



**The Center**  
 Early Childhood Programs  
 Lake County School District R-1

315 West 6<sup>th</sup> Street  
 Leadville, CO 80461

Phone 719 486-6928  
 Fax 719 486-9992

*Head Start, Colorado Preschool Program, Tuition-Based Preschool, and Services for Children with Special Needs*

Dear Parent,

Thank you for your interest in The Center Early Childhood Programs. Our program offers a school readiness preschool program and extended day high quality child care.

**The following items must be included with your application in order for it to be processed.**

- Child's Birth Certificate
- Child's Immunization Record - Must be up-to-date on immunizations
- Health Insurance Card - Private Insurance, Medicaid, or CHP+  
 If no health insurance - Please pick up an application from Lisa or Jenny in the Family Resource Office
- CACFP Child and Adult Food Care Program) Eligibility form
- If you wish to be considered for a Head Start preschool spot, you must include one of the following as evidence of eligibility:
  - \* 1040 Tax Form from 2018 or W-2 forms from 2018 or
  - \* Check stubs representing one year of income
  - \* Statement from Employer for one year of income or
  - \* Documentation of foster care status.

**If you do not have one of these forms of income on file, your child will not be considered for Head Start enrollment, only for the other preschool programs.** Please do not leave originals of these items - we will be happy to make copies if needed.

Once you have completed and signed this application, please bring it and the required supporting documents to The Center. We will evaluate your requests and let you know which programs you qualify for, which programs have openings, and work to create a schedule that will fit your family's needs. ***Please note: This application is printed on the front and back of the page.***

Completion of this application does not guarantee your child a place in the program.

If you have any questions at all, or if you would like assistance completing this application, please call Lisa at 719-486-6928 or Jenny at 719-486-6925 for Spanish.

<b>Date and Time Received by Office:</b>	<b>Person receiving application:</b>	<b>Developmental Screening appointment</b>

**Child's Name** \_\_\_\_\_ **Date of Application** \_\_\_\_\_

Our preschool program emphasizes school readiness, and includes family-style breakfast and lunch, group activities, formal lessons, child-directed activities, outdoor time, and lots of fun.

Some families may qualify for the preschool program free of charge or on a low-cost basis, based on the information you provide in this application packet.

In addition, we are open for child care before preschool at 7:30am and after preschool until 5:30pm. During those extra hours, we provide high-quality child care on a tuition basis.

*Please provide the most accurate scheduling information possible to help us provide you with appropriate services.*

**1) Which daily schedule are you interested in (if available)?**

**Circle One -          Preschool Only          Extended Day**

**If you need an extended day, please list the days and times you would like your child to attend.**

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**2) How many days per week are you interested in having your child attend?**

**Circle One -          4 days          5 days**

THANK YOU. We will evaluate your requests and your completed application. We will then let you know which programs you are eligible for that will also meet your needs.

**Program Descriptions**

**All children receive the same quality preschool experience in all programs at The Center.**

Based on your needs, we will evaluate your child for some or all of the programs below:

**Head Start** - This federally funded program provides a regular daily preschool schedule at no cost, according to the program's calendar. Head Start is a program for low income families, and your **child must be 3 or 4 by October 1, 2018**. Selection is based on age, income, and family size, as well as child and family needs. **TRANSPORTATION MAY BE PROVIDED TO THOSE WITHIN BUSSING AREA.**

**Full Day Head Start** - For families who qualify for Head Start. 40 hours a week of preschool at no cost for families who are in school or job training, or work full time. To be enrolled in Full Day Head Start, there must be no parent at home available to care for the child. **TRANSPORTATION MAY BE PROVIDED TO THOSE WITHIN BUSSING AREA.**

**Colorado Preschool Program** - This program is state funded and provides 10 hours of a regular preschool schedule at no cost. A special tuition rates may be available to extend your child's preschool day. CPP can be combined with Head Start, special education funding or tuition-based preschool for a longer day. **Children must be 3 or 4 by October 1, 2018**. There are no income requirements for this program. Selection is based on age and educational risk factors. **NO TRANSPORTATION PROVIDED.**

**Tuition-Based Preschool** - For a pre-paid monthly tuition fee, **children who are at least 3 years old by October 1, 2018**, can attend a regular daily preschool schedule and/or extend their hours to meet their family's needs for child care. A scale is available with reduced rates for families who qualify for the Free or Reduced Lunch Program. Tuition-Based Preschool can be combined with Head Start, special education services, or the Colorado Preschool Program. **NO TRANSPORTATION PROVIDED.**

**Services for Children with Special Needs** – Lake County School District is the local service provider for children with diagnosed disabilities. Hours and services are determined by the Special Education staff and the child's family. If you have concerns about your child's development, please ask for information about Child Find.



