Dear Parent,

Thank you for your interest in the Arkansas Better Chance programs offered by Bright Beginnings Preschool.

Enclosed you will find the necessary forms for our ABC programs. Part of the eligibility criteria for our program is a copy of your child's birth certificate, up-to-date immunization record, social security card, insurance card, well-child checkup form conducted in the last 2 years, signed by a Doctor, proof of income and a current picture. All completed forms must be turned in to us before your child can be determined for eligibility to be enrolled in the program.

At Bright Beginnings we have to follow an attendance policy where promptness and regular attendance are imperative for students to receive full benefits of our school program.

Please be advised that at Bright Beginnings Preschool we are a family. Monthly Parent Involvement in your child's school is required by the Arkansas Better Chance Program. Ideally, we would love for you to volunteer in the classroom one hour a week. That is how you really learn what we do and fall in love with the way we teach and learn. If you are a working parent, we understand that isn't possible. We will expect you to give your hour in one of the planned activities a month.

If you are looking for a daycare that you can just drop off your child…
We are NOT a good fit for you.

If you want to work with us and create memories with your child …
WELCOME!

Please complete and return the enclosed forms as soon as possible so that your child will have the opportunity to be a part of this exciting preschool program.

If you have any questions or are in need of further information please contact us at (479) 427-8110.

Learning Together,

Debbie Mays

Child's Name: _____

CHECKLIST

Please use blue or black ink when filling out all forms

Please submit the following documents for your child's enrollment:
(We can not place a child for enrollment until all forms are completed and returned including immunizations.)

_____ BRIGHT BEGINNINGS ENROLLMENT APPLICATION
(Pages 2-5 including this checklist)

_____ Food Program Form (page 6)

_____ Intake Form (page 7)

_____ Personal Data Form (page 8)

_____ Contract/Signature Pages (pages 9-10)

_____ Well Child Check-up (pages 11-12)
(*Health Screening including **hearing** and **vision**, **must** be evaluated, signed and dated by a doctor)*

_____ Screening Request Form (page 13)

_____ Authorization for release of records (page 14)

_____ Immunization Record (up to date)

_____ Current Family Photo (may be emailed to debbiemays@me.com)

_____ Copy of Insurance Card

_____ Copy of Birth Certificate

_____ Copy of Social Security Card

_____ Proof of income for the last 30 days. (Last 4 check stubs, letter from employer, tax forms, or documentation of other qualifiers. If you do not have any income please use the included form at the top of page 6.)

ENROLLMENT APPLICATION/CONTRACT

Parent/Guardian Signature _____

Application Date: _____/_____/20_____

Start Date: _____/_____/20_____

CHILD INFORMATION

Child's Name: _____ Date of Birth: _____/_____/_____

Gender: (circle one) Male or Female Social Security Number: _____/_____/_____

Ethnicity: _____ Primary Language: _____ Is child a US Citizen? (Circle one) Yes or No

Does Child speak English? (Circle one) 1) Very Well 2) Well 3) Not Well 4) Not at all

Physical Address: _____City:_____State:_____ Zip: _____

Mailing Address: _____ City: _____ State: _____Zip: _____

Doctor: _____Phone:_____Address:_____

Are there any medical problems we should be aware of: _____

Type of Medical Insurance: (for child) _____

List any known allergies: _____

Has this child attended a state-funded Pre-K (ABC) program before? Yes or No If so, where? _____

_____

Will this child be enrolled at another ABC center and/or HIPPY/PAT program? Yes or No If so where? _____

_____

Is this child currently receiving therapy services? Yes or No If so, what type and where? _____

Emergency Contact Information (person to contact if Parent/Guardians are not available)

Name: _____Relationship to child: _____

Mailing Address: _____State:_____Zip: _____

Home Phone: _____ Work phone: _____ Cell phone: _____

List other people (excluding emergency contact & Parent/Guardians) that may pick up your child:

Name: _____Relationship:_____ Phone: _____

Name: _____Relationship:_____ Phone: _____

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

I have read and agree to the above statements on this page.

Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN INFORMATION

Fill this information out for the adults living with the child who are primarily responsible for the support and care of the child.

