Bearkatz Academy

Registration Form

Child's Information

Child's Name _____ DOB _____

Father _____ Mother _____

Physical Address _____

Mailing Address _____

Father's Employer _____ Work Phone _____

Work Hours _____ Cell Phone _____

Mother's Employer _____ Work Phone _____

Work Hours _____ Cell Phone _____

Emergency Contact Information

Person to notify if parents are unreachable _____

Relationship _____ Phone _____

Address _____

Is this person authorized to take the child from Bearkatz Academy? _____

List all other adults who are authorized to take the child from the center.

Name and Relationship _____ Phone Number _____

Address _____

Name and Relationship _____ Phone Number _____

Address _____

Name and Relationship _____ Phone Number _____

List any adults who are NOT authorized to take the child from the center. Documenting paperwork must be attached and discussed personally with the Director. All information will be kept confidential.

_____

_____

_____

BEARKATZ ACADEMY

Medical, Disease, and Developmental Info

Child's Name _____ Child's Physician _____

Address _____ Phone Number _____

I hereby give my consent to the Director of Bearkatz Academy, or her duly appointed representative, for my 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 her duly appointed representative to transport said child for emergency medical treatment if the parents cannot be reached.

I also _____ give/_____ do not give the Director or her appointed representative permission to give acetaminophen to my child. I understand that I will be notified that the medication has been administered.

I understand that it is my responsibility to keep Bearkatz Academy's Director up to date on any medical changes with my child. I also understand I must submit immunization records to the Director and that immunizations must be current at all time.

I understand by signing this form that I am stating I have read and agree with all information above.

_____ _____

Parent/Guardian Signature Date

Please mark any of the diseases/medical conditions that your child has had or currently has:

- — Measles
- — Chicken Pox
- — Mumps
- — German Measles
- — Whooping Cough
- — Tuberculosis
- — Frequent Ear Infections
- — Frequent Throat Infections
- — Defective Heart

Please describe in detail any conditions marked above. _____

_____

_____

Please list any physical or emotional problems your child might have. _____

_____

_____

Child's Special Food Needs _____ Diabetic Diet _____

Please list any allergies your child has...food or otherwise. _____

_____

_____

Is your child toilet trained? _____ Words used in toileting _____

BEARKATZ ACADEMY

Please mark areas in which your child requires assistance:

- — Dressing
- — Undressing
- — Toileting
- — Eating Washing Hands

Please indicate any of the following that your child has experienced or is currently experiencing.

- — Allergies
- — Temper Tantrums
- — Diabetes
- — Frequent Colds
- — Biting
- — Sun Sensitivity
- — Seizures
- — Fainting Spells
- — Bed Wetting

Please describe in detail any items marked above. _____

_____

_____

What are your child's favorite games, toys, foods, etc.? _____

_____

_____

Does your child have siblings? _____ If yes, please list their names and ages. _____

_____

_____

Please list any other information that you feel would be beneficial for us to know in order to best serve your child. ____

_____

_____

_____

Policies and Procedures

INTERVIEWING

I have been informed in writing upon enrollment of my child that children may be subject to interviews by licensing staff, child maltreatment investigators, and/or law enforcement officials for the purpose of determining licensing compliance or for investigative purposes. Child interviews do not require parental notice or consent. This is in accordance with Minimum Licensing Requirements.

SPECIAL NEEDS

I have been informed in writing that all child care facilities are require dby IDEA to refer a child with any suspected delays or disabilities to the appropriate lead agency as determined by age. Bearkatz Academy uses the services of Pediatric Therapy Services for ages birth – 3 years of age and NAESC for ages 3-5 years of age. This is in accordance with Minimum Licensing Requirements.

PHOTOGRAPH/VIDEO PERMISSION

I give permission for photographs or video recordings of my child to be placed on Bearkatz Academy and/or Melbourne School District's Facebook page and website. I also agree to allow my child's photo and or artwork, etc. to be shared with Work Sampling, Child Planning and Outcome, Arkansas State University Early Childhood Services, Arkansas Division of Childcare, and local newspapers. This is in accordance with Minimum Licensing Requirements.

