Pre-K Registration Form
2014-2015

CHECK LIST

- ☐ Registration Form ____
- ☐ Verifiable proof of income (MUST be turned in for each caregiver with application to verify eligibility):
  Such as:
  Primary Caregiver
  - ☐ Check Stub (Please provide the last 30 days of income)
  - ☐ Copy of W2 Form
  - ☐ Copy of 1040 or Income tax Form (this is the best form of documentation for proof of income.)
  - ☐ Letter from EMPLOYER stating income and how often paid
  - ☐ Notarized statement stating no earned income

  Secondary Caregiver
  - ☐ Check Stub (Please provide the last 30 days of income)
  - ☐ Copy of W2 Form
  - ☐ Copy of 1040 or Income tax Form (this is the best form of documentation for proof of income.)
  - ☐ Letter from EMPLOYER stating income and how often paid
  - ☐ Notarized statement stating no earned income
- ☐ Copy of Birth Certificate ____
- ☐ Copy of social Security Card____
- ☐ Copy of Shot Record (Must be current)_________________________________
  This includes any shots due after 4th Birthday but before entering school.
- ☐ Well Child Screening Form/Health History _______________________________
- ☐ Physical Form (for Doctor's use)____
  This form should be completed by a doctor. Wellness checks must include a functional hearing and vision screening. This form must be turned in before the first day of school.
- ☐ Health Information & Medication Sheet/Nurses Form ______________________
- ☐ Childcare Food Program enrollment form__________________________________

If Applicable:

- ☐ AR Kids I.D. card for child who is to be enrolled
- ☐ Legal guardianship paper (for foster parents and/or grandparents)

Thank you for your interest in our ABC Pre-K Program. We are excited about what we do and can't wait to get to know you and your child. Once you have completed the information please turn it into our elementary office. We will let you know sometime around the end of June beginning of July if you have been accepted or not.

Thank you,

Lincoln ABC Pre-K

- **Child Application/Registration Form**

  Please fill out include all the requested information on this form.

- **Income**

  Please include all verifiable income with the application. **Applications turned in without verifiable income will not be considered until we receive the income.** If this is a two parent household each parent or caregiver will need to provide proof of income.

  Acceptable Verifiable Income:

  Check Stubs---Check stubs must be 30 days of income from date of application. (ex: if you are paid weekly we will need four check stubs, bi-weekly or every two weeks two check stubs, monthly one check stub) Please indicate on the check stub how often paid.

  Copy of 1040 or Income tax for 2013---This is the best form of verifiable income. If two parent household and you did not file jointly, income will need to be proven for each parent.

  Copy of W-2---A copy of W-2 must be for 2013.

  Letter from Employer---A form available from our program for your employer if this is how you choose to verify your income. It will have to be notarized.

  Notarized Statement---A form is available from our program for you to have notarized.

- **Copy of Birth Certificate**

  If you do not have a copy and have requested one please provide proof of the request. If you need to request one let us know we have the form. You may also obtain a request form online from the Arkansas Department of Health at www.healthy.arkansas.gov/

- **Copy of Social Security Card**
  If you do not have a copy and have requested one please provide proof of the request. If you need to request a social security card we have the form, you can obtain one online at www.ssa.gov/online/ss-5fs.html or you can go to the Social Security Office at 2153 E. Joyce Blvd., Fayetteville.

- **Well Child Screening Form/Health History Form**
  This form needs to be completed by the caregiver(s).

- **Physical**
  This form must be completed by the doctor. A form is provided but the doctor may use their own form.

- **Health Information and Medication Sheet/Nurses Form**
  This form is for our school nurse, our playground and when we leave the school with your child on a field trip. Please fill out all the requested information and let us know if anything changes. **If your child has asthma, drug allergy, insect allergy, food allergy or chronic illness a doctors note and action plan will need to be provided before the first day of school.**

- **Childcare Food Program Form**
  This form is for our cafeteria. If your child has any food allergies a doctors note and action plan will need to be provided before the first day of school.