PARENT/GUARDIAN 1:

Name (first, mi, last): _____ Relationship to child: _____
Gender: Male or Female Date of birth: _____/_____/_____Social Security number: _____/_____/_____
Cell Phone: (_____) _____ May we send text messages to your cell phone? Yes or No
Ethnicity: _____ Primary Language: _____ Disabled? Yes or No
Marital Status: _____ Highest level of education: _____ Email address: _____
Type of Medical Insurance: _____
Do you receive Food Stamp/SNAP or WIC: _____ Yes _____ No _____ SNAP Case # _____
Employer: _____ Employer's Phone: _____ (ext.) _____
Number of hours work per week: _____ Annual income from work or unemployment: _____
If attending school, where: _____ Number of semester hours: _____

PARENT/GUARDIAN 2:

Name (first, mi, last): _____Relationship to child: _____
Gender: Male or Female Date of birth: _____/_____/_____Social Security number: _____/_____/_____
Cell Phone: (_____) _____ May we send text messages to your cell phone? Yes or No
Ethnicity: _____ Primary Language: _____ Disabled? Yes or No
Marital Status: _____ Highest level of education: _____ Email address: _____
Type of Medical Insurance: _____
Do you receive Food Stamp/SNAP or WIC: _____ Yes _____ No _____ SNAP Case # _____
Employer: _____ Employer's Phone: _____ (ext.) _____
Number of hours work per week: _____ Annual income from work or unemployment: _____
If attending school, where: _____ Number of semester hours: _____

HOUSEHOLD INFORMATION

Number people in immediate family (Parent/Guardians, siblings): _____ Total Household: _____
List the name of all family members in the household & relation to the child enrolling:

Name:	Relationship:

Current housing status: Own ____ Rent ____ Homeless ____ Other _____
Date began current housing: _____
Previous Housing: Own ____ Rent ____ Homeless ____ Other _____
Has the family moved in the last 24 months: ___ Yes ___No

I have read and agree to the above statements on this page.
Parent/Guardian Signature: _____ Date: _____

Please list all people who can pick child up from care without written consent from parents/guardians. (Use another sheet if needed)

1._____ Phone (____) _____

2._____ Phone (____) _____

3._____ Phone (____) _____

4._____ Phone (____) _____

5._____ Phone (____) _____

If you want someone who is not on this list to pick up your child you must give the preschool written notice in advance. A phone call is not acceptable. Under no circumstances will a child be released until these conditions are met. I also require identification from anyone picking up a child if I have not seen them before.

HOURS AND TUITION

Hours: You're hours contracted for care will be from 8:00 a.m. to 3:00 p.m. on the following days: Mon. - Fri. Child must be picked up promptly at 3:00 p.m. You will be charged a late fee of $5.00 for every 10 minutes you are late. After three documented late occurrences you will be asked to make other arrangements for your child. **It is important that arrival and departure times are punctual so that we can all get settled and proceed with our activities.** If you need care beyond the contracted hours you will need to prearrange this with the provider. The provider is under no obligation to provide an extension of time if such extension conflicts with the provider's own plan. Late arrival does not justify late departure. Please feel free to visit with me concerning your child any time.

Holidays and Closings: We are closed for all major holidays including Memorial Day, July 4th, Labor Day, Thanksgiving, Christmas and New Year's Day. We are also closed for Spring Break and Christmas Break. Please see attached schedule for any additional closings.

Tuition: The basic charge will be $0 per week for full time care. There are no additional fees except those stated in this contract. Tuition is unaffected by closings such as snow, your child's absence, holidays or scheduled closings. The only time tuition is affected is if provider is unable to care for the children on a scheduled school day. If such an occasion should arise, you will not be charged. If you are ABC any days missed will be made up at the end of the school year. As a licensed child care professional, I claim your tuition as income and provide each family with a receipt when you pay as well as detailed receipt at the end of the tax year. This receipt can be used to obtain credit for child/dependent care expenses.

TERMINATION/TRIAL PERIOD

A two-week trial period will be in effect starting on the first day of care. During this trial period either party may choose to discontinue services with written notice. Both parties reserve the right to terminate without notice if the other party is in substantial violation of the agreement and/or safety or health of children is endangered.

I have read and agree to the above statements.

ATTENDANCE

The ABC Program is from 8:00 a.m. to 3:00 p.m. **Promptness and regular attendance are imperative for students to receive full benefits of the school program. The educational loss resulting from absences from class, which cannot be adequately measured, is the rationale for this attendance policy.** The parent or guardian has the responsibility to decide times and reasons a student should not come to school, but if you are an ABC student it is the preschool's responsibility to set limits on a student's absences from school because attendance is so important for success in school. In order to maintain enrollment students may not miss more than 12 days a semester.

Tardiness is defined as an unexcused appearance of a student past the scheduled time a class begins. Five incidents of unexcused tardiness to class will be considered to be equal to one absence.

I have read and agree to the above statements on this page.

Parent/Guardian Signature: _____ Date: _____

VERIFICATION OF NO INCOME (IF REQUIRED)

I, _____ parent of _____ do not have any income to report at this time.