KINDERGARTEN READINESS SKILLS

I have received information of Kindergarten Readiness Skills Calendar for my child (ages 3-5) at the following website – http://humanservieces.arkansas.gov/dccece/classroom_docs/DHS_RICalendar and http://arbettterbeginnings.com . This is in accordance with Minimum Licensing Requirements.

SHAKEN BABY SYNDROME

I have received information on the prevention of Shaken Baby Syndrome in accordance with Carter's Law. www.purplecrying.info This is in accordance with Minimum Licensing Requirements.

MEDICAL HOMES

I have received information for medical homes for children from my provider. This is in accordance with Minimum Licensing Requirements.

PERMISSION TO APPLY SUNSCREEN

I give written permission for the use of suntan lotions/sunscreen for my child as needed to prevent overexposure to the sun. Permission must be obtained yearly. I understand I am responsible for supplying sunscreen. This is in accordance with Minimum Licensing Requirements.

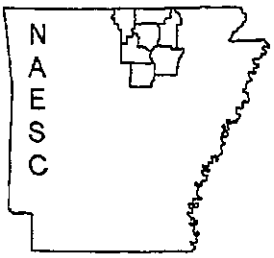
BEHAVIOR GUIDANCE SIGNATURE

Bearkatz Academy uses the following methods of discipline: using language to discuss feelings and making good choices regarding behavior, time out, loss of privileges, suspension and/or expulsion from the center. Bearkatz Academy asks that parents talk with their children regarding appropriate behavior at school. Appropriate behavior includes respect for teachers and using proper manners. Screaming, throwing toys, hurting others, tec... is not tolerable behavior of a child. Please encourage your child to use their words to communicate how they are feeling.

_____ _____

Parent/Guardian Signature Date

Comments: _____



Gerald Cooper, Director

NAESC

Northcentral Arkansas Education Service Cooperative

Telephone 870-581-3601
FAX 870-368-4920

99 Haley Street • P.O. Box 739
Melbourne, Arkansas 72556

BAXTER
MOUNTAIN HOME
NORFORK

CLEBURNE
CONCORD

FULTON
MAMMOTH SPRING
SALEM
VIOLA

INDEPENDENCE
BATESVILLE
CEDAR RIDGE
MIDLAND
SOUTHSIDE

IZARD
CALICO ROCK
IZARD COUNTY CONSOLIDATED
MELBOURNE

SHARP
CAVE CITY
HIGHLAND

STONE
MOUNTAIN VIEW

Developmental-Speech Screening

The Northcentral Arkansas Education Service Center's Early Childhood Program will be conditioning a screening for children 3-5 years of age. A screening will look at the following areas of development:
Hearing
Vision
Speech and Language
Development (motor skills, social development, & language development)

If you would like for us to check your child in these areas of development, please fill in the following information, sign and date this form. If you have any questions about this service, please feel free to call 870-368-7955.

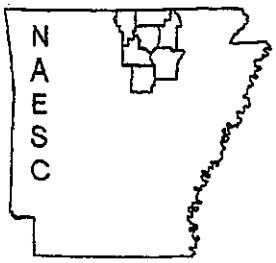
Child's Name_____
Date of Birth_____
Race & Sex_____
Child's Social
Security Number_____
Medicaid Number_____
Parent's Name_____
Address_____
Phone Number_____

__ Yes, I would like to have my child screened by NAESC Early Childhood Staff.
__ No, I would not like to have my child screened by NAESC Early Childhood Staff.

__ Yes, My child has Arkansas Medicaid (ARKIDS A) and I give NAESC Early Childhood permission to bill Medicaid for the hearing screening.

__ No, My child does Not have Arkansas Medicaid.

Parent's Signature_____ Date_____



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I hereby authorize the N4ESC Early Childhood program to release information concerning _____ *to the*

Child's Name

Bearkatz Academy

Name of Preschool

_____

Parent Signature

_____

Date

I hereby authorize the Bearkatz Academy *to release*

Name of Preschool

information requested by N4ESC Early Childhood Program concerning

_____

Child's Name

_____

Parent Signature

_____

Date

An Equal Opportunity Employer

Child Information (Circle one answer or write in answer)

Name:_____

Primary Language: English Spanish Other

Speak English at Home: Yes No

English Skills: Very Well Well Not Well Not at All

US Citizenship: Yes No

Parental Status: Two Parents Single Parent

Current School District: (Where resides 50% of time) _____

Medical Insurance: Yes No

Specify Medical Insurance (if applicable):

