are your living arrangements due to a loss of housing, economic hardship or similar situation with the past year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you have a primary fixed nighttime residence?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>The total number of people living in the household (including you) for whom you provide financial support: _____</p>	

CADC EHS/HS/ABC Enrollment Application (2)

Primary Caregiver General Information

First Name		Last Name		Social Security #	
Address (if different than the child) _____ _____ _____		Birth Date: _____ Age: _____			
		Email Address: _____ <input type="checkbox"/> I agree to receive emails			
		Home Phone Number: _____			
		Cell Phone Number: _____ <input type="checkbox"/> I agree to receive text messages			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Lives with child <input type="checkbox"/> Yes <input type="checkbox"/> No	Legal Custody <input type="checkbox"/> Full Custody <input type="checkbox"/> Joint Custody	Has Income <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Child Support Do you receive Child Support? <input type="checkbox"/> Yes <input type="checkbox"/> No If your answer is yes, How much do you receive? _____ How often do you receive it? _____ Please provide documentation of Child Support		Ethnicity <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic <input type="checkbox"/> Hispanic Black <input type="checkbox"/> Hispanic White <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Other Spanish, Hispanic, Latino <input type="checkbox"/> Yes, Puerto Rican		Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Bi-Racial/Multi-Racial <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____	
		Highest Level of Education <input type="checkbox"/> 0-8 th Grade <input type="checkbox"/> 9 th -12 th (Non-Grad) <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> 12 th + Some Post-Secondary <input type="checkbox"/> 2 or 4 year Grad <input type="checkbox"/> Graduate of Other Post-Secondary <input type="checkbox"/> Bachelor's or Advanced Degree			
		Education Completion Date _____			
		<input type="checkbox"/> Completed a Job Training Program, Professional Certificate, or license? Program completion date _____			
If unemployed, when did you last work? _____		If unemployed, where did you last work? _____			
Employment Status <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Full-Time & Training <input type="checkbox"/> Employed Seasonal <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Job Training/School (Part-time) <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Part-Time & Training <input type="checkbox"/> Migrant Farm Worker <input type="checkbox"/> Farmer <input type="checkbox"/> Job Training or in School <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Seasonal Farm Worker <input type="checkbox"/> Unknown					
Employer/School Name		Work/School Hours FROM _____ TO _____		How long have you been employed at current job? Years _____ Months _____	
Employer/School Phone Number		<input type="checkbox"/> Member of the US military on active duty <input type="checkbox"/> A veteran of the United States military			
Health Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State Insurance for Adults <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> None <input type="checkbox"/> Military Health Care <input type="checkbox"/> Direct Purchase <input type="checkbox"/> Employee Based		Current Housing <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Other _____		Previous Housing <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless <input type="checkbox"/> Other	
Have you moved in the last 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Parent less than 18 years of age at birth <input type="checkbox"/> Yes <input type="checkbox"/> No	Family Structure <input type="checkbox"/> Single Parent/Person <input type="checkbox"/> Two Parents/Persons		Family Type <input type="checkbox"/> Single Parent Female <input type="checkbox"/> Single Parent Male <input type="checkbox"/> Two-Parent Household <input type="checkbox"/> Two Parent Unmarried <input type="checkbox"/> Multi-Generational Household <input type="checkbox"/> Non-Related Adults with Children <input type="checkbox"/> Other _____		Housing Type <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Duplex <input type="checkbox"/> Mobile Home <input type="checkbox"/> Other _____
The date you moved into your current home? _____		Parent(s) /Guardian(s) Best Descriptor <input type="checkbox"/> Mother (Biological, Adoptive, Stepmother, Etc.) <input type="checkbox"/> Father (Biological, Adoptive, Stepfather, Etc.) <input type="checkbox"/> Grandparent <input type="checkbox"/> Relative other than grandparent <input type="checkbox"/> Foster Parent not including relative <input type="checkbox"/> Other _____		Do you currently live in Public Housing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Non Cash Benefits <input type="checkbox"/> LIHEAP <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Child Care Voucher <input type="checkbox"/> Affordable Care Act Subsidy Other _____		Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		Do you currently receive Section 8 Housing Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	