**The Center Early Childhood Programs  
Lake County Schools  
2019-2020 Application Form**



Revised 2/19/2019

*Please read the questions carefully and provide the most accurate information possible.*

**OFFICE USE ONLY**  
Enrollment Date \_\_\_\_\_ Entry Date \_\_\_\_\_

**Child Information**

Last Name	First Name	Middle Name	Nickname
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Date of Birth	Birthplace	<input type="checkbox"/> Male	
		<input type="checkbox"/> Female	

Lives with (check all that apply): <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Both <input type="checkbox"/> Mom's Partner <input type="checkbox"/> Dad's Partner <input type="checkbox"/> Grandparents <input type="checkbox"/> Foster Parents <input type="checkbox"/> Other _____	If a parent does not live in the child's home, do we have permission to contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Is there a court order affecting your child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, you must provide a copy Details of order-
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**Language / Race / Ethnicity Questionnaire**

Primary Language spoken at home :	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Both <input type="checkbox"/> Other : _____
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Primary Language for letters sent home :	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Both <input type="checkbox"/> Other : _____
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Ethnicity : Please mark one.	<input type="checkbox"/> Hispanic or Latino origin <input type="checkbox"/> Non-Hispanic or Latino origin
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Race : Please mark one or more.	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Pacific Islander or Native Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Other : _____
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**Mother / Guardian Information**

Name	Mailing Address
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Date of Birth	Physical Address	Preferred Daytime Contact Home / Cell / Text / Email
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Preferred Language on Phone? English / Spanish	Home Phone:	Cell Number / Text Y - N	Email Address
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Employer	Employer Address	Work Phone
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Does Mother live with child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Mother have legal custody? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Mother's Employment Information : <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Homemaker <input type="checkbox"/> In job training or school <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Actively Deployed Military
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Mother's Education Information : <input type="checkbox"/> Less than High School Diploma <input type="checkbox"/> High School Diploma or GED <input type="checkbox"/> Some college, vocational, AA/AS degree <input type="checkbox"/> Bachelor or Advanced College degree
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Mother's Educational Goals : <input type="checkbox"/> GED classes <input type="checkbox"/> English classes <input type="checkbox"/> college classes <input type="checkbox"/> parenting classes <input type="checkbox"/> Other
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Was mother under 18 at time of this child's birth? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Was mother unmarried at the time of this child's birth? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Parent/Guardian Signatures**

Mother/Guardian Signature	Date	Father/Guardian Signature	Date
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<b>Father / Guardian Information</b>
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Name		Mailing Address	
Date of Birth	Physical Address		Preferred Daytime Contact Home / Cell / Text / Email
Preferred Language on Phone? English / Spanish	Home Phone	Cell or text message	Email Address
Employer	Employer Address	Work Phone	

Does Father live with child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Father have legal custody? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Father's Employment Information : <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Homemaker <input type="checkbox"/> In job training or school <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Actively Deployed Military
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Father's Education Information : <input type="checkbox"/> Less than High School Diploma <input type="checkbox"/> High School Diploma or GED <input type="checkbox"/> Some college, vocational, AA/AS degree <input type="checkbox"/> Bachelor or Advanced College degree
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Father's Educational Goals : <input type="checkbox"/> GED classes <input type="checkbox"/> English classes <input type="checkbox"/> college classes <input type="checkbox"/> parenting classes <input type="checkbox"/> Other
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Was father under 18 at time of this child's birth? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was father unmarried at the time of this child's birth? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Other Adult Caregiver in Home:</b> <input type="checkbox"/> <b>Guardian</b> <input type="checkbox"/> <b>Step Parent</b> or <input type="checkbox"/> <b>Live-in Partner Information</b> (check one)
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<b>Is this person related to the applicant child by blood or through a marriage or adoption?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name		Date of Birth	
Preferred daytime contact	Home Phone	Cell or Message	Email Address
Employer	Address	Work Phone	

Caregiver's Employment Information : <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Homemaker <input type="checkbox"/> In job training or school <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Actively Deployed Military
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<b>List all other family members not listed above who live in your household and for whom you are responsible for the care and welfare.</b>
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Name	Relationship to child	Date of Birth	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

<b>Total number of people living in the household (including you) for whom you provide financial support.</b>	
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The Center respects and protects your family's privacy. The information you provide in this enrollment packet will be used to determine you eligibility for programs and services and will not be shared without your permission.

I understand this is an application for services that may be paid for with government funds and that intentionally providing misleading, inaccurate, or untruthful information may result in my child being terminated from the program.