Parent/Guardian Signature: _____ Date: _____

Notary Signature: _____ Date: _____

Child & Adult Care Food Program Enrollment Form

Your child care provider participates in the USDA, Child & Adult Care Food Program, (CACFP). This program extends the benefits of the National School Lunch program to children in family child care. Under the regulations of the CACFP, your provider may not charge separate fees for meals nor may you be asked to provide food for those meals claimed on the program (with the exception of infant formula).

As a CACFP sponsor, we need verification that your child/ren are enrolled in this family child care home. Please complete the following:

Child's Name	Date of Birth	Age	Milk Allergy	Meals to be Served to Child (*Please circle*)
_____	_____	____	Yes No	~~B~~ AM ~~L~~ PM S EV
_____	_____	____	Yes No	~~B~~ AM ~~L~~ ~~PM~~ S EV
_____	_____	____	Yes No	~~B~~ AM ~~L~~ ~~PM~~ S EV

B-Breakfast AM-Morning Snack L-Lunch PM-Afternoon Snack S-Supper EV-Evening Snack

- **What are the child/rens normal hours in child care:** 8:00 a.m. to 3:00 p.m.
- **What are the child/rens normal days in child care:** Monday - Friday

If contacted by phone to update and/or verify this information, I would prefer being called:

(please check one) _____ **at home** ____ **mother's work** ____ **father's work**

Telephone Numbers (_____) (_____) (_____)

Parent's signature _____ **Date** _____

Parent's address _____ **Zip** ___

Provider's Name: Debbie Mays

If you have questions please contact:

Northwest Arkansas Family Child Care Association, Inc.
P.O. Box 1522, Fayetteville, AR 72702 (479) 521-7449 or 1-800-445-3326

This program is operated in accordance with USDA policy which does not permit discrimination because of race, color, sex, age, handicap, or national origin. *White-Sponsor Yellow-Provider Pink-Parent*

CACFP State Information Contact
Special Nutrition Program
P.O. Box 1437 Slot S-155
Little Rock AR 72203
(501) 682-8860

CHILD'S INTAKE FORM

Thank you for sharing this information with me.

By providing this information about your child, you will be assisting me in creating a positive experience for him/her while in my care. Please list any information about your child's habits, abilities or personality that you feel will be helpful to me while caring for your child.

General state of health: _____

Child's physician: _____

Address: _____ City: _____ State: ___ Zip: _____

Work Phone: (___) _____ Emergency Phone: (___) _____

Child's dentist: _____

Address: _____City: _____ State: ___ Zip: _____

Work Phone: (_____) _____ Emergency Phone: (_____) _____

Are your child's immunizations up to date? Y or N

Does your child have any known allergies? Y or N

If yes, please describe: _____

_____

Are you concerned that your child may be prone to any type of allergies? Y or N

If yes, please describe: _____

Does your child have any medical conditions or disabilities which I should be made aware of? Y or N

If yes, please describe: _____

Please mark any that apply:

o Constipation	o Frequent Ear Infections	o Biting	o Anger issues
o Seizures	o Frequent Sore Throats	o Skin Rash	
o Diarrhea	o Sun Sensitivity	o Urinary Problems	
o Frequent Colds		o Temper Tantrums	
o Fainting Spells		o Allergies	

Does your child have any speech, hearing or visual problems? Y or N

If yes, please describe: _____

Would there be any restrictions to play or activities? Y or N

If yes, please describe: _____

When your child is upset or unhappy, what seems to comfort him/her? _____

As the parent what are your preferences regarding:

Eating: _____

Sleeping: _____

Discipline: _____

Toileting: _____

What frightens your child and how is it shown: _____

_____

I have read and agree that the above statements are true to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____

CHILD'S PERSONAL DATA FORM

Has your child ever been in child care before? ____ Name of Provider _____
What type (center, family daycare, grandma etc.) _____ was it a positive experience? Y or N
Why are you looking for child care? _____
How does your child feel about going to preschool? _____
Are there any recent traumatic situations your child has been exposed to such as a death in the family, divorce, new sibling etc.? _____
What is your normal method of discipline? _____
What is your child's temperament? (Easy going, hard to please, demanding, aggressive, etc.) _____
Are there any food restrictions? (Requires dr.'s note) _____
What is your child's favorite food? _____
What food does your child dislike? _____
Can your child be relied upon to indicate bathroom wishes? Y or N
What words does your child use for: Bowel movements _____Urination_____
What time does your child awaken? _____ What time does your child go to sleep at night? _____
Do they sleep through the night? Y or N Does your child sleep in a bed or crib, other? _____
Does your child need assistance with: (a) dressing/undressing Y or N and/ or (b) eating: Y or N
Names of Family Pets _____
Are there any siblings? Y or N
Please name them and specify ages and gender.