CADC EHS/HS/ABC Enrollment Application (3)

Secondary Caregiver General Information No Secondary Caregiver (skip application for secondary caregiver)

First Name		Last Name		Social Security #	
Address (if different than the child) _____ _____ _____		Birth Date: _____ Age: _____			
		Email Address: _____ <input type="checkbox"/> I agree to receive emails			
		Home Phone Number: _____			
		Cell Phone Number: _____ <input type="checkbox"/> I agree to receive text messages			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Lives with child <input type="checkbox"/> Yes <input type="checkbox"/> No	Legal Custody <input type="checkbox"/> Full Custody <input type="checkbox"/> Joint Custody	Has Income <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Child Support Do you receive Child Support? <input type="checkbox"/> Yes <input type="checkbox"/> No If your answer is yes, How much do you receive? _____ How often do you receive it? _____ Please provide documentation of Child Support		Ethnicity <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic <input type="checkbox"/> Hispanic Black <input type="checkbox"/> Hispanic White <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Other Spanish, Hispanic, Latino <input type="checkbox"/> Yes, Puerto Rican		Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Bi-Racial/Multi-Racial <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____	
		Highest Level of Education <input type="checkbox"/> 0-8 th Grade <input type="checkbox"/> 9 th -12 th (Non-Grad) <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> 12 th + Some Post-Secondary <input type="checkbox"/> 2 or 4 year Grad <input type="checkbox"/> Graduate of Other Post-Secondary <input type="checkbox"/> Bachelor's or Advanced Degree		Education Completion Date _____ <input type="checkbox"/> Completed a Job Training Program, Professional Certificate, or license? Program completion date _____	
		If unemployed, when did you last work? _____		If unemployed, where did you last work? _____	
Employment Status <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Full-Time & Training <input type="checkbox"/> Employed Seasonal <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Job Training/School (Part-time) <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Part-Time & Training <input type="checkbox"/> Migrant Farm Worker <input type="checkbox"/> Farmer <input type="checkbox"/> Job Training or in School <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Seasonal Farm Worker <input type="checkbox"/> Unknown					
Employer/School Name		Work/School Hours FROM _____ TO _____		How long have you been employed at current job? Years _____ Months _____	
Employer/School Phone Number		<input type="checkbox"/> Member of the US military on active duty <input type="checkbox"/> A veteran of the United States military			
Health Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State Insurance for Adults <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> None <input type="checkbox"/> Military Health Care <input type="checkbox"/> Direct Purchase <input type="checkbox"/> Employee Based		Current Housing <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Other _____		Previous Housing <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless <input type="checkbox"/> Other	
Parent less than 18 years of age at birth <input type="checkbox"/> Yes <input type="checkbox"/> No		Family Structure <input type="checkbox"/> Single Parent/Person <input type="checkbox"/> Two Parents/Persons		Family Type <input type="checkbox"/> Single Parent Female <input type="checkbox"/> Single Parent Male <input type="checkbox"/> Two-Parent Household <input type="checkbox"/> Two Parent Unmarried <input type="checkbox"/> Multi-Generational Household <input type="checkbox"/> Non-Related Adults with Children <input type="checkbox"/> Other _____	
Date you moved into your current home?		Parent(s) /Guardian(s) Best Descriptor <input type="checkbox"/> Mother (Biological, Adoptive, Stepmother, Etc.) <input type="checkbox"/> Father (Biological, Adoptive, Stepfather, Etc.) <input type="checkbox"/> Grandparent <input type="checkbox"/> Relative other than grandparent <input type="checkbox"/> Foster Parent not including relative <input type="checkbox"/> Other _____		Housing Type <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Duplex <input type="checkbox"/> Mobile Home <input type="checkbox"/> Other _____	
Non Cash Benefits <input type="checkbox"/> LIHEAP <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Child Care Voucher <input type="checkbox"/> Affordable Care Act Subsidy Other _____		Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		Do you currently live in Public Housing? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you currently receive Section 8 Housing Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	