_____

Additional File Information

Primary Caregiver (Circle one answer or write in answer)

Name:_____

Gender: Male Female

Language: English Spanish Other

Food Stamp/SNAP: Yes No

Race: _____

Township:_____

County:_____

Marital Status: Married Single Divorced Widowed Separated Other

Disabled: Yes No Insurance: Yes No

Specify Medical Insurance (if applicable):_____

Current Housing: Homeless Own Rent Other

Current Housing Date: (Day you moved in)_____

Has Family Moved in 24 Months: Yes No

Member of US Military on Active Duty: Yes No

Secondary Caregiver (Circle one answer or write in answer)

Name:_____

Gender: Male Female

Language: English Spanish Other

Race: _____

Marital Status: Married Single Divorced Widowed Separated Other

Disabled: Yes No Insurance: Yes No

Specify Medical Insurance (if applicable):_____

Member of US Military on Active Duty: Yes No

Enrollment Form

General Student Information

First Name:_____ Middle Name:_____ Last Name:_____

SSN:_____ Grade:_____ Birth Date:_____ Age:_____ Gender: Male or Female (circle)

Ethnicity(check one): □Hispanic □Non-Hispanic

Primary Race(check only one):

□American Indian/Alaska Native □Asian □Black □White □Native Hawaiian/Other Pacific Islander

Method of Transportation (check all that apply):

□Bus □Parent/Guardian (includes walkers, child care vans, etc.) □Drives Self □District Paid Transportation

Last School Attended:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____ Fax:_____

Has this student been suspended or expelled from another school district?□ If yes, which school and district_____

Is this student currently involved in suspension or expulsion proceedings? □ If yes, which school and district_____

Has this student been retained? _____ If yes, what grade?_____

Does this student require special services? _____ If yes, Circle all that apply:

ESL Speech 504 Plan Gifted and Talented Resource Inclusion

Does this student reside in the household of a person who is currently on active duty in or serving in the reserve component of a branch of the United States Armed Forces? _____ If yes, please list branch:_____

Parent/Guardian Information

Student is living with: **Circle One**

A-Alone
D-Father & Stepmother
E- Mother & Stepfather
F-Father Only
G-Grandparents
H- Homeless
I-Institution
L-Legal Guardian
M-Mother Only
P-Both Parents
S-Spouse
T-Foster Parent

Legal Guardianship: **Circle One**

A-Both Parents B-Mother Only C-Father Only D-Other

Are there any legal restrictions which would prevent your child from being checked out by a particular adult?_____

(If yes, please provide the office with a copy of the legal document.)

Names and ages of other children living in the household:_____

Language spoken at home:_____

Mother/Guardian Name:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Physical Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell#:_____

Email Address:_____

Employer:_____

Work Phone:_____

Father/Guardian Name:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Physical Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell#:_____

Email Address:_____

Employer:_____

Work Phone:_____

In the event the parent/guardian cannot be reached, please contact:

Name:_____ Phone #:_____ Relationship to Student:_____

Name:_____ Phone #:_____ Relationship to Student:_____

Physician Name:_____ Physician Phone:_____ Please list any medical concerns for this child:_____

Please list the numbers you would like us contact for school announcements, closings, ect.:

Name:_____ Phone #:_____ Does this number receive text messages? Yes / No

Name:_____ Phone #:_____ Does this number receive text messages? Yes / No

Name:_____ Phone #:_____ Does this number receive text messages? Yes / No

Parent/Guardian Signature:_____ Date:_____

CHILD CARE FOOD PROGRAM

ENROLLMENT FORM

(to be completed by parent or guardian)

Provider's Initial: _____

Date: _____

For Facility/Provider Use Only:

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.

Bearkatz Academy
Name of Day Care Facility

PO Box 250
Address

870-368-0380
Telephone

Melbourne, AR 72556
Address

The following information is required by USDA Federal Regulation CFR 226.15(e)(2).

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** ~~Supper~~ ~~Late Snack~~

Child(ren) Information (please print)

First Name	Last Name	Age	Birthdate	Hrs of Care	Days /Week	Gender
			/ /	from to	~~SAT~~ - ~~SUN~~ M – T – W – TH - FR	M F
			/ /	from to	~~SAT~~ - ~~SUN~~ M – T – W – TH - FR	M F
			/ /	from to	~~SAT~~ - ~~SUN~~ M – T – W – TH - FR	M F

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

_____

Doctor's Name: _____ Doctor's Telephone: _____

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.

