PK

Clarinda Community School District
Enrollment/ Emergency Form

Student_____ Grade_____ Date of Birth_____ Male/Female_____

middle name: _____

Home Phone_____ Address_____ City,State,Zip_____

Family Information:

List Name and Relationship to child:	Address	Home Phone	Cell Phone	Employer	Work Phone	Email address	Has contact with student Yes/No
Parent/Guardian Living with Student:							
Spouse of Parent/Guardian Listed Above:							
AND							
Parent/Guardian Not Living with Student:							
Spouse of Parent/Guardian Listed Above:							

Please Mark if student: Is Open Enrolled Y/ N in Special Education Y/ N in Band Y/ N If Y, list instrument:_____

Student lives with: __Parent(s) __Caretaker __Legal Guardian **Student lives in:** __Parent home __Relatives/Friends home __Hotel __Other

Contact Information (please list LOCAL contacts):

Ask about texting notifications!

Child Care_____ Child Care Phone_____

Emergency Contact #1_____ Phone (1)_____ Phone (2)_____

Emergency Contact #2_____ Phone (1)_____ Phone (2)_____

Emergency Contact #3_____ Phone (1)_____ Phone (2)_____

For Residents New to Clarinda: What Brought You to Clarinda: ___Employment ___Relatives ___Other - please list_____ (Over)

School Medical Registration Form – Health History

Please list a local provider that you prefer in the case of an emergency.

Family Doctor _____ Date of last exam _____ Does student have a current school physical Y/N

Dentist _____ Date of last exam _____

Eye Doctor _____ Date of last exam _____

***In the event of an emergency, 911 will be called and your child will be taken to Clarinda Regional Health Center.**

List other doctors, specialists, counselors (local or out-of-town): _____

Allergies (list allergy and type of reaction): _____

Medications taken routinely: _____

Will your child take medicine at school: Yes/No If yes, what medication? _____

* Note- All medications given at school must be supplied by the parent in the original container and a medication permit form must be completed and signed by the parent.

1. Does your child have health insurance? Yes/No Provider Name: _____
2. Do you have any concerns about your child's general health? (eating, sleeping, weight, etc.) Yes/No
3. Does your child have any chronic illness or medical condition? (seizures, asthma, heart condition, ADHD, etc.) Yes/No
4. Has your child had any serious accidents? (burns, head injury, broken bones, etc.) Yes/No
5. Does your child have any problems with:

Hearing	Yes/No	Vision	Yes/No	Does your child wear glasses?	Yes/No
Speech	Yes/No	Physical Disabilities	Yes/No		

Explain all yes answers in the space provided below:

_____

_____

_____

This form will be added to the students health file and shared with appropriate school staff.

Parent Signature: _____ *Date:* _____

(Over)

Student Name: _____ Birth Date: _____ Sex: ☐ M ☐ F

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ Phone (W): _____ Phone (C): _____

School: _____ Grade: _____

Was your child born in the United States? ☐ Yes ☐ No

If yes, in which state? _____

If not, in what other country? _____

Has your child attended any school in the United States for any three years during their lifetime? ☐ Yes ☐ No

If yes, please provide school name(s), state, and dates attended:

Name of School _____ State_____ Dates Attended_____

Name of School _____ State_____ Dates Attended_____

Name of School _____ State_____ Dates Attended_____

In which language do you prefer to receive written information from school? _____

In which language do you prefer to receive spoken information from school? _____

Home Language Survey Questions

1. What is the primary language used in the home, regardless of the language spoken by the student? _____
2. What is the language most often spoken by the student? _____
3. What is the language that the student first acquired? _____

_____ _____

Parent/Guardian Signature Date

Nombre del/de la alumno(a): _____ Fecha de nacimiento: _____ Sexo: ❑ M ❑ F

Nombre del padre/madre/tutor: _____

Dirección: _____

Teléfono (casa): _____ Teléfono (trabajo): _____ Teléfono (celular): _____

Escuela: _____ Grado: _____

¿Nació su hijo(a) en los Estados Unidos? ❑ Sí ❑ No

Si la respuesta es "sí", ¿en qué estado? _____

Si la respuesta es "no", ¿en qué país? _____

¿Asistió su hijo(a) a alguna escuela en los Estados Unidos durante tres años a lo largo de su vida? ❑ Sí ❑ No

Si la respuesta es "sí", dé el nombre de la escuela/las escuelas, el estado y las fechas de asistencia:

Nombre de la escuela _____ Estado _____ Fechas de asistencia _____

Nombre de la escuela _____ Estado _____ Fechas de asistencia _____

Nombre de la escuela _____ Estado _____ Fechas de asistencia _____

¿En qué idioma prefiere recibir información escrita de la escuela? _____

¿En qué idioma prefiere recibir información oral de la escuela? _____

Preguntas de la encuesta sobre la lengua materna

1. ¿Cuál es el idioma principal que se usa en su casa, independientemente del idioma que hable el/la alumno(a)? _____
2. ¿Cuál es el idioma que habla con más frecuencia el/la alumno(a)? _____
3. ¿Cuál es el idioma que el/la alumno(a) adquirió por primera vez? _____

_____ _____

Firma del padre/madre/tutor Fecha

Additional Required Information

Please answer all of the following questions. Your responses may give us information about your student's knowledge and skills allowing us to better support your child's educational needs. All information collected is needed for district data and funding and is completely unrelated to immigration and citizenship.