CADC EHS/HS/ABC Enrollment Application (4) **VERIFICATION OF AGE**

<u>FOR OFFICE USE ONLY</u>	
VERIFICATION OF AGE ELIGIBILITY WAS MADE BY REVIEWING ONE OF THE FOLLOWING DOCUMENTS:	
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
Copy of Birth Certificate or Hospital record unavailable: <input type="checkbox"/> Yes	<input type="checkbox"/> Reviewed immunization record to verify age
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>	

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?	Income Source	Gross Income Amount
			<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		

Please complete for Non Primary/Secondary Caregivers (additional pages available if needed)

Name: _____ Age: _____

SSN: _____ Date of Birth: _____ Relationship to Applicant _____

Disabled: Yes No Ethnicity: Hispanic or Latino NOT Hispanic or Latino Gender: Male Female Veteran: Active Veteran No

Race: American Indian or Alaskan Native Asian Black

Native Hawaiian and Other Pacific Islander White Multi Race Other

Education: 0-8th 9th-12th (non-grad) High School/GED 12+some post-secondary 2 or 4 year grad graduate of other post-secondary

Health Insurance: Medicaid Medicare State Children's Health Insurance Program None

State Insurance for Adults Military Health Care Direct Purchase Employment Based

When & Where Last Worked: _____

Name: _____ Age: _____

SSN: _____ Date of Birth: _____ Relationship to Applicant _____

Disabled: Yes No Ethnicity: Hispanic or Latino NOT Hispanic or Latino Gender: Male Female Veteran: Active Veteran No

Race: American Indian or Alaskan Native Asian Black

Native Hawaiian and Other Pacific Islander White Multi Race Other

Education: 0-8th 9th-12th (non-grad) High School/GED 12+some post-secondary 2 or 4 year grad graduate of other post-secondary

Health Insurance: Medicaid Medicare State Children's Health Insurance Program None

State Insurance for Adults Military Health Care Direct Purchase Employment Based

When & Where Last Worked: _____

CADC EHS/HS/ABC Enrollment Application (5)

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 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.

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

REQUIRED ORAL HEALTH EXAMINATION

An oral health examination by a dentist is required. If you do not have a copy of a current oral health 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.

Is a copy of a current Oral Health Examination included with this application? ___ Yes ___ No Date of child's last oral health examination _____

HEALTH INFORMATION/CHILD-FAMILY HISTORY

Doctor's Name (Medical Home) <input type="checkbox"/> At time of application <input type="checkbox"/> After enrollment	Phone ()	Address	City	Zip
Dentist's Name (Oral Health Home) <input type="checkbox"/> At time of application <input type="checkbox"/> After enrollment	Phone ()	Address	City	Zip
Health Insurance Coverage: <input type="checkbox"/> Medicaid # _____ <input type="checkbox"/> AR Kids (CHIP) # _____ Specify <input type="checkbox"/> ARKids A <input type="checkbox"/> ARKids B <input type="checkbox"/> Military Health (Tri-Care or CHAMPUS) # _____ <input type="checkbox"/> Non-Insured at the time of enrollment <input type="checkbox"/> Private 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"/> Not Applicable <input type="checkbox"/> No		Dental Insurance Coverage: <input type="checkbox"/> Delta Dental <input type="checkbox"/> MCNA <input type="checkbox"/> Other		<i>For Office use only</i> Immunization History <small>(answer <u>only one</u> of the following questions)</small> *Is child up-to-date on all immunizations appropriate for his/her age? ___ Yes ___ No *Has child received all immunizations possible at this time but has not received all immunizations appropriate for his/her age? ___ Yes ___ No *Child met State's guidelines for an exemption from immunizations. ___ Yes ___ No *Has received no immunizations. ___ Yes ___ No
Are you receiving services from: <u>WIC</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously <u>Food Stamps/SNAP</u> <input type="checkbox"/> Yes - If yes, please provide # _____ <input type="checkbox"/> No Budget Id/Case # (not card #)		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)? _____		
Does your family have a pre-existing Family Plan with another agency (DHS, Mental Health Agencies, etc). <input type="checkbox"/> Yes <input type="checkbox"/> No		How did you hear about CADC EHS/HS/ABC? <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"/> Unknown <input type="checkbox"/> Poor		Father's Health History/Status <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Unknown <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 (6)