- **AR Kids I.D. card** for child who is to be enrolled

- **Legal guardianship paper**
  If you are the foster parent or legal guardian of the child enrolling it is *very* important we have these legal documents.

ARKANSAS BETTER CHANCE FOR SCHOOL SUCCESS
CHILD APPLICATION

PRIMARY CAREGIVER INFORMATION
(Parent or guardian with most contact with child)

*Name(First/Middle/Last):				*Date of Birth:
*Physical Address:			*Mailing Address:	
*City		*State		*Zip
*Home Phone	*Cell Phone		*Work Phone	
Employer Name:		Employment City, State, Zip Code:		
*# of hrs per week:	*How often paid:	*Employment Status (FT, PT):		Email Address:
*Race:	*Ethnicity:	*Primary Language:		*Gender
If attending school, where:		# of semester hours:	Education Level (HS, College, etc.):	
Annual Income From Work Sources or Unemployment:				

SECONDARY CAREGIVER INFORMATION
(2nd Parent or guardian in household with child and is used for determining eligibility)

*Name(First/Middle/Last):				*Date of Birth:
*Current address: ☐ same as Primary Caregiver			*Mailing Address:	
*City		*State		*Zip
*Home Phone	*Cell Phone		*Work Phone	
Employer Name:		Employment City, State, Zip Code:		
*# of hrs per week:	*How often paid:	*Employment Status (FT, PT):		Email Address:
*Race:	*Ethnicity:	*Primary Language:		*Gender
If attending school, where:		# of semester hours:	Education Level (HS, College, etc.):	
Annual Income From Work Sources or Unemployment:				

Household Information

*Number in Family (The number of immediate family members living in house. (Parent, Guardian, Siblings):	
*Number in Household (The total number of people living in the house):	
List the name and relationship to the child enrolled of all family members in the household:	
Name:	Relationship:

*Must be entered in COPA

Child Information

*Name(First/Middle/Last):				
*Date of Birth:		Social Security Number:		
*Gender	*Ethnicity:		*Primary Language:	
Has this child attended a state-funded pre-K (ABC) program before?		☐ Yes ☐ No	If so, where?	
Will this child be concurrently enrolled in a n ABC center and Hippy or PAT program?	☐ Yes ☐ No	If so, which HIPPY or PAT?		
List any allergies:				
Does the child have any special dietary needs?				
Receiving any special education services?				
Primary Language:				

Emergency Contact and Consent Information

Name of emergency contact if parent/guardian cannot be reached:		
Address:		Phone:
City:	State:	Zip Code:
Relationship:		
Physicians Name:		
Address:		Phone:
City:	State:	Zip Code:

Consent for Emergency Medical Care

I ______________________________________ ____________________ of____________________________________

Parent/Guardian's name Relationship Child's Name

Do hereby request and give consent to the Director/Caregiver of the Child Care Facility, or their duly appointed representative, for said child to receive such medical or surgical aid as may be deemed necessarily expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parent(s) cannot be reached. Consent is also given for the Director/Caregiver or their duly appointed representative to transport said child for emergency medical treatment, if parent(s) cannot be reached. I additionally give consent for my child to attend the above named field trip.

______________________________________ ______________________________

Parent/Guardian signature Date

Signature

I declare under the penalty of perjury and the rules and regulations of the Arkansas Better Chance program that the information supplied is true and correct at the time of application. I understand that the information I supplied may be independently verified by the Arkansas Division of Child Care and Early Childhood Education and that any false statements may result in exclusion from DHS programs and criminal prosecution.

Signature of Primary Caregiver:	Date:

*Must be entered in COPA.

Arkansas Department of Human Services
Division of Child Care and Early Childhood Education

ARKANSAS BETTER CHANCE PROGRAM
WELL CHILD SCREENING (EPSDT) FORM

To Parent or Guardian:
In order to provide the best learning experience for your child, teacher must understand your child's health needs. State regulations require any child enrolled in the Arkansas Better Chance Pre-K program to have a well child check-up. In addition, the child must be current on all required immunizations. Please complete this page of the form, sign it and give it to your child's physician or licensed nurse practitioner. Once form is completed and signed on both sides, return the form to your Pre-K program.