In case of emergency, please call: HOME # _____ WORK # _____

Parent Address: _____

Parent Signature: _____ Date: _____

(form valid one (1) year from this date)

HOW TO APPLY FOR FREE AND REDUCED PRICE SCHOOL MEALS

Please use these instructions to help you fill out the application for free or reduced price school meals. You only need to submit one application per household, even if your children attend more than one school in **Melbourne School District.** The application must be filled out completely to certify your children for free or reduced price school meals. Please follow these instructions in order! Each step of the instructions is the same as the steps on your application. If at any time you are not sure what to do next, please contact **Mrs. Amanda Bledsoe at 870.368.0380 or via email at amanda.bledsoe@melbourneschools.org.**

PLEASE USE A PEN (NOT A PENCIL) WHEN FILLING OUT THE APPLICATION AND DO YOUR BEST TO PRINT CLEARLY.

STEP 1: LIST ALL HOUSEHOLD MEMBERS WHO ARE INFANTS, CHILDREN, AND STUDENTS UP TO AND INCLUDING GRADE 12

Tell us how many infants, children, and school students live in your household. They do NOT have to be related to you to be a part of your household.

Who should I list here? When filling out this section, please include ALL members in your household who are:

- Children age 18 or under AND are supported with the household's income;
- In your care under a foster arrangement, or qualify as homeless, migrant, or runaway youth;
- Students attending **Melbourne School District**, regardless of age.

A) List each child's name.	B) Is the child a student at Melbourne School District?	C) Do you have any foster children?	D) Are any children homeless, migrant, or runaway?
Print each child's name. Use one line of the application for each child. When printing names, write one letter in each box. Stop if you run out of space. If there are more children present than lines on the application, attach a second piece of paper with all required information for the additional children.	Mark 'Yes' or 'No' under the column titled "Student" to tell us which children attend **Melbourne School District.** If you marked 'Yes,' write the grade level of the student in the 'Grade' column to the right.	If any children listed are foster children, mark the "Foster Child" box next to the child's name. If you are ONLY applying for foster children, after finishing **STEP 1**, go to **STEP 4**. Foster children who live with you may count as members of your household and should be listed on your application. If you are applying for both foster and non-foster children, go to step 3.	If you believe any child listed in this section meets this description, mark the "Homeless, Migrant, Runaway" box next to the child's name and complete all steps of the application.

STEP 2: DO ANY HOUSEHOLD MEMBERS CURRENTLY PARTICIPATE IN SNAP (Supplemental Nutrition Assistance Program)?

If anyone in your household (including you) currently participates in one or more of the assistance programs listed below, your children are eligible for free school meals:

- The Supplemental Nutrition Assistance Program (SNAP).

A) If no one in your household participates SNAP:	B) If anyone in your household participates in any of the above listed programs:
• Leave **STEP 2** blank and go to **STEP 3.**	• Write a case number or identified for SNAP. You only need to provide one case number. If you participate in SNAP and do not know your case number or identified, contact: Izard County DHS at 870.368.4318. • Go to **STEP 4**

STEP 3: REPORT INCOME FOR ALL HOUSEHOLD MEMBERS

How do I report my income?

- Use the charts titled **"Sources of Income for Adults"** and **"Sources of Income for Children,"** printed on the back side of the application form to determine if your household has income to report.
- Report all amounts in GROSS INCOME ONLY. Report all income in whole dollars. Do not include cents.
  - Gross income is the total income received before taxes
  - Many people think of income as the amount they "take home" and not the total, "gross" amount. Make sure that the income you report on this application has NOT been reduced to pay for taxes, insurance premiums, or any other amounts taken from your pay.
- Write a "0" in any fields where there is no income to report. Any income fields left empty or blank will also be counted as a zero. If you write '0' or leave any fields blank, you are

certifying (promising) that there is no income to report. If local officials suspect that your household income was reported incorrectly, your application will be investigated.

- Mark how often each type of income is received using the check boxes to the right of each field.