**\* I understand this is an application only and does not guarantee enrollment in the program \***

<b>Parent/Guardian Signatures</b>			
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Mother/Guardian Signature	Date	Father/Guardian Signature	Date
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**Special Considerations** (Check all that apply to your household and add any extra information you would like to provide.)

<input type="checkbox"/> Developmental concerns	<input type="checkbox"/> Speech / language concerns
<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Family member incarcerated
<input type="checkbox"/> Family violence / abuse	<input type="checkbox"/> Family in crisis
<input type="checkbox"/> Child in out of home placement	<input type="checkbox"/> Previously in Head Start
<input type="checkbox"/> Referral from agency Name of agency: _____	<input type="checkbox"/> Other- (Please describe):

**Child Residency Questionnaire**

This questionnaire is intended to address the McKinney-Vento Homeless Education Assistance Improvements Act 42 USC 11435. The answers to this residency information help determine the services the child may be eligible to receive.

- How many times has your family / child moved in the last 3 years? \_\_\_\_\_
- Is your current address a temporary living arrangement?  Yes  No
- Is this temporary living arrangement due to loss of housing or economic hardship?  Yes  No

**If you answered YES to the above questions, please complete the remainder of this section.  
If you answered NO, you may skip to the next section.**

Where is the child presently living?  (Check one box)	<input type="checkbox"/> In a motel or hotel	<input type="checkbox"/> In an emergency or transitional shelter
	<input type="checkbox"/> Awaiting foster care placement	<input type="checkbox"/> With more than one family in a house or apartment
	<input type="checkbox"/> Abandoned in a hospital	<input type="checkbox"/> Moving from place to place
	<input type="checkbox"/> In a place not designed for ordinary sleeping accommodations, such as a car, park, abandoned building, or campsite	

**Mandated Child Abuse and Neglect Reporting**

This is to inform you that all employees of The Center Early Childhood Programs are required by State Law to report all instances of suspected child abuse/neglect to the Lake County Department of Human Services. This agency will visit The Center to evaluate the circumstances, and if abuse or neglect is determined, and if the child is felt to be in danger of further abuse or neglect, the Department of Human Services will call the legal authorities and request that they take the child into protective custody, and they will notify you of the steps you must take.

Parent's Initials \_\_\_\_\_

**Payment for Child Care Services**

The Center's tuition-based child care services must be pre-paid. The Head Start Program is federally funded, and Colorado Preschool Program is funded by the state. These programs do not charge for their services provided for enrolled children. I agree to pay all fees incurred by the attendance of my children which are not covered by the funding of these or other programs, before or after their hours of operation.

Parent's Initials \_\_\_\_\_

**Parent/Guardian Signatures**

**\* I understand this is an application only and does not guarantee enrollment in the program \***

Mother/Guardian Signature	Date	Father/Guardian Signature	Date
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Child's Name

Enrollment Form

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**Primary Emergency Contact and Authorized Pick Up Person – In case of illness or emergency, if we cannot reach parents or guardians, who is the next person we should try to contact?**

Name		Relationship to child	
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Phone	Address	Note-	
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**People Permitted to Pick Up Child or be contacted in case of emergency**

(Do not list parents/guardians. All persons listed here must be over 18)

**2018-2019**

Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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**Parent/Guardian Signatures**

Mother/Guardian Signature	Date	Father/Guardian Signature	Date
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**Health Screening Consent** **2018-2019**

I understand the following health screenings and examinations are required for my child's enrollment and participation in early childhood programs at The Center. I give my consent for my child named above to receive some or all of the following screenings, observations, and/or evaluations, and follow-up. This consent is valid for the program year immediately following the date it is signed. I understand that a parent or guardian must be present for Head Start dental and physical examinations. The results of these screenings and evaluations will be made available to me. I authorize release of information pertinent to any of these screenings, observations and evaluations to service providers deemed necessary by the Head Start, CPP, or Tuition based programs.

<p><b>Health requirements for parents to complete:</b> <i>Required forms will be provided. Assistance in making appointments is available upon request.</i></p>	Physical exam
	Dental examination - <i>required for Head Start only</i>
	Blood Lead Screening
	Immunizations
	Ages & Stages social/emotional screening – <i>(paperwork will be provided by school)</i>
<p><b>Health screenings to be completed at school by staff:</b></p>	Developmental screening
	Hearing screening
	Vision screening
	Heights & weights

**Parent's Initials** \_\_\_\_\_

**Medical Treatment Authorization**

I authorize staff members of The Center Early Childhood Programs to arrange for medical or surgical care for my child named above, and give consent for care and/or treatment in the event of an emergency. Staff members may use their judgment in deciding what an emergency is, and may request the services of our doctor named on the Health Information form or another if he/she is unavailable, and call the hospital, and/or an ambulance. I understand that an attempt will be made to reach me and/or the emergency contacts provided to The Center, but contact is not necessary for the above consent to be in effect. A copy of this form will be presented as medical treatment authorization, and will be considered valid as the original. This consent will be in effect until withdrawn in writing by the person(s) signing. I accept responsibility for related expenses incurred, which are not the responsibility of The Center Early Childhood Programs or its employees.

