Child Enrollment Checklist

Child's Name:_____ d.o.b:_____

- ☐ ABC Child Application
- ☐ ABC Well Child Screening Form
- ☐ Birth Certificate
- ☐ Immunization Record (with catch up schedule if necessary)

Proof of Income - Total Family Income:

- ☐ 30 days of current pay stubs
- ☐ Income Tax Form
- ☐ W2
- ☐ Other _____

If Unemployed:

- ☐ Notarized statement signed by the parent stating that there is no earned income.

With the signature below, I agree that the above requirements are completed.

Program Staff: _____ Date: _____

****All applications must have ALL documentation and other materials attached before the application can be reviewed by the enrollment committee. This includes verification of income. Any status changes between submitting of application and enrollment must be updated for your application to be valid. At the time of review, you may be sked to submit more current information.**

Primary Caregiver General Information

First Name:_____ M. Initial:_____ Last Name:_____

Gender: Male Female Date of Birth:_____

SS#:_____ Receiving WIC: YES NO Previously

Language:_____ Other Language:_____

Ethnicity: ____Hispanic ____Yes, Cuban
____Yes, Mexican American, Chicano ____Yes, Other Spanish, Hispanic, Latino,
____Yes, Puerto Rican

Race: ____American Indian or Alaska Native ____Asian Indian
____Black or African American ____Multi-Racial
____Other:_____
____White:

Education Level: ___Bachelor or Advanced Degree
___College degree or training school certificate
___ ESL ____GED
___ Grade 10 ____ Grade 11 ___ Grade 12
___ Grade 9 or Less
___ High School Graduate
___ Some College/Vocational/Associates Degree

Employment Status: ___ Farmer ___ Full-time & Training ___Employed full-time
___ Homemaker ___ Job training/school (part-time)
___ Migrant farm worker ___ Employed part-time
___ Retired or Disabled ___ employed seasonal
___ seasonal farm worker ___ self employed
___ unemployed

Employer/School Name:_____

Phone (home):_____ Phone (mobile): _____ Phone (work):_____

Home address:_____

City:_____ County:_____ State:_____ Zip code:_____
in Family: _____ # in household:_____
NAME: RELATIONSHIP TO CHILD:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Marital status: ___married ___single ___ divorced ___ widowed ___separated ___other

Disabled: YES NO
Medical Insurance (for Child): YES NO
Specify: __ARKids 1st ___ARKids A ___ARKids B
__Medicaid ___Medicare __ OTHER:_____

Current Housing: ___homeless ___own ___rent ___other
Current housing date:_____
Previous housing: ___homeless ___own ___rent ___other

Has family moved in the last 24 months? YES NO

Primary Caregiver Comment:

No Secondary Caregiver (skip application for secondary caregiver) _____

Secondary Caregiver General Information

First Name:_____ M. Initial:_____ Last Name:_____

Gender: Male Female Date of Birth:_____

SS#:_____ Receiving WIC: YES NO Previously

Language:_____ Other Language:_____

Ethnicity: ____Hispanic ____Yes, Cuban
____Yes, Mexican American, Chicano ____Yes, Other Spanish, Hispanic, Latino,
____Yes, Puerto Rican

Race: ____American Indian or Alaska Native ____Asian Indian
____Black or African American ____Multi-Racial
____Other:_____
____White:

Education Level: ___Bachelor or Advanced Degree
___College degree or training school certificate
___ ESL ____GED
___ Grade 10 ____ Grade 11 ___ Grade 12
___ Grade 9 or Less
___ High School Graduate
___ Some College/Vocational/Associates Degree

Employment Status: ___ Farmer ___ Full-time & Training ___Employed full-time
___ Homemaker ___ Job training/school (part-time)
___ Migrant farm worker ___ Employed part-time
___ Retired or Disabled ___ employed seasonal
___ seasonal farm worker ___ self employed
___ unemployed

Employer/School Name:_____

Phone (home):_____ Phone (mobile): _____ Phone (work):_____

Home address:_____

City:_____ County:_____ State:_____ Zip code:_____

Disabled: YES NO
Medical Insurance: YES NO Specify:_____

Income Information

Mark all sources of family income…..