Was your child born in the United States? ☐ Yes ☐ No
If yes, in which state? _____
If no, in what other country? _____
2. Has your child attended any school in the United States for *any three years* during their lifetime?
☐ Yes ☐ No
If yes, please provide school name(s), state, and dates attended:
Name of School _____ State _____
Dates Attended _____
Name of School _____ State _____
Dates Attended _____

Right to Translation and Interpretation Services Your response will help the school provide communication in a language you prefer.	In which language do you prefer to receive written information from school? _____ In which language do you prefer to receive spoken information from school? _____

Have parent/guardian sign and date this document ensuring that the answers within are factual.

Parent Name:	
Parent Signature:	
Interpreter Name (if applicable)	

Student Race and Ethnicity Reporting

Student Name: _____ Date Form Completed: _____

Date of Birth: _____ ☐ Male ☐ Female

Person Completing This Form: ☐ Parent/Guardian ☐ Student ☐ Other: _____

The U.S. Department of Education has implemented new standards for school districts to report student race and ethnicity. Your answers to the following will be held strictly confidential and data will be used only in the aggregate.

1. Is your child of Hispanic, Latino, or Spanish ethnicity: ☐ Yes ☐ No
   Includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

If you answered "Yes" to question #1, you may also check one or more of the racial categories in question #2. If you answered "No", please check one or more of the following racial categories.

2. Racial Categories:

   ☐ American Indian or Alaska Native
   Origins in any of the original peoples of North, Central, and South America who maintain a tribal affiliation or community attachment.

   ☐ Asian
   Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam.

   ☐ Black or African American
   Origins in any of the black racial groups of Africa

   ☐ Native Hawaiian or Other Pacific Islander
   Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   ☐ White
   Origins in any of the original peoples of Europe, the Middle East, or North Africa.

IOWA
MIGRATORY
EDUCATION
PROGRAM

Revision Date: September 8, 2023

Parent Form

School District: _____ Date Completed: _____

Your children may be eligible to receive supplemental services, depending on the answers to this form.

General Information

Name of Parent(s) or Guardian(s): _____

Current Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Best time to be contacted: _____

1. Have both parents lived in this town continuously for the past 3 years or longer? ___YES ___NO
   If **YES**, *please stop completing the form. If* **NO**, *please continue.*

2. Please select any of the following jobs that the family has done in the last 3 years:
   ___Slaughter, processing, meat locker (beef, poultry, pork) Tyson, JBS, Monsanto, Smithfield, Seaboard
   ___Feeding, milking, taking care of cows or goats (dairy farms)
   ___Planting or detasseling corn, soybeans, fruits, vegetables, nurseries, or greenhouses
   ___Hog farms, chicken farms, eggs, or turkey farms
   ___Preparing farm fields
   ___Other agricultural work. What was the activity or company? _____

Children's Information

Name of Child	Name of School	Grade

Please return this form to the school.

ATTN: School district migratory liaison, please scan and email completed forms to alex.johnson@iowa.gov before filing the original copy in the student's records. Please contact Rachel Pettigrew, Migratory Education Program Consultant, with any questions regarding this form: rachel.pettigrew@iowa.gov or 515-380-5115.

IOWA
MIGRATORY
EDUCATION
PROGRAM

Revision Date: September 8, 2023

Formulario Para Padres

Distrito Escolar: _____ Fecha: _____

Sus hijos pueden ser elegibles para recibir servicios suplementarios, dependiendo de sus respuestas.

Información General

Nombres de los padres o tutores: _____

Dirección actual: _____ Número de apartamento: _____

Ciudad: _____ Estado: _____ Código postal: _____ Número de teléfono: _____

Mejor horario para ser contactado: _____

1. ¿Ambos padres han vivido en esta ciudad continuamente durante los últimos 3 años? **SÍ** **NO**
   *Si marcó **SÍ**, puede dejar de completer el formulario. Si marcó **NO**, por favor continúe.*

2. Seleccione cualquiera de los siguentes trabajos que la familia ha realizado en los últimos 3 años:
   ___ Matanza o procesamiento de animales/carnes (res, aves, cerdo) Tyson, JBS, Monsanto, Seaboard
   ___ Alimentación, ordeño, cuidado de vacas, cabras (granja lechera)
   ___ Siembra o desespiga maíz, soja, frutas, hortalizas, viveros, invernaderos
   ___ Granjas de cerdos, granjas de pollos, huevos, granjas de pavos
   ___ Preparación de campos de cultivo
   ___ Otra actividad laboral agrícola/Empresa_____

Información Infantil

Nombre del Niño	Nombre de Escuela	Grado

Por favor devuelva este formulario a la escuela.