3.A. REPORT INCOME EARNED BY CHILDREN

A) Report all income earned or received by children. Report the combined gross income for ALL children listed in STEP 1 in your household in the box marked "Child Income." Only count foster children's income if you are applying for them together with the rest of your household.

What is Child Income? Child income is money received from outside your household that is paid DIRECTLY to your children. Many households do not have any child income.

3.B REPORT INCOME EARNED BY ADULTS

Who should I list here?

- When filling out this section, please include ALL adult members in your household who are living with you and share income and expenses, even if they are not related and even if they do not receive income of their own.
- ***Do NOT include:***
  - People who live with you but are not supported by your household's income AND do not contribute income to your household.
  - Infants, Children and students already listed in **STEP 1.**

B) List adult household members' names. Print the name of each household member in the boxes marked "Names of Adult Household Members (First and Last)." Do not list any household members you listed in **STEP 1.** If a child listed in **STEP 1** has income, follow the instructions in **STEP 3, part A.**	**C) Report earnings from work.** Report all income from work in the "Earnings from Work" field on the application. This is usually the money received from working at jobs. If you are a self-employed business or farm owner, you will report your net income. ***What if I am self-employed?*** Report income from that work as a net amount. This is calculated by subtracting the total operating expenses of your business from its gross receipts or revenue.	**D) Report income from public assistance/child support/alimony.** Report all income that applies in the "Public Assistance/Child Support/Alimony" field on the application. Do not report the cash value of any public assistance benefits NOT listed on the chart. If income is received from child support or alimony, only report court-ordered payments. Informal but regular payments should be reported as "other" income in the next part.
E) Report income from pensions/retirement/all other income. Report all income that applies in the "Pensions/Retirement/ All Other Income" field on the application.	**F) Report total household size.** Enter the total number of household members in the field "Total Household Members (Children and Adults)." This number MUST be equal to the number of household members listed in **STEP 1** and **STEP 3**. If there are any members of your household that you have not listed on the application, go back and add them. It is very important to list all household members, as the size of your household affects your eligibility for free and reduced price meals.	**G) Provide the last four digits of your Social Security Number.** An adult household member must enter the last four digits of their Social Security Number in the space provided. You are eligible to apply for benefits even if you do not have a Social Security Number. If no adult household members have a Social Security Number, leave this space blank and mark the box to the right labeled "Check if no SSN."

STEP 4: CONTACT INFORMATION AND ADULT SIGNATURE

All applications must be signed by an adult member of the household. By signing the application, that household member is promising that all information has been truthfully and completely reported. Before completing this section, please also make sure you have read the privacy and civil rights statements on the back of the application.

A) Provide your contact information. Write your current address in the fields provided if this information is available. If you have no permanent address, this does not make your children ineligible for free or reduced price school meals. Sharing a phone number, email address, or both is optional, but helps us reach you quickly if we need to contact you.	**B) Print and sign your name.** Print the name of the adult signing the application and that person signs in the box "Signature of adult."	**C) Write today's date.** In the space provided, write today's date in the box.	**D) Share children's racial and ethnic identities (optional).** On the back of the application, we ask you to share information about your children's race and ethnicity. This field is optional and does not affect your children's eligibility for free or reduced price school meals.

2019-2020 Household Application for Free and Reduced Price School Meals

Complete one application per household. Please use a pen (not a pencil)

STEP 1 List ALL Household Members who are infants, children, and students up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member:** "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced Price**

Child's First Name	MI	Child's Last Name	Name of School	Grade	Student? Yes	Student? No	Foster Child	Homeless, Migrant, Runaway
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

Check all that apply

STEP 2 Do any Household Members (including you) currently participate in the following assistance program: Supplemental Nutrition Assistance Program (SNAP)?

If NO> Go to STEP 3. If YES > Write a case number or identifier here then go to STEP 4. (Do not complete STEP 3)

Write only one case number or identifier. **Case Number or Identifier:**

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here?

Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with the All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child income $ ☐☐☐ How often? Weekly ○ Bi-Weekly ○ 2x Month ○ Monthly ○

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often?	Public Assistance / Child Support/Alimony	How often?	Pensions/Retirement/ All Other Income	How often?
	$	Weekly ○ Bi-Weekly ○ 2x Month ○ Monthly ○	$	Weekly ○ Bi-Weekly ○ 2x Month ○ Monthly ○	$	Weekly ○ Bi-Weekly ○ 2x Month ○ Monthly ○
	$		$		$	
	$		$		$	
	$		$		$	
	$		$		$	

Total Household Members (Children and Adults) ☐☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: X X X X X ☐☐☐☐

Check if no SSN. ☐

Disclosure (Optional) ○ I do not want school officials to share information from my free and reduced price meal application with Medicaid or the State Children's Health Insurance Program (ArKids 1st).

STEP 4 Contact information and adult signature

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Street Address (if available) Apt # | City | State | Zip | Daytime Phone and Email (Optional)

Printed name of the adult signing the form | Signature of adult | Today's date

INSTRUCTIONS Sources of Income

Sources of Income for Children	
Source of Child Income	**Example (s)**
Earnings from work	A child has a regular full or part-time job where they earn a regular salary or wages.
Social Security • Disability Payments • Survivor's Benefits	A child is blind or disabled and receives social security benefits. A parent is disabled, retied, or deceased, and their child receives Social Security benefits.
Income from person outside the household	A friend or extended family member regularly give a child spending money.
Income from any other source	A child receives regular income form a private pension fund, annuity, or trust.

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All Other Income**
•Salary, wages, cash bonuses •Net income from self-employment (farm or business) If you are in the U.S. Military: •Basic pay and cash bonuses (do not include combat pay, FSSA or privatized housing allowances) •Allowances for off-base housing, food and clothing	• Unemployment benefits • Worker's compensation • Supplemental Security Income (SSI) • Cash assistance from state or local government • Alimony payments • Child support payments • Veteran's benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private pensions or disability benefits • Regular income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments form outside household

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP) case number or other SNAP identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

fax: (202) 690-7442;

email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Do not fill out For School Use Only

School use only

Total Income: _____

Per: ○ Week ○ Every 2 Weeks ○ Twice a Month ○ Month ○ Year

Household Size: _____ SNAP: _____ Categorically Eligible: _____ Date Withdrawn: _____

Eligibility: ○ Free ○ Reduced ○ Denied

Reason for denial : _____

Determining Official's Signature: _____ Determination Date: _____

Annual Income Conversion: **show calculations**

Weekly _____ X 52= _____

2x/month _____ X 24= _____

Every 2 wks _____ X 26= _____

Monthly _____ X 12= _____

Annual _____ X 1= _____

2019 - 2020

ARKANSAS BETTER CHANCE FOR SCHOOL SUCCESS
CHILD APPLICATION

Complete the next 4 pages only if you wish to be considered for ABC.

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

*Name(First/Middle/Last):		
*Date of Birth:	Home Phone:	Work Phone:
*Current address:		
*City:	*State:	*ZIP Code:
*Employment Status (FT, PT):	Employer Name:	
Employment City:	State:	Employment Zip Code:
*# of hrs per week:	*Education Level (high school, college, etc.)	
If attending school, where:		# of semester hours:
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:	Home Phone:	Work Phone:
*Current address: ☐ same as Primary Caregiver		
*City:	*State:	*ZIP Code:
*Employment Status (FT, PT):	Employer Name:	
Employment City:	Employment State:	Employment ZIP Code:
# of hrs per week:	Education Level (high school, college, etc.)	
If attending school, where:		# of semester hours:
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 into 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 an 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:		
Physician 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 into COPA.**

ADE SPED
REQUIRED FORM
JULY-2008
AGES 3-5

SOCIAL HISTORY

Child: _____ Age: _____ Race: _____ ☐ Male ☐ Female

Parent/Guardian: _____ Relation to Child: _____ Date: _____

Circle your choices. If you need more room for comments, please write on back or attach a sheet of paper.