SOURCE	Household member who receives this INCOME	AMOUNT	How Often	Annual Income
Employment**				
TEA/SSI				
Social Security				
Unemployment				
Child Support				
Other Income				
			Total Annual Income $	

** Employment may be verified by the following:
-Four (4) CONSECUTIVE check stubs -Notarized letter from employer -latest W-2 form
- If there is no income, you must have a Notarized statement stating you have no earned income

Child Application

First Name:_____ M. Initial:_____ Last Name:_____
Gender: Male Female Date of Birth:_____

Primary Langugae:_____ Other Language:_____
Speak English at home: YES NO English Skills: ___Very Well ___Well ___Not Well ___ Not at all

Ethnicity: ____Hispanic ____Yes, Cuban
____Yes, Mexican American, Chicano ____Yes, Other Spanish, Hispanic, Latino,
____Yes, Puerto Rican

Race: ____American Indian or Alaska Native ____Asian Indian
____Black or African American ____Multi-Racial
____Other:_____
____White:

SSN:_____ US Citizen: YES NO

*Parental Status

___ Two Parent ___Single Parent

___teen parent ___disabled parent ___foster parent ___active male
___homeless ___ guardian ___group home ___ dual custody
___student parent ___migrant parent ___grandparent ___ previously in foster care

Relationship to Primary Caregiver:_____
Relationship to Secondary Caregiver:_____

Secondary Source of Child Care:
___ none ___family child care home ___Child Care Center or Classroom
___ Home or Another home with a relative or unrelated adult
___ other:_____

Current School District (where child resides):_____

Medical Information:
Child's Physician or emergency treatment facility _____

Address_____City_____ AR Phone:_____

I, _____Father Mother (Circle the one that applies) of

Guardian
_____ do hereby give my consent to the Director of the
(Child's Name)
Child Care Facility or his 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 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 the parents cannot be reached.

Signed:_____ Date:_____
Witness:_____ Date:_____

Disease History – List dates of each
Measles_____ Mumps_____ German Measles_____
Chicken Pox_____ Whooping Cough_____

Contracted Tuberculosis: YES ____ NO____ Frequent Ear Infections: YES ____ NO____
Frequent Throat Infections: YES ____ NO____ Defective Heart: YES ____ NO____

Other Conditions or Comments:_____

Child's Developmental Needs:
Physical or emotional problems the child might have:_____

Child's special food needs: Formula_____ Diabetic Diet_____ Allergies_____
please note: we MUST have a current doctor note with special diets or food allergies*

Allergies____ Temper Tantrums____ Diabetes____ Frequent colds____ Biting____
Sun Sensitivity____ Seizures____ Fainting Spells ____ Bed Wetting ____ Other ____

Requires help in: Dressing____ undressing____ toileting ____ eating ____ washing hands____
Is child toilet trained: YES____ NO____ Words used in toileting:_____

Favorite: Games_____ Toys_____ Foods_____
Siblings: Yes__ No__ Name(s) of siblings_____
Child Care Used before_____

Other useful information:_____

Child's Personal Data Sheet

Student name:_____ DOB:_____

Mother's Name _____

Father's Name _____

Home address_____

City_____ Arkansas Zip_____ Phone_____

Emergency Contact Information

Name of person to call if parents cannot be reached _____

Relationship_____ telephone_____

Address_____ City_____ AR

Is this person authorized to take the child from the center?_____

List all adults who are authorized to take the child from the center (must be 18)

_____	_____	_____
Name relationship	Name relationship	Name relationship
_____	_____	_____
address	address	address
_____	_____	_____
City State Zip	City State Zip	City State Zip
_____	_____	_____
telephone	telephone	telephone

****If you would like to add additional people to your child's pick up list, please write information on the back of this page.**

ENROLLMENT APPLICATION CHECKLIST

No application is complete until all requirements are checked on the list below:

☐ ABC Child Application

☐ ABC Well Child Screening Form

☐ Birth Certificate

☐ Immunization Record (with catch up schedule if necessary)

☐ Proof of Income: Total Family Income
- ☐ 30 days current pay stubs
- ☐ Income Tax Form
- ☐ W2
- ☐ Other _____

☐ If unemployed:
- ☐ Notarized statement signed by the parent stating that there is no earned income.

With the signature(s) below, I agree that the above requirements are completed and that all information is accurate. I understand that the submission of false documentation to receive ABC services may result in exclusion from participation in any DHS program (including Medicaid) and referral for criminal prosecution.

Child's Name: _____

Parent Signature: _____ Date: _____

Program Staff: _____ Date: _____

***Do NOT write below this line. Preschool staff will complete if our child is accepted*.**

Date enrolled in center:_____ Date withdrawn from center:_____

Name of Center: Clarendon ABC Pre-K Clock hours in center: 7