ATTN: School district migratory liaison, please scan and email completed forms to alex.johnson@iowa.gov before filing the original copy in the student's records. Please contact Rachel Pettigrew, Migratory Education Program Consultant, with any questions regarding this form: rachel.pettigrew@iowa.gov or 515-380-5115.

MILITARY CONNECTED STATUS

Revised 10/24/13

STUDENT NAME:

CHECK ONE

- ◯ Neither Parent or Guardian is serving in any military service
- ◯ A Parent or Guardian is serving in the National Guard but is not deployed
- ◯ A Parent or Guardian is serving in the Reserves but is not deployed
- ◯ A Parent or Guardian is serving in the National Guard and is currently deployed
- ◯ A Parent or Guardian is serving in the Reserves and is currently deployed
- ◯ A Parent or Guardian is serving in the military on active duty but is not deployed
- ◯ A Parent or Guardian is serving in the military on active duty and is currently deployed
- ◯ The student's Parent or Guardian died while on active duty within the last year

COMMENTS: _____

_____

_____

_____

_____

Community Schools and West Central Community Action Head Start
Partnership Application

Documentation that can be used for Preschool Partnership Application Verification

2023 Tax Return

2023 W-2

FIP Documentation (Notice of Decision)

SNAP Benefits (Copy of SNAP Card or Notice of Decision)

Pay stub or pay envelopes (Last 12 months)

Education Grants/Awards (Last 12 months)

Unemployment (from when unemployment begun to present)

Written statements from employers (last 12 months)

Foster care reimbursement or Letter from DHS Social Worker stating child in Foster Care

SSI Documentation (Last 12 months or 2021 year)

Child Support (Last 12 months or 2021 year)

Other_____
_____
_____
_____
_____

2024-2025 Clarinda and West Central Community Action Head Start
Partnership Application

Applicant/Prenatal

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Other Language

Other Language Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Primary Health Coverage | Other Coverage | Insurance # | Medicaid Eligibility | Medicaid # | Doctor/Medical Home

Medicaid Eligibility
☐ Not Eligible
☐ On Medicaid
☐ Potentially

Dental Coverage | Dental Coverage # | Dentist/Dental Home

Document Used to verify date of birth:

Primary Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Other Language

Other Language Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Highest Grade Completed
☐ Associate's
☐ Bachelor's
☐ Col Deg/Train
☐ Col or Adv Train
☐ GED
☐ Grade 10
☐ Grade 11
☐ Grade 12
☐ < Grade 9
☐ HS Graduate
☐ Master's

Employment Status
☐ Full Time
☐ Part Time
☐ Seasonal
☐ Unemployed
☐ Full Time & Training
☐ Part Time & Training
☐ Training or School
☐ Retired or Disabled

Child's Relationship
☐ Biological/Adopted/Step
☐ Grandchild
☐ Other Relative
☐ Foster
☐ Other_____

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

Email Address:

Secondary or Other Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Other Language

Other Language Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Highest Grade Completed
☐ Associate's
☐ Bachelor's
☐ Col Deg/Train
☐ Col or Adv Train
☐ GED
☐ Grade 10
☐ Grade 11
☐ Grade 12
☐ < Grade 9
☐ HS Graduate
☐ Master's

Employment Status
☐ Full Time
☐ Part Time
☐ Seasonal
☐ Unemployed
☐ Full Time & Training
☐ Part Time & Training
☐ Training or School
☐ Retired or Disabled

Child's Relationship
☐ Biological/Adopted/Step
☐ Grandchild
☐ Other Relative
☐ Foster
☐ Other _____

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

Email Address:

2nd Applicant applying for services

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Other Language

Other Language Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Primary Health Coverage | Other Coverage | Insurance # | Medicaid Eligibility | Medicaid # | Doctor/Medical Home

Medicaid Eligibility
☐ Not Eligible
☐ On Medicaid
☐ Potentially

Dental Coverage | Dental Coverage # | Dentist/Dental Home

Document used to verify date of birth:

Additional Child (Non-Applicant) *								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency			
☐ Asian ☐ Black ☐ White ☐ Other: ____________	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient			

Additional Child (Non-Applicant) *								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency			
☐ Asian ☐ Black ☐ White ☐ Other: ____________	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient			

Additional Child (Non-Applicant) *								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency			
☐ Asian ☐ Black ☐ White ☐ Other: ____________	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient			

Family Information, Income & Contacts

Family Information

Family Living Address

Started Living at Date	Living Address	Address Line 2	ZIP	City	State	County

Family Mailing Address

Same as living?	Started Using Date	Mailing Address	Address Line 2	ZIP	City	State
☐ Yes ☐ No						