**Parent's Initials** \_\_\_\_\_

**Information Release**

I give permission for The Center Early Childhood Programs to exchange information with the following community partners for the purpose of providing the best services for my child and family. This authorization will continue in force until revoked by me in writing, and a copy or fax shall serve in its stead. This includes permission to copy, release, or discuss information with the purpose of facilitating interagency communication in providing services to myself and my family.

**Parent's Initials** \_\_\_\_\_

• Lake County School District	• Family Literacy Program
• Lake County Department of Human Services	• Disabilities Services Provider and Coordinator
• Lake County Public Health Agency	• WIC Nutrition Program
• My child's medical and dental care providers	• SolVista Health

**Photo and Video Release**

Yes  No I authorize The Center Early Childhood Programs to photograph or permit photographs to be taken and for the filming of video of my child named above. The photos or videos may be posted in The Center, published in the newsletter, on The Center's website or social media pages, news media, or used in promotional materials for these programs.

**Transportation Permission**

Yes  No I give permission for my child named above, to be transported to The Center Early Childhood Programs and to be transported home or to an alternate location named by me. If necessary, this includes health or dental visits. I give permission for my child named above to walk or be transported to activities, programs, or field trips as part of participation in The Center Early Childhood Programs.

**Parent/Guardian Signature**

Mother/Guardian Signature	Date	Father/Guardian Signature	Date
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Child's Name _____	Date of Birth _____	Enrollment Form Page 6
<b>Medical and Dental Information</b>		<b>2018-2019</b>
<b>Health Provider and Coverage Information</b>		
Do you have a primary health care provider who provides your child's regular health care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Provider's Name _____ Address _____ Phone _____		
Do you have medical coverage or insurance? <input type="checkbox"/> Yes (please bring the card to make a copy) <input type="checkbox"/> No		
If "Yes" what type <input type="checkbox"/> Medicaid ID# _____		
<input type="checkbox"/> CHP+ ID# _____		
<input type="checkbox"/> Private insurance Company Name & Policy # _____		
Does your insurance include dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "No", please request an application for Medicaid and CHP+. Assistance is available in completing this form.		
Has your child been seen by a dentist before? <input type="checkbox"/> Yes <input type="checkbox"/> No		
When was your child's last dental appointment? _____		
Please list the preferred dentist for your child's dental care:		
Dentist Name _____ Address _____ Phone _____		
<b>Please note : in case of an emergency, children will be transported to St. Vincent General Hospital, 822 West 4<sup>th</sup> Street Leadville, CO 80461 719-486-0230</b>		
<b>Medical History and Special Concerns</b>		
Is your child seeing a medical specialist for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain : _____		
Specialist's Name _____ Address _____ Phone _____		
Has your child had a serious injury, accident, been hospitalized or had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain : _____		
Is your child being treated for a medical, disabling or mental health condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain : _____		
Is your child currently taking any medication or does he/she require any medical procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, what type? _____		
Will this medicine or medical procedure be given at school? <input type="checkbox"/> Yes <input type="checkbox"/> No (Note: Doctor's written authorization is needed before any medication/or procedure can be given at school.)		
Are there health problems or conditions that will limit activities or affect your child at school? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please explain : _____		
<b>Immunizations</b>		
Is your child up to date on their immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No		
(Note: Either a copy of your child's immunization records or a signed Statement of Exemption must be on file before your child's first day of school.)		
(Note : Colorado State policies require all children to be up to date on immunizations within 14 days of starting school)		
<b>Disability</b>		
Does your child have a diagnosed disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, what is the disability? _____		
Is your child on an Individual Education Plan (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, what is the IEP for? _____		
Do you have other concerns about other children in your family who may have delays and or disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Would you like The Center to refer you to the Child Find early intervention program to help with your concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Parent's Initials</b>		



Child's Name

Date of Birth

Enrollment Form

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**Child's Medical Background and Health Concerns****2018-2019****Does your child now suffer from or have they suffered in the past from: (Please check all that apply.)**