I. Tell us about your child's skills and personality.

1. Is your child's speech understood by others? Never or Rarely Sometimes Most of the time Always
2. Does your child talk to people other than family? Never or Rarely Sometimes Most of the time Always
3. Does your child get along with other children? Never or Rarely Sometimes Most of the time Always
4. Does your child separate from you willingly? Never or Rarely Sometimes Most of the time Always
5. Does your child have tantrums? Never or Rarely Sometimes Frequently
6. Are your child's skills behind his age in: Washing hands Dressing Toileting Eating
7. What are your child's favorite things to play with or do? _____
8. What things frighten your child? _____
9. What things are you most concerned about? _____

II. Tell us about your family.

10. Child lives with: Mother Step mother Father Step Father Grandparent(s) Foster Parents Other Adult(s)
    Brother(s) Sister(s) Others _____ Total family members? _____
11. Have any family changes upset your child? ☐ Yes ☐ No
12. Language spoke in home: _____

III. Tell us about your child's development and medical history.

13. Child has had specialized testing in the area of: hearing vision speech motor behavior development
    If yes, when and where? _____
    Do you have any test reports? ☐ Yes ☐ No If yes, can you provide copies? ☐ Yes ☐ No
14. Child receives (or has received): Speech Therapy Physical Therapy Occupation Therapy
    Counseling Play Therapy Early Intervention (below age 3)
    If yes, when and where? _____
15. Child wears glasses? ☐ Yes ☐ No If yes, how long? _____ Diagnosis: _____
16. Child wears hearing aides? ☐ Yes ☐ No If yes, how long? _____ Diagnosis: _____
17. Child was late in: age weaned sitting alone walking talking
18. Child has a history of: ear infections/tubes allergies food allergies (list) _____
19. Child has a medical condition that effects learning and/or limits participation? ☐ Yes ☐ No
    If yes, diagnosis: _____ Medications: _____
20. Describe other significant events related to child's birth, illnesses, accidents, and/or physical development:

_____

_____

_____

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

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

Health

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

Social and Behavioral

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

PHYSICAL EXAM

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

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

D Yes D No All immunizations are current.
D Yes D No Child has had all immunizations possible at this time.
Child needs: D DTaP D IPV D HepB D HiB D MMR D Varivax D PCV-7 at_____years/_____months

Referrals

D Follow up visit needed in _____ weeks / months
D Return check at_____years_____months
D Needs to see dentist. Referral to be made by physician or nurse practitioner.

Impressions

D Well child, normal growth and development
D _____

_____, MD / DO / NP
Date_____

CLINIC INFORMATION (or stamp)

Name_____
Address_____
City_____
Zip Code_____Phone_____

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	
D AR Kids A	D Private Insurance
D AR Kids B	D 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.	D	D	Do you have any concerns about your child's general health?
2.	D	D	Has your child been diagnosed with any chronic disease (such as asthma or diabetes)?
3.	D	D	Does your child have any allergies (like to food, medicine, dust)?
4.	D	D	Does your child take any medications (daily or occasionally)?
5.	D	D	Does your child have any problems with vision, hearing or speech?
6.	D	D	Has your child had any hospitalization, operation, major illness or injury?
7.	D	D	In the past 12 months, has your child experienced any difficulty with wheezing or night coughing?
8.	D	D	In the past 12 months, has your child experienced excessive weight loss or weight gain?
9.	D	D	Has your child had a dental examination in the last 12 months?
10.	D	D	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 _____

IMAGINATION LIBRARY OF IZARD COUNTY

Registration Form for Children Ages 0-5

Child's First Name:_____ Middle Initial:_____ Last Name:_____

Child's Date of Birth:_____ Sex: Male Female *(Circle One)*

Parent/Guardian First and Last Name:_____

Parent/Guardian Phone:_____ Email:_____

Child's Mailing Address:_____

_____

School District In Which Child Resides (or attends if enrolled in preschool):_____

I hereby explicitly consent to allow the Dollywood Foundation, Inc. to use the information provided herein for the purposes of participating in Dolly Parton's Imagination Library book gifting program. To measure the benefits of this program, the Dollywood Foundation, Inc. may crate data sets with the information provided herein and share them with research and educational advancement partners. You agree to review the Dollywood Foundation, Inc. full terms and conditions and Privacy Policy by visiting Imaginationlibrary.com. By signing and submitting this form, you expressly consent to the terms set forth herein.

Authorized Adult Signature:_____ Date:_____

Please return this form to:

Melinda Light, Director of Events and Volunteer Services

United Way of North Central Arkansas

P.O. Box 2639, Batesville, AR 72503-2639

(870) 793-5991

Your child will receive their first book in approximately 8-10 weeks after enrollment. Questions? E-mail Melinda Light at info@liveunitednca.org