Phone Number(s)	Type (*check one*)	Note (extension or best time to call)	Opt in for Text Messages
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No

Parental Status (*check one*)	Primary Language at Home	Relationship to Participant(s)	Acquired/learning another language in addition to English	Homeless Family	Active Duty Military	Military Veteran	Referred by Child Welfare Agency	Receiving SNAP	WIC
☐ One ☐ Two			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Family Income

Income Verified by	Verification Date	TANF Status	SSI
		☐ Yes ☐ No ☐ Formerly on TANF/Not now	☐ Yes ☐ No

Family Member	*Amount*	*Per (for example: week, month, year)*	*Annual Amount*	*Description (for example: SSI, Job, Child Support)*	*Verification (for example: W2, check stub)*	*Note*
	$		$			
	$		$			
	$		$			

Income Notes

Eligibility Verification

Child eligible to	Total number in family	Type of eligibility interview	Income Status	Documentation used for verification: Circle all that apply	
☐ Yes ☐ No		☐ In-person ☐ Telephone ☐ Online	☐ Over Income ☐ Public Assistance ☐ Eligible (Below 100%) ☐ Foster child ☐ Homeless 101%-130%	☐ Tax Return ☐ W-2 ☐ FIP Documentation ☐ Pay stub or pay envelopes ☐ Education Grants/Awards Information confirmed by phone	☐ Unemployment ☐ Written statements from employers ☐ Foster care reimbursement ☐ SSI Documentation ☐ Child Support ☐ Housing Questionnaire ☐ Self-Declaration ☐ SNAP Card/Notice of Decision Other_____
Enter Annual Income	Documentation of No Income (Write a detailed statement how the family met basic needs) Use additional paper if needed. Attach the Self-Declaration Form				
	Income received and documentation is not available Write a clear explanation for the reasons documents cannot be provided				

Additional Family Information for Consideration

	Circle One			Circle One	
Moved once in the past year?	YES	NO	Does your child have any special needs we need to be aware of?	YES	NO
Moved 2 or more times in the past year?	YES	NO	Currently is your child on?	IFSP	IEP
Can you provide transportation to and from school for your child(ren)?	YES	NO		YES	NO
Families' primary language?	_____		Has your immediate family experienced any of the following: Circle all that apply	Terminal Illness High Risk Pregnancy (EHS Home based Only) Death of Parent/Guardian/Sibling Abuse (Physical, Emotional, Neglect) Neglect (Physical, Emotional) Mental Illness Divorce Alcohol/Substance Misuse Incarceration	
Are there any custody issues we need to be aware of? Please explain (e.g., Dual/shared custody, no contact order, etc.) Please provide a copy of the court order	_____ _____ _____ _____ _____ _____				

How did you hear about the WCCA Head Start program? Parent Flyer Post Card Newspaper Social Media Agency School

Other: _____

Please note: Your child's application will NOT be processed until all required income documents are received and processed.

Certification: *I certify that the information I provided in person, by telephone or electronically is true and correct to the best of my knowledge. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency.*

Parent/Guardian Signature Date

Staff Signature _____ Date _____

WEST CENTRAL
COMMUNITY ACTION

HEAD START/EARLY HEAD START Child Health & Nutrition Questionnaire (13 months-5 years)

Child's Name: _____ Date of Birth: _____

Center: _____

I give permission for the Health & Nutrition Questionnaire to be reviewed by a licensed dietician for the purpose of providing and sharing nutritional recommendations as applicable for my child with me.

Parent/Guardian Signature: _____ Date: _____

Well Child Questions
Is your child current with well-child exams? Yes No Date of last physical exam: _____
Does your child have a diagnosed medical health condition? Yes No
Diagnosis: _____
Do you have any health concerns regarding your child? _____
Doctor(s) your child sees and reason: _____
Does your child currently wear glasses: Yes No Date of last eye exam: _____
Eye Doctor: _____
Eye Problems: _____
Does your child have an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)? Yes No
Does your child take prescribed medicine? Yes No Name: _____
Will your child be required to take this medicine at school? Yes No How often: _____
Does your child take a multi-vitamin or mineral? Yes No Tablet or Gummy

Does your child brush his or her teeth? Yes No Independently or With Support

How many times a day? None Once Twice Three

Dentist: _____ Date of last dental exam: _____

Concerns? _____Is treatment needed? Yes No

What does your child drink from? Regular Cup Sippy Cup Bottle

Is this bottle/sippy cup taken to bed? Yes No

Does your child have any difficulty with toileting?_____

Does your child use diapers or pull-ups? Yes No

Nutrition Questions

Does your child drink milk? Yes No Type: Whole/Vitamin D 2% 1% Fat-Free

Soy Almond Lactaid Other: _____How much daily?

Does your child have any food allergies? Yes No List:_____

What are your child's favorite foods or beverages? Example: milk, juice, chicken nuggets, soda/pop, veggies/fruit etc.

Are there any new foods you would like to see your child eat more or less of?