Name: _____ Age: _____ Gender: M or F

Name: _____ Age: _____ Gender: M or F

Name: _____ Age: _____ Gender: M or F

Name: _____ Age: _____ Gender: M or F

Has your child had experience playing with other children? Y or N

Please describe: _____

What language(s) are spoken at home? _____

Does your child have any security objects such as a blanket or toy etc.? Y or N

Please describe: _____

What are your child's favorite activities, toys, books, or games? _____

_____

Does your family celebrate birthdays and holidays? Y or N

_____

Child's Developmental History: Please attach any documents pertaining to assessments or services provided for developmental delays or disabilities. **Please use the back side of this form to add any other comments, information, or specific concerns you would like to let us know about.**

I have read and agree that the above statements are true to the best of my knowledge.
Parent/Guardian Signature: _____ Date: _____

CONTRACT/SIGNATURE PAGES

CONSENT FOR EMERGENCY CARE:

Medical Emergencies: In the event of a medical emergency, we will first call 911, the parents/guardians will be contacted as soon as possible. If the parent/guardian cannot be reached the directions on the enrollment form will be followed. In the event immediate medical attention should be required, we will use the local hospital. If you have a preference other than the one listed, we will try to accommodate you, if possible. All accidents are reported on an accident report.

Natural Disasters: In the event of a fire or other natural disaster we will try to remain on the premises if at all possible. If we are unable to do so, we will relocate to a safe place. If this happens we will try to contact you as soon as possible and post information via one/or more of the following: social media, our website, and on the door of our location.

I/we, _____, Parents/guardians of _____ do hereby request and give consent to Bright Beginnings, and the duly appointed representative for said child to receive such 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 duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached.

DEVELOPMENTAL SCREENING:

Bright Beginnings tries to meet the needs of every child enrolled. To do this we screen your child so that we can structure his/her learning to meet their specific developmental needs. Results of this screening will be presented to you during parent/teacher conferences or by contact from our therapy coordinator.

VIDEO, PICTURE, VOICE DISCLOSURE:

Bright Beginnings has my permission to videotape, take pictures, or video record of my child for educational or marketing purposes. I understand that my child may have their picture included on educational or training videotapes, audiotapes, scrapbooks, yearbooks, bulletin boards, etc. My child's photo may also be included in Bright Beginnings online marketing tools including but not limited to social networks and website.

PARENTAL REQUEST FOR CONFERENCE:

I, the parent/guardian of this child understand that I may request a conference with program staff as needed.

DIVISION OF CHILDREN AND FAMILY SERVICES:

Please sign that you have read and understand the following:

200.4 Upon enrollment of your child they 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.

601.2 Licensing compliance forms (DCC-521) are maintained at the facility for three years. The compliance forms are available for review upon request.

CONTRACT AGREEMENT

I / we have read the Bright Beginnings policy handbook and contract and will comply with all the provisions contained therein. At this time I/we shall enter into contract with Bright Beginnings for care of above named child/ren with the understanding that we shall work together on the behalf of the child/ren.

This contract is in effect until a change is mutually agreed upon in writing or upon termination of care. Both parties agree to cooperate and work together on behalf of the child and accept this agreement as a binding contract.

This contract is subject to review and renewal. Any changes made by the provider to the terms of the contract must be made on the renewal date unless mutually agreed to beforehand by the provider and parents or guardians who are parties to this contract. Otherwise, this contract will remain in effect until the renewal date or upon termination of care as set forth herein.

I have discussed and reviewed this contract and policy handbook and agree to provide care for the above-indicated child/ren, to be placed in my home as long as the terms of this contract are upheld.

PARENT INVOLVEMENT

It is your responsibility to find a way once a month that you can give time back to your child's school. This is a "family hour." It can be done by mom or dad or even a grandparent. If there is a family event planned for that month the involvement can be counted at that time.

I have read and agree to the above statements on this page.

Parent/Guardian Signature: _____ Date: _____

CONTRACT/SIGNATURE PAGES (cont.)

ABSENTEE POLICY

After 10 non excused absences per semester a child CAN be dropped from the program at the director's discretion. Each situation will be addressed individually by the Bright Beginnings Director.
Tardy is any time past 8:10. Five tardy's will equal ONE UNEXCUSED absence. ABC children arriving AFTER 9:00 am may use that day as ONE of their absences for the year. The state is paying for your child's preschool education, not babysitting as you need it.
Bright Beginnings MAY ask for a doctor's note if excessive absences occur.