MEDICATIONS

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

Parents/Guardians/Authorized Caregivers Please Note: Your child will not be given any medication at school unless it is prescribed by a doctor.

ALLERGIES AND SPECIAL DIET

(If child has allergies or a special diet, please fill out the Questionnaire for Child with Chronic Condition/Illness and Food Allergy or Food Intolerance, and forward to the Health and Safety Specialist and/or the Nutrition Specialist and make sure Teachers and Cooks (if applicable) are aware before enrollment.) (Please Note: ask parents for a statement from their health care professional)

List all allergies that your child has (Food, Medications 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 Not Applicable
 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 Not Applicable
 Pencils
 Ice Chips
 Refrigerator Frost
 Cornstarch

SPECIAL NEEDS/CHRONIC ILLNESS

(Circle Yes or No)

Asthma <small>(If yes, an asthma action plan is required from your child's Doctor)</small>	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? <small>(If yes, what was child's birth weight? _____)</small>	Yes	No
Did Mother smoke while pregnant or exposed to second-hand 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/authorized caregiver?	Yes	No
Is your child currently receiving mental health services?	Yes	No
If yes, please list agency: _____		
*If yes, please sign a Consent to Release Information form and forward it to the Mental Health and Disabilities Specialist and make sure Teachers aware before enrollment.		
Do you have any other concerns about your child's behavior?	Yes	No
If yes, please discuss: _____		

CADC EHS/HS/ABC Enrollment Application (7)

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?	Yes	No

If yes, please list agency: _____
***If yes, please sign the Consent to Release Information form and forward to the Mental Health and Disabilities Specialist and make sure Teachers aware before enrollment.**

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?
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PARENTAL/GUARDIAN/AUTHORIZED CAREGIVER CONSENTS

CADC EHS/HS/ABC Emergency Medical/Oral Health Treatment Consent
 I hereby give my consent for emergency medical or oral health 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 in the EHS/HS/ABC program to the end of the current program year.

Parent/Guardian/Authorized Caregiver has read and **AGREES** to this consent
 Parent/Guardian/Authorized Caregiver 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 in the EHS/HS/ABC program to the end of the current program year.

Parent/Guardian/Authorized Caregiver has read and **AGREES** to this consent
 Parent/Guardian/Authorized Caregiver has read and **DISAGREES** to this consent

CADC EHS/HS/ABC Consent for Classroom Observation
 All EHS/HS/ABC students may be 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 in the EHS/HS/ABC program to the end of the current program year.

Parent/Guardian/Authorized Caregiver has read and **AGREES** to this consent
 Parent/Guardian/Authorized Caregiver has read and **DISAGREES** to this consent

I Would Like Information About the Following Services:
 Transportation Weatherization Utility Assistance Commodity Food Distribution Senior Activity Center
 Single Parent Scholarship Family Development Community Development Other _____

Acknowledgment:
 I am a CADC Employee I am a CADC Board Member I am a family member a CADC Employee or Board Member N/A

EMERGENCY CONTACT INFORMATION

CADC EHS/HS/ABC staff will first attempt to contact the parent/guardian/authorized caregiver 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 (these contacts also need to be on the Child Pick-up and Visitation Authorization Form)

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/Guardian/Authorized Caregiver Consents and therefore give my consent.

Parent/Guardian/Authorized Caregiver'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 ELIGIBILITY VERIFICATION for this information.