Is there anything you would like to see different about your child's eating?

Is there any difficulties in your child eating? Example: allergies, patterns, frequency, refusal etc.

What are mealtimes like? Examples-environment, tone of mealtime, where, with whom, etc?

Home Environment

How many hours is your child on computer, Cellular Phone, IPAD, Tablet or watch TV daily?

Does anyone in the home or vehicle smoke or vape? Yes No

Child's Name_____ Center_____

What type of activities does your child enjoy?

Does your child live currently live in or visit a home built before 1960? Yes No

Is there peeling or chipping paint or remodeling of this home? Yes No

Does your child eat dirt or candy from Mexico? Yes No

Does a sibling or playmate have a high lead level >15 ug/dl? Yes No

Does your child have frequent contact with an adult that works with lead or do you live near a battery manufacturing or recycling plant or lead smelter? Yes No

Do you give your child any home or folk remedies? Yes No

Has your child lived in Mexico, Central or South America, Africa, Asia, Eastern Europe or visited one of these countries for longer than 2 months? Yes No

If yes or you don't know to any of these questions request a blood test at your child's next exam if it has been a year since your child last had a blood lead test. ALL children in Iowa must have at least one blood lead test before entering kindergarten.

WEST CENTRAL
COMMUNITY ACTION

Head Start
Early Head Start

PERMISSION FOR PROGRAM ACTIVITIES SCHOOL PARTNER

Child's Name_____Classroom:_____

Your child's school partners with staff from the West Central Community Action Head Start program to assist in keeping children current with health and developmental screenings. These screenings are provided in the child's classroom at no cost to you.

As the parent/guardian of the above child, I give permission to West Central Community Action Head Start to provide the following services for my child to participate in the activity stated below. I understand that by circling the "Yes" answer, permission is granted for that specific service to be completed. By circling the "No" answer, permission has NOT been granted.

I give permission for my child to have growth (height and weight measurements), blood pressure, vision and hearing screens completed by Head Start staff. Public Health requirements will be followed reporting any otoacoustic emissions (OAE) screens to the state representative.	Yes or No
I give permission for my child to have, speech, developmental, social/emotional, behavior and mental health screens and/or observations as needed by qualified specialists and/or Head Start staff. This may include individual, group or pull out session and share necessary information with each other as needed. (Essex Community School Only)	Yes or No or NA

Valid through_____school year.

Parent Signature:_____Date:_____

ASQ-3™ Ages & Stages Questionnaires®

48 Month Questionnaire

45 months 0 days through 50 months 30 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:
◯ Male ◯ Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:
◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider
◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

Street address: _____

City: _____ State/ Province: _____ ZIP/ Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

_____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____

P101480100

ASQ-3™

48 Month Questionnaire

45 months 0 days through 50 months 30 days

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your child before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your child name at least three items from a common category? For example, if you say to your child, "Tell me some things that you can eat," does your child answer with something like "cookies, eggs, and cereal"? Or if you say, "Tell me the names of some animals," does your child answer with something like "cow, dog, and elephant"?	○	○	○	___
2. Does your child answer the following questions? *(Mark "sometimes" if your child answers only one question.)*	○	○	○	___

"What do you do when you are hungry?" *(Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.")* Please write your child's response:

"What do you do when you are tired?" *(Acceptable answers include "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.")* Please write your child's response:

3. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does she say something like, "It's round. I throw it. It's big"?	○	○	○	___
4. Does your child use endings of words, such as "-s," "-ed," and "-ing"? For example, does your child say things like, "I see two cats," "I am playing," or "I kicked the ball"?	○	○	○	___

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COMMUNICATION *(continued)*

	YES	SOMETIMES	NOT YET	
5. Without your giving help by pointing or repeating, does your child follow three directions that are *unrelated* to one another? Give all three directions before your child starts. For example, you may ask your child, "Clap your hands, walk to the door, and sit down," or "Give me the pen, open the book, and stand up."	○	○	○	___
6. Does your child use all of the words in a sentence (for example, "a," "the," "am," "is," and "are") to make complete sentences, such as "I *am* going to *the* park," or "*Is* there *a* toy to play with?" or "*Are* you coming, too?"	○	○	○	___
			COMMUNICATION TOTAL	___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child catch a large ball with both hands? *(You should stand about 5 feet away and give your child two or three tries before you mark the answer.)* 	○	○	○	___
2. Does your child climb the rungs of a ladder of a playground slide and slide down without help?	○	○	○	___
3. While standing, does your child throw a ball *overhand* in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. *(Dropping the ball or throwing the ball underhand should be scored as "not yet.")* 	○	○	○	___
4. Does your child hop up and down on either the right or left foot at least one time without losing her balance or falling?	○	○	○	___
5. Does your child jump forward a distance of 20 inches from a standing position, starting with his feet together?	○	○	○	___
6. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? *(You may give your child two or three tries before you mark the answer.)* 	○	○	○	___
			GROSS MOTOR TOTAL	___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child put together a five- to seven-piece interlocking puzzle? *(If one is not available, take a full-page picture from a magazine or catalog and cut it into six pieces. Does your child put it back together correctly?)*	○	○	○	___