<input type="checkbox"/> Asthma Will your child require an inhaler or nebulizer at school? <input type="checkbox"/> Yes <input type="checkbox"/> No What are the asthma triggers?	<input type="checkbox"/> Visual Problems (Difficulty seeing, headaches, wears glasses)	<input type="checkbox"/> Hearing Problems (Hearing aids, difficulty hearing, frequent earaches, tubes in ears)
<input type="checkbox"/> Skin Problems (Eczema, Hives, etc.)	<input type="checkbox"/> Bone, Joint or Muscle Injury Or Bone Disease	<input type="checkbox"/> Speech Problems (Hard to understand, Talked late)
<input type="checkbox"/> Pneumonia/RSV	<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Anemia or Sickle Cell Anemia	<input type="checkbox"/> Gastro Esophageal Reflux (GER)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Frequent fevers	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Orthopedic Problems	<input type="checkbox"/> Lead Poisoning	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Frequent stomach aches, indigestion, or vomiting	<input type="checkbox"/> Constipation, diarrhea, frequent or painful urination	<input type="checkbox"/> Fainting Spells
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Trouble chewing or swallowing	<input type="checkbox"/> Second hand smoke
<input type="checkbox"/> Wears diapers or pull ups	<input type="checkbox"/> Other:	
Has this child ever passed out during extreme physical exertion?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone in the family suffered a sudden, unexplained death before the age of 50?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain any concerns listed above:

**Allergies**

Medication Allergies	<input type="checkbox"/> Penicillin <input type="checkbox"/> Cephalosporins <input type="checkbox"/> Other
Describe reactions and specify allergies if "other".	
Food Allergies	<input type="checkbox"/> Eggs <input type="checkbox"/> Fish <input type="checkbox"/> Milk/Milk Products <input type="checkbox"/> Nuts <input type="checkbox"/> Seeds <input type="checkbox"/> Gluten <input type="checkbox"/> Soy <input type="checkbox"/> Shellfish <input type="checkbox"/> Other
Describe reactions and specify allergies if "other".	
Environmental Allergies	<input type="checkbox"/> Bee stings <input type="checkbox"/> Insect bites <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Animals / Animal fur <input type="checkbox"/> Dust <input type="checkbox"/> Latex <input type="checkbox"/> Other
Describe reactions and specify allergies if "other".	
Does your child require any medication, such as an Epi Pen, to manage his/her allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No (Note: Doctor's written authorization is needed before any medication/or procedure can be given at school.)	
<b>Special Diets</b>	
Is your child on a special diet? (Diabetic, vegetarian, medical, religious, personal)	<input type="checkbox"/> Yes <input type="checkbox"/> No (Note: A special diet statement signed by a medical authority, including their recommendations, is required to substitute any food served at The Center.)

Parent's Initials \_\_\_\_\_

Date Completed \_\_\_\_\_

**Child Development**

**2018-2019**

Does Your Child:	Mark one	Please Explain :
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**Toileting**

Consistently use the bathroom on their own?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Need help going to the bathroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ever have potty accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Self-Care**

Wash and dry hands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dress self with little help?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Know first and last name?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Self Esteem and Emotions**

Show aggression/inability to get along with others?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have sudden mood changes or unexplained moodiness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Act shy / withdrawn / fearful?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Separate from parents easily?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have experience playing with other children?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have any family changes or problems, which may affect him/her?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Sleep Habits**

Have any trouble sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have discipline problems at bedtime?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Take a nap?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
When is your child's bedtime?		How many hours per night does your child sleep?

**Development**

Did your child do any of these things later than expected; causing concerns about his/her development? <input type="checkbox"/> Sit up <input type="checkbox"/> Walk <input type="checkbox"/> Talk <input type="checkbox"/> Respond to directions
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**Child's Interests**

What is your child good at?
What does your child like to do when he/she plays?

**Does your child....?**

Show an interest in using new words?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Every once in a while <input type="checkbox"/> Never
Show an interest in books?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Every once in a while <input type="checkbox"/> Never
Listen and follow directions?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Every once in a while <input type="checkbox"/> Never
Show interest in counting, sorting, and numbers?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Every once in a while <input type="checkbox"/> Never
Get along / problem solve with other children?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Every once in a while <input type="checkbox"/> Never
Show interest in cutting, coloring, drawing, and writing?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Every once in a while <input type="checkbox"/> Never
Complete tasks that he/she starts?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Every once in a while <input type="checkbox"/> Never
Show an interest in nutritious foods and trying new foods?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Every once in a while <input type="checkbox"/> Never
Form attachments to new adults?	<input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Every once in a while <input type="checkbox"/> Never

**Parents Initials** \_\_\_\_\_

**Date Completed** \_\_\_\_\_