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

Address, City and Zip Code

Name of Pre-K Program Where Enrolled	Pre-K Program Phone Number

Type of Health Insurance	
☐ AR Kids A	☐ Private Insurance
☐ AR Kids B	☐ Other:

Part I – To be completed by parent or guardian before well child screening.

Check answers to the following questions. Explain any "yes" answers in the space provided.

	Yes	No	
1.	☐	☐	Do you have any concerns about your child's general health?
2.	☐	☐	Has your child been diagnosed with any chronic disease (such as asthma or diabetes)?
3.	☐	☐	Does your child have any allergies (like to food, medicine, dust)?
4.	☐	☐	Does your child take any medications (daily or occasionally)?
5.	☐	☐	Does your child have any problems with vision, hearing or speech?
6.	☐	☐	Has your child had any hospitalization, operation, major illness or injury?
7.	☐	☐	In the past 12 months, has your child experienced any difficulty with wheezing or night coughing?
8.	☐	☐	In the past 12 months, has your child experienced excessive weight loss or weight gain?
9.	☐	☐	Has your child had a dental examination in the last 12 months?
10.	☐	☐	Would you like to discuss anything about your child's health with the health care provider?

If you answered "yes" to any question, please explain below. For illnesses or injuries, include your child's age at the time.

Question #	Explanation

Parent/Guardian Permission and Release:
I give my permission for the information on this form to be used in meeting my child's health and educational needs while enrolled in the Arkansas Better Chance program.

______________________________ ____________________
Signature of Parent/Guardian Date

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

To Health Care Professional:
This child is enrolled in the Arkansas Better Chance Pre-K program. State regulations require a comprehensive well child screening for all enrolled children. The Division of Child Care and Early Childhood Education recommends an Early Periodic Screening and Diagnostic Treatment (EPSDT) which is age-appropriate. For children enrolled in AR Kids, the cost of the EPSDT may be billed to AR Kids A or B using the procedure codes below:

Patient Type	AR KIDS A		AR KIDS B	
	1-4 years	5-11 years	1-4 years	5-11 years
New	99382 EP U1	99383 EP U1	99382	99383
Established	99382 EP U2	99383 EP U2	99382	99383

Part II – To be completed by Health Care Provider. Complete all sections and sign at the bottom.

Weight	Height	BMI	Temp	Blood Pressure
lb. %ile	in. %ile	%		/

History Update
☐ Yes ☐ No Any changes in patient health since last visit? Explain:____
☐ Yes ☐ No Any family history of heart disease for anyone under 55 years of age?
☐ Yes ☐ No Any family history of abnormal cholesterol?

Health
☐ Good appetite
☐ Drinks lowfat milk
☐ Encourage diet of fruit and vegetables
☐ Limits fast food
☐ Picky or variable eater
☐ Brushes teeth, sees dentist

Social and Behavioral
☐ Parents discipline appropriately
☐ Dresses self, helps at home
☐ TV and video games are limited
☐ Praised for good behavior
☐ Has friends and playmates

PHYSICAL EXAM

	Norm	Abnormal
General	☐	☐
Head	☐	☐
Neck	☐	☐
Eyes	☐	☐
Ears	☐	☐
Nose	☐	☐
Throat	☐	☐
Mouth	☐	☐
Teeth	☐	☐
Lungs	☐	☐
Heart	☐	☐
Femoral Pulses	☐	☐
Genitals	☐	☐
Extremities	☐	☐
Gait	☐	☐
Spine	☐	☐
Skin	☐	☐
Neuro	☐	☐

Screening and Laboratory Results

Test	Result	Date	Comments if abnormal
Vision Test type:	L________________ R________________		
Hearing Test type:			
TB Risk: Yes / No			
Hemoglobin Risk: Yes / No			
Cholesterol Risk: Yes / No	mg/dL		

Immunizations
☐ Yes ☐ No All immunizations are current.
☐ Yes ☐ No Child has had all immunizations possible at this time.
Child needs: ☐ DTaP ☐ IPV ☐ HepB ☐ HiB ☐ MMR ☐ Varivax ☐ PCV-7 at ______years/_______ months

Referrals
☐ Follow up visit needed in ______________ weeks / months
☐ Return check at ________ years _________ months
☐ Needs to see dentist. Referral to be made by physician or nurse practitioner.