FINE MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
2. Using child-safe scissors, does your child cut a paper in half on a more or less straight line, making the blades go up and down? *(Carefully watch your child's use of scissors for safety reasons.)* 	○	○	○	___
3. Using the shapes below to look at, does your child copy at least three shapes onto a large piece of paper using a pencil, crayon, or pen, without tracing? *(Your child's drawings should look similar to the design of the shapes below, but they may be different in size.)* 	○	○	○	___
4. Does your child unbutton one or more buttons? *(Your child may use his own clothing or a doll's clothing.)*	○	○	○	___
5. Does your child draw pictures of people that have at least three of the following features: head, eyes, nose, mouth, neck, hair, trunk, arms, hands, legs, or feet?	○	○	○	___
6. Does your child color mostly within the lines in a coloring book or within the lines of a 2-inch circle that you draw? *(Your child should not go more than 1/4 inch outside the lines on most of the picture.)*	○	○	○	___
		FINE MOTOR TOTAL		___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When you say, "Say 'five eight three,'" does your child repeat *just* the three numbers in the same order? *Do not repeat the numbers.* If necessary, try another series of numbers and say, "Say 'six nine two.'" *(Your child must repeat just one series of three numbers to answer "yes" to this question.)*	○	○	○	___
2. When asked, "Which circle is the smallest?" does your child point to the smallest circle? *(Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.)* 	○	○	○	___
3. Without your giving help by pointing, does your child follow three different directions using the words "under," "between," and "middle"? For example, ask your child to put the shoe "*under* the couch." Then ask her to put the ball "*between* the chairs" and the book "in the *middle* of the table."	○	○	○	___
4. When shown objects and asked, "What color is this?" does your child name five different colors, like red, blue, yellow, orange, black, white, or pink? *(Mark "yes" only if your child answers the question correctly using five colors.)*	○	○	○	___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
5. Does your child dress up and "play-act," pretending to be someone or something else? For example, your child may dress up in different clothes and pretend to be a mommy, daddy, brother, or sister, or an imaginary animal or figure.	○	○	○	___
6. If you place five objects in front of your child, can he count them by saying, "one, two, three, four, five," in order? *(Ask this question without providing help by pointing, gesturing, or naming.)*	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child serve herself, taking food from one container to another using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl?	○	○	○	___
2. Does your child tell you at least four of the following? Please mark the items your child knows.	○	○	○	___

- ○ a. First name
- ○ b. Age
- ○ c. City she lives in
- ○ d. Last name
- ○ e. Boy or girl
- ○ f. Telephone number

3. Does your child wash his hands using soap and water and dry off with a towel without help?	○	○	○	___
4. Does your child tell you the names of two or more playmates, not including brothers and sisters? *(Ask this question without providing help by suggesting names of playmates or friends.)*	○	○	○	___
5. Does your child brush her teeth by putting toothpaste on the toothbrush and brushing all of her teeth without help? *(You may still need to check and rebrush your child's teeth.)*	○	○	○	___
6. Does your child dress or undress himself without help (except for snaps, buttons, and zippers)?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain:	○ YES	○ NO

OVERALL *(continued)*

2. Do you think your child talks like other children her age? If no, explain: ○ YES ○ NO

3. Can you understand most of what your child says? If no, explain: ○ YES ○ NO

4. Can other people understand most of what your child says? If no, explain: ○ YES ○ NO

5. Do you think your child walks, runs, and climbs like other children his age? If no, explain: ○ YES ○ NO

6. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

7. Do you have any concerns about your child's vision? If yes, explain: ○ YES ○ NO

OVERALL *(continued)*

8. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

9. Do you have any concerns about your child's behavior? If yes, explain: ○ YES ○ NO

10. Does anything about your child worry you? If yes, explain: ○ YES ○ NO

ASQ-3 48 Month ASQ-3 Information Summary

45 months 0 days through 50 months 30 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	30.72		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	32.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	15.81		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	31.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	26.60		●	●	●	●	●	●	○	○	○	○	○	○	○

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Hears well? Yes **NO** Comments:
2. Talks like other children his age? Yes **NO** Comments:
3. Understand most of what your child says? Yes **NO** Comments:
4. Others understand most of what your child says? Yes **NO** Comments:
5. Walks, runs, and climbs like other children? Yes **NO** Comments:
6. Family history of hearing impairment? **YES** No Comments:
7. Concerns about vision? **YES** No Comments:
8. Any medical problems? **YES** No Comments:
9. Concerns about behavior? **YES** No Comments:
10. Other concerns? **YES** No Comments:

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ☐ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▒ area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

_____ No further action taken at this time

_____ Other (specify): _____

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101480800

48 Month Questionnaire

42 months 0 days through 53 months 30 days

ASQ:SE-2 Ages & Stages Questionnaires® Social-Emotional SECOND EDITION

Date ASQ:SE-2 completed: _____

Child's information

Child's first name: | Child's middle initial: | Child's last name:

Child's date of birth:

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name: | Middle initial: | Last name:

Street address:

City: | State/ province: | ZIP/postal code:

Country: | Home telephone number: | Other telephone number:

E-mail address:

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Other: _____
◯ Grandparent/ other relative ◯ Foster parent ◯ Child care provider

People assisting in questionnaire completion:

Program information

(For program use only.)