EMERGENCY EVACUATION PLAN

In the event of a community emergency that causes Bright Beginnings to evacuate more than 2 miles from our home we have signed an agreement with First Baptist Church 2000 Dawn Hill Road to be a safe haven for us. You will be alerted if at all possible through remind 101 when we are in-route and when we have arrived. If an emergency takes place that forces us to leave the safety of our home (but not two miles away) we will take shelter in the new library building or the lot it is situated on.

BEHAVIOR GUIDANCE POLICY

I/we have been informed and agree to the behavior guidance policy at Bright Beginnings Preschool.

SEPARATION OF CHURCH AND STATE

As Per a memo from the state Department of Education we will not be teaching or promoting religious activities during normal school hours.

KINDERGARTEN READINESS

I have received a copy of the kindergarten readiness materials.

SUNSCREEN

I give permission to use sunscreen in the event it is needed.

WATER PLAY

I give permission for my child to be involved in water play.

WALKING FIELD TRIPS

I give permission for my child to take walking field trips.

EPI-PEN/RESCUE INHALER

I have provided a plan of care written by my doctor for an Epi-Pen or Rescue inhaler if one is needed.

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 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 DCCECE/DHS programs and criminal prosecution.

I have read and agree to the above statements on this page.
Parent/Guardian Signature: _____ Date: _____

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
Bright Beginnings Preschool	479.427.8110

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

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

Northwest Arkansas Education Service Cooperative
Early Childhood Program
4 N. DOUBLE SPRINGS RD.
FARMINGTON, AR 72730
479-267-5960 FAX: 479-267-5965

SCREENING REQUEST FORM

CHILD'S NAME_____ **M F DOB** _____

SS#_____ **MEDICAID? N Y #**_____

PARENTS NAME_____**SCHOOL DISTRICT:**_____

ADDRESS_____**CITY**_____**ZIP**_____

PHONE_____ **CELL OR EMERGENCY PHONE**_____

LANGUAGE SPOKEN IN HOME?_____ **TRANSLATOR FOR PARENTS? Y N**

PRESCHOOL PROGRAM Bright Beginnings **TEACHER** Debbie Mays **PH#** 479.427.8110

CHILD ENROLLED IN: _____HEAD START ✓ ABC _____ DAYCARE _____ PRESCHOOL _____NONE

I GIVE PERMISSION FOR NORTHWEST ARKANSAS EDUCATION SERVICE COOPERATIVE TO SCREEEN MY CHILD. I GIVE PERMISSION FOR SCREENING, EVALUATION, AND TREATMENT RECORDS TO BE DISCLOSED TO AUTORIZED PERSONNEL OF NWAESC FOR THE PURPOSE OF EVALUATION AND ESTABLISHMENT OF A TREATMENT PROGRAM, IF APPROPRIATE.

PARENT/GUARDIAN SIGNATURE_____**DATE**_____

PARENT COMPLETES TOP PORTION ONLY

****

***TO BE COMPLETED BY SCREENING STAFF*:**

DIAL 4 SCREENING DATE*_____ *CHILD'S SCORE 7% (1.5 SD) CUTOFF

MOTOR	_____	_____	**INTELLIGIBILITY:**
CONCEPTS	_____	_____	
LANGUAGE	_____	_____	_____**GOOD**
SELF-HELP	_____	_____	_____**OK**
SOCIAL	_____	_____	_____**POOR**

OTHER SCREENING INSTRUMENT:_____***SCORES:***_____

HEARING: _____ **PASS FAIL** **VISION:**_____ **PASS FAIL**

BEHAVIOR CONCERNS: N Y * IF YES, EXPLAIN BELOW AND ATTACH ANY DOCUMENTATION

_____

_____

ANY OTHER CONCERNS?_____

PROGRAM DIRECTIONS:
1. **PARENT COMPLETES TOP SECTION**
2. **TEACHER COMPLETES BOTTOM SECTION**
3. **SEND TO CENTRAL OFFICE**
4. **MAIL OR FAX COPY TO 479-267-5965**

**********ECC USE**********

REC'D DATE:_____ RECOMMENDATION: ____PASS _____REFER ____RESCREEN

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Bright Beginnings Preschool to disclose any information necessary from my child's record. I understand that nay subject matter obtained in connection with these services can be disclosed to any agency affiliated with Bright Beginnings requesting such information.

Child's name: _____

Date of Birth: _____ Social Security Number: _____

Phone number: _____

Information to be disclose to:

(Please leave blank)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____
Caregiver Printed Name: _____

Relationship to Child: _____