Impressions
☐ Well child, normal growth and development
☐ ____

____, MD / DO / NP
Date____

CLINIC INFORMATION (or stamp)

Name______________________________
Address____________________________
City_______________________________
Zip Code______ Phone_______________

2014-2015

Lincoln Consolidated Schools Health Information and Medication Sheet

PLEASE FILL OUT BOTH SIDES & RETURN AS SOON AS POSSIBLE

Student Name ___________________, __________________ _________________ ___________________________
last first middle preferred (nickname)

Gender:F/M Birthdate _____/_____/_____ Grade: _______ Teacher: _________________ Bus: ______________

Custodial Parent/LEGAL Guardian with whom student has Primary Residence:

His Name: _________________________Relationship: _________________ HM (____)_____________________
____WK(____)______________CELL(____)___________________
Address (Street, City, State, Zip)

Her Name:__________________________ Relationship: _________________ HM (____)____________________
______________________________________WK(____)_________________CELL(____)___________________
Address (Street, City, State, Zip)

Name(s) of Co-Custodial or Non-Custodial Parent(s) if applicable:

His Name: __________________________ Relationship: ________________ HM (____)_____________________
______________________________________WK(____)_________________CELL(____)___________________
Address (Street, City, State, Zip)

Her Name:__________________________ Relationship: ________________ HM (____)______________________
______________________________________WK(____)________________CELL(____)_____________________
Address (Street, City, State, Zip)

May the student be released to the non-custodial parent listed above (if applicable)? YES/NO

Siblings (please list) ____

Alternate Adult Contacts: In case of emergency, I herby authorize to allow my child to leave school only with the parent or legal guardian(s) listed above or the following persons:

_____________________________ 1. (____)_____________ 2.(____)_____________3.(____)_____________
Name Relationship Contacts Phone #'s

_____________________________ 1. (____)_____________ 2.(____)_____________3.(____)_____________
Name Relationship Contacts Phone #'s

Doctor Name:_____________________Phone:____________Dentist Name:__________________Phone:________

Hospital Preference: ____

ALERT TO PARENTS: If your child has a serious medical condition, it is vital that you discuss this with your School Nurse and teacher(s) immediately. **It is very important to know of Life Threatening Conditions.** In order to provide a safe and healthy environment for your child this information may be shared with appropriate personnel for health and eduction purposes.

MEDICAL HISTORY: Check the ones that apply to your child and describe under the comment section.

____ADD/ADHD
____Anxiety/Panic attack
____Asthma
____Bee/Insect Sting allergy
____Cerebral Palsy
____Diabetes
____Color Blindness
____Epi-Pen
____Emotional Concerns

___Headaches
___Hearing Problem
___Heart Condition
___Kidney/urinary problems
___Neurological Concern
___Orthopedic Problem
___Seizures
___Vision problems

___Other:__________________
(explain)
___PE Activity
Limited____
Not Limited________________
____
____

Comments: ____

ALLERGIES: List allergies your child has that cause a problem at school:

Cause of allergy:________________________________ Treatment:____

Cause of allergy:________________________________ Treatment:____

Has your child ever had a severe "anaphylactic" reaction requiring emergency care (list date)?__________________

List any operations, injuries, hospitalizations and give dates: ____
____

PLEASE TURN OVER AND FILL OUT BACK PAGE.