Child's ID #: | Age at administration in months and days:

Program ID #:

Program name:

P201480000

48 Month Questionnaire *42 months 0 days through 53 months 30 days*

ASQ:SE-2

Questions about behaviors children may have are listed on the following pages. Please read each question carefully and check the box ☑ that best describes your child's behavior. Also, check the circle ⊘ if the behavior is a concern.

Important Points to Remember:

- ☐ Answer questions based on what you know about your child's behavior.
- ☐ Answer questions based on your child's *usual* behavior, not behavior when your child is sick, very tired, or hungry.
- ☐ Caregivers who know the child well and spend more than 15–20 hours per week with the child should complete ASQ:SE-2.
- ☐ Please return this questionnaire by: _____
- ☐ If you have any questions or concerns about your child or about this questionnaire, contact: _____
- ☐ Thank you and please look forward to filling out another ASQ:SE-2 in _____ months.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
1. Does your child look at you when you talk to him?	☐ z	☐ v	☐ x	◯ v	____
2. Does your child cling to you more than you expect? 	☐ x	☐ v	☐ z	◯ v	____
3. Does your child talk or play with adults she knows well?	☐ z	☐ v	☐ x	◯ v	____
4. When upset, can your child calm down within 15 minutes?	☐ z	☐ v	☐ x	◯ v	____
5. Does your child like to be hugged or cuddled? 	☐ z	☐ v	☐ x	◯ v	____
6. Does your child seem too friendly with strangers?	☐ x	☐ v	☐ z	◯ v	____
7. Does your child settle himself down after exciting activities?	☐ z	☐ v	☐ x	◯ v	____
8. Does your child cry, scream, or have tantrums for long periods of time?	☐ x	☐ v	☐ z	◯ v	____

TOTAL POINTS ON PAGE ____

48 Month Questionnaire

ASQ:SE-2

Check the box ☑ that best describes your child's behavior. Also, check the circle ◎ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
9. Is your child interested in things around her, such as people, toys, and foods? 	☐ z	☐ v	☐ x	◎ v	_____
10. Does your child stay dry during the day?	☐ z	☐ v	☐ x	◎ v	_____
11. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.) _____ _____	☐ x	☐ v	☐ z	◎ v	_____
12. Do you and your child enjoy mealtimes together?	☐ z	☐ v	☐ x	◎ v	_____
13. Does your child do what you ask her to do?	☐ z	☐ v	☐ x	◎ v	_____
14. Does your child seem happy?	☐ z	☐ v	☐ x	◎ v	_____
15. Does your child sleep at least 8 hours in a 24-hour period?	☐ z	☐ v	☐ x	◎ v	_____
16. Does your child seem more active than other children his age?	☐ x	☐ v	☐ z	◎ v	_____
17. Does your child use words to tell you what she wants or needs?	☐ z	☐ v	☐ x	◎ v	_____
18. Does your child stay with activities he enjoys for at least 10 minutes (other than watching shows or videos, or playing with electronics)?	☐ z	☐ v	☐ x	◎ v	_____
19. Does your child use words to describe her feelings and the feelings of others? For example, does she say, "I'm happy," "I don't like that," or "She's sad?"	☐ z	☐ v	☐ x	◎ v	_____

TOTAL POINTS ON PAGE _____

48 Month Questionnaire

ASQ:SE-2

Check the box ☑ that best describes your child's behavior.
Also, check the circle ◎ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
20. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	☐ z	☐ v	☐ x	◯ v	____
21. Does your child explore new places, such as a park or a friend's home?	☐ z	☐ v	☐ x	◯ v	____
22. Does your child do things over and over and get upset when you try to stop him? For example, does he rock, flap his hands, spin, or _____? (Please describe.) _____ _____	☐ x	☐ v	☐ z	◯ v	____
23. Does your child hurt herself on purpose?	☐ x	☐ v	☐ z	◯ v	____
24. Does your child follow rules at home or at child care?	☐ z	☐ v	☐ x	◯ v	____
25. Does your child destroy or damage things on purpose?	☐ x	☐ v	☐ z	◯ v	____
26. Does your child stay away from dangerous things, such as fire and moving cars?	☐ z	☐ v	☐ x	◯ v	____
27. Can your child name a friend?	☐ z	☐ v	☐ x	◯ v	____
28. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt? 	☐ z	☐ v	☐ x	◯ v	____
29. Do *other* children like to play with your child?	☐ z	☐ v	☐ x	◯ v	____

TOTAL POINTS ON PAGE ____

48 Month Questionnaire

ASQ:SE-2

Check the box ☑ that best describes your child's behavior.
Also, check the circle ◎ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
30. Does *your child* like to play with other children? 	☐ z	☐ v	☐ x	◯ v	____
31. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	☐ x	☐ v	☐ z	◯ v	____
32. Does your child show an unusual interest in or knowledge of sexual language and activity?	☐ x	☐ v	☐ z	◯ v	____
33. Does your child wake three or more times during the night?	☐ x	☐ v	☐ z	◯ v	____
34. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____	☐ x	☐ v	☐ z	◯ v	____
35. Does your child have simple back-and-forth conversations with you? For example, Parent: "It's raining!" Child: "And cold outside." Parent: "Let's get your coat." Child: "I got it!"	☐ z	☐ v	☐ x	◯ v	____
36. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: _____ _____ _____	☐ x	☐ v	☐ z	◯ v	____

TOTAL POINTS ON PAGE ____

OVERALL Use the space below for additional comments.

37. Do you have concerns about your child's eating, sleeping, or toileting habits? If yes, please explain: ◯ YES ◯ NO

38. Does anything about your child worry you? If yes, please explain: ◯ YES ◯ NO

39. What do you enjoy about your child?

48 Month Information Summary *42 months 0 days through 53 months 30 days*

ASQ:SE-2

Child's name: _____ Date ASQ:SE-2 completed: _____

Child's ID #: _____ Child's date of birth: _____

Person who completed ASQ:SE-2: _____ Child's age in months and days: _____

Administering program/provider: _____ Child's gender: ◯ Male ◯ Female

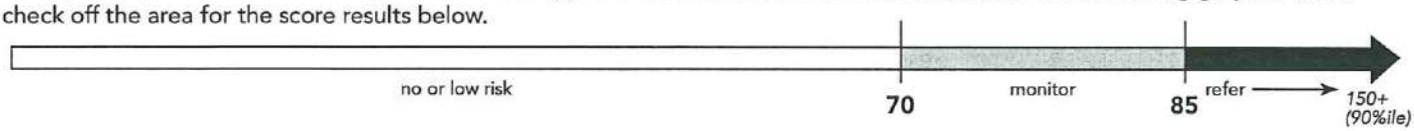
1. ASQ:SE-2 SCORING CHART:

- Score items (*Z* = 0, *V* = 5, *X* = 10, *Concern* = 5).
- Transfer the page totals and add them for the total score.
- Record the child's total score next to the cutoff.

TOTAL POINTS ON PAGE 1	
TOTAL POINTS ON PAGE 2	
TOTAL POINTS ON PAGE 3	
TOTAL POINTS ON PAGE 4	
Total score	

Cutoff	Total score
85	

2. ASQ:SE-2 SCORE INTERPRETATION: Review the approximate location of the child's total score on the scoring graphic. Then, check off the area for the score results below.



____ The child's total score is in the ☐ area. It is below the cutoff. Social-emotional development appears to be on schedule.

____ The child's total score is in the ▭ area. It is close to the cutoff. Review behaviors of concern and monitor.

____ The child's total score is in the ■ area. It is above the cutoff. Further assessment with a professional may be needed.

3. OVERALL RESPONSES AND CONCERNS: Record responses and transfer parent/caregiver comments. YES responses require follow-up.

1–36. Any Concerns marked on scored items? **YES** no Comments:

37. Eating/sleeping/toileting concerns? **YES** no Comments:

38. Other worries? **YES** no Comments:

4. FOLLOW-UP REFERRAL CONSIDERATIONS: Mark all as Yes, No, or Unsure (Y, N, U). See pages 98–103 in the *ASQ:SE-2 User's Guide*.

____ **Setting/time factors** (e.g., Is the child's behavior the same at home as at school?)

____ **Developmental factors** (e.g., Is the child's behavior related to a developmental stage or delay?)

____ **Health factors** (e.g., Is the child's behavior related to health or biological factors?)

____ **Family/cultural factors** (e.g., Is the child's behavior acceptable given the child's cultural or family context? Have there been any stressful events in the child's life recently?)

____ **Parent concerns** (e.g., Did the parent/caregiver express any concerns about the child's behavior?)

5. FOLLOW-UP ACTION: Check all that apply.

____ Provide activities and rescreen in ____ months.

____ Share results with primary health care provider.

____ Provide parent education materials.

____ Provide information about available parenting classes or support groups.

____ Have another caregiver complete ASQ:SE-2. List caregiver here (e.g., grandparent, teacher): _____

____ Administer developmental screening (e.g., ASQ-3).

____ Refer to early intervention/early childhood special education.

____ Refer for social-emotional, behavioral, or mental health evaluation.

____ Other: _____

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