2014-2015
Lincoln Consolidated Schools Health Information and Medication Sheet

MEDICATION: Include prescription, over-the-counter and herbal medication taken on a regular basis.

	Name	Used to Treat	Taken at School?
1.	______________________	______________________	Yes_______ No _______
2.	______________________	______________________	Yes_______ No _______
3.	______________________	______________________	Yes_______ No _______

Before medication of any kind can be administered at school, area below to be filled out for OTC's or a medication administration form for prescription medication.

MEDICATION ALLERGIES ____________________________Treatment ________________________________

I give permission for my child __________________________________ to receive any medication I have indicated below as deemed necessary by the school nurse. I understand that generic equivalent medications may be used in place of more expensive brand-name items.

PLEASE CHECK ANY OVER THE COUNTER MEDICATIONS YOU WISH TO BE MADE AVAILABLE TO YOU R CHILD UNDER NURSING DISCRETION, DOSAGE DETERMINED BY AGE AND/OR WEIGHT.

For headache/fever/muscle aches/menstrual cramps:
______Acetaminophen (like Tylenol) - Will give age appropriate dose.
______ Ibuprofen (like Advil or Motrin) _ Will give age appropriate dose.

For mild allergic reactions (such as hives, seasonal allergies):
______Benadryl _ Will give age appropriate dose.

For mild stomach discomfort:
_____Antacid (1-2 tabs)

For mild skin irritation (poison ivy, insect bites, minor rashes, abrasions)
_____Hydrocortisone cream 1%
_____Triple antibiotic ointment

_____ I DO NOT WANT ANY MEDICATION GIVEN TO MY CHILD.

I UNDERSTAND THE ABOVE MEDICATIONS I HAVE CHECKED WILL BE ADMINISTERED BY THE SCHOOL NURSE, OR HER DESIGNEE, IN ACCORDANCE WITH ESTABLISHED PROTOCOLS.

By signing below, I understand that information provided on this form may be shared with appropriate personnel for health and educational purposes and/or emergency medical personnel in the event of injury or medical emergency.

Parent Signature ____ Date _______________________________

I, ______________________________, Father, Mother, Guardian (CROSS OUT WORDS THAT DO NOT APPLY) of ______________________________ do hereby give my consent to the Director of the Child Care Facility, or his
(Child's Name)
duly representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director or his duly appointed representative to transport said child for emergency medical treatment, if parents cannot be reached.

Parent/Guardian's Signature __________________________________ Date _______________________________

Provider's Initial: ________
Date: ____________   (Form valid for one year from this date)

CHILD CARE FOOD PROGRAM
ENROLLMENT FORM
(to be completed by parent or guardian)

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information may be verified. The meal times, the meal pattern and the daily menus should be posted and available for parents at all times. If you have questions, or comments, or would like to learn more about the Child and Adult Care Food Program, contact our office.

Marsha Hash
Name of Provider/Director

Lincoln Elementary Pre-K
Name of Day Care Facility

479-824-7350
Telephone

613 County Avenue Lincoln, AR 72744
Address

I wish to enroll my child (ren), whose names and enrollment information are given below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious, well balanced meals/snacks to day care children.

My child (ren) will be served the following meals:

(PLEASE CIRCLE) ***BREAKFAST*** ***AM SNACK*** ***LUNCH*** ***PM SNACK*** ***OTHER*** __________

Child (ren) Information (please print)

First Name	Last Name	Age	Birthdate	Time of Care	Days of Week (circle)	Sex
			/ /		SAT - SUN M – T – W – TH - FR	M F
			/ /		SAT - SUN M – T – W – TH - FR	M F
			/ /		SAT - SUN M – T – W – TH - FR	M F
			/ /		SAT - SUN M – T – W – TH - FR	M F

Note here any food allergies or special needs your child(ren) have: ________________________

____

______________________________________ Doctor's Name: ________________________

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex, or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

In case of emergency, please call: HOME # _________________ WORK # ______________

Parent Address: ____

Parent Signature: ____________________________ Date: _____________
(Enroll-2007)