

Clarinda Community School District Enrollment/ Emergency Form

Student _____ Grade _____ Date of Birth _____ Male/Female _____

Home Phone _____ Address _____ City, State, Zip _____

Family Information:

List Name and Relationship to child:	Address	Home Phone	Cell Phone	Employer	Work Phone	Email address	Has contact with student Yes/No
Parent/Guardian Living with Student:							
Spouse of Parent/Guardian Listed Above:							
AND							
Parent/Guardian Not Living with Student:							
Spouse of Parent/Guardian Listed Above:							

Please Mark if student: is Open Enrolled Y/N in Special Education Y/N in Band Y/N If Y, list instrument _____

Student lives with: Parent(s) _____ Caretaker _____ Legal Guardian _____ Student lives in: Parent home _____ Relatives/Friends home _____ Hotel _____ Other _____

Contact Information (please list LOCAL contacts):

Child Care _____ Child Care Phone _____

Emergency Contact #1 _____ Phone (1) _____ Phone (2) _____

Emergency Contact #2 _____ Phone (1) _____ Phone (2) _____

Emergency Contact #3 _____ Phone (1) _____ Phone (2) _____

For Residents New to Clarinda: What Brought You to Clarinda: _____ Employment _____ Relatives _____ Other - please list _____ (Over)

Ask about texting notifications!

School Medical Registration Form - Health History

Please list a local provider that you prefer in the case of an emergency.

Family Doctor _____ Date of last exam _____ Does student have a current school physical Y/N _____
Dentist _____ Date of last exam _____
Eye Doctor _____ Date of last exam _____

*In the event of an emergency, 911 will be called and your child will be taken to Clarinda Regional Health Center.

List other doctors, specialists, counselors (local or out-of-town): _____

Allergies (list allergy and type of reaction): _____

Medications taken routinely: _____

Will your child take medicine at school: Yes/No _____ If yes, what medication? _____
*Note- All medications given at school must be supplied by the parent in the original container and a medication permit form must be completed and signed by the parent.

- | | | | |
|---|--------|-----------------------|-------------------------------|
| 1. Does your child have health insurance? | Yes/No | Provider Name: _____ | Yes/No |
| 2. Do you have any concerns about your child's general health? (eating, sleeping, weight, etc.) | | | Yes/No |
| 3. Does your child have any chronic illness or medical condition? (seizures, asthma, heart condition, ADHD, etc.) | | | Yes/No |
| 4. Has your child had any serious accidents? (burns, head injury, broken bones, etc.) | | | Yes/No |
| 5. Does your child have any problems with: | | | Yes/No |
| Hearing | Yes/No | Vision | Does your child wear glasses? |
| Speech | Yes/No | Physical Disabilities | Yes/No |

Explain all yes answers in the space provided below:

This form will be added to the students health file and shared with appropriate school staff.

Parent Signature: _____ Date: _____ (Over)

Home Language Survey (2022) - IA – English+12

Date: _____
Student Name: _____ Birth Date: _____ Sex: ☐ Male ☐ Female
Parent/Guardian Name: _____
Address: _____
Phone (H): _____ Phone (W): _____ Phone (C): _____
School: _____ Grade: _____

Note to districts:

- In accordance with federal law and required by Iowa code, districts are required to administer this HLS for all students at the time of enrollment. This form should be completed once, upon enrollment and not each year.
- **To obtain accurate information, schools should reassure parents that the HLS is used solely to offer appropriate educational services, not for determining legal status, for immigration purposes or any other purpose than best serving the student's educational needs.**
- A complete HLS, signed and dated by the parent must be appropriately filed with the other permanent student enrollment documentation.

Home Language Survey Questions for Parents

The state of Iowa values the diversity represented throughout Iowa, home of more than 200 languages. We collect information on the home language survey from *all* students to make decisions to ensure all students receive equitable access to education.

These questions have been approved by the U.S. Department of Education Office for Civil Rights (OCR) and the U.S. Department of Justice (DOJ) and are the required HLS questions for all students enrolling into Iowa's K-12 schools beginning the 2022-23 school year.

Please note: The three required, questions are translated into Iowa's top 12 languages other than English. These translations are required for Iowa's HLS.

English

1. What is the primary language used in the home, regardless of the language spoken by the student?

2. What is the language most often spoken by the student? _____

3. What is the language that the student first acquired? _____

Spanish

1- ¿Cuál es el idioma principal que se usa en la casa, independientemente del idioma que hable el estudiante? _____

2- ¿Cuál es el idioma que el estudiante habla con más frecuencia? _____

3- ¿Cuál es el idioma que el estudiante adquirió por primera vez? _____

Arabic

_____ الطالب؟ بها يتحدث التي اللغة عن النظر بصرف، المنزل في المستخدمة الأساسية اللغة هي ما - 1

_____ الطالب؟ بواسطة تحدثًا اللغات أكثر هي ما - 2

_____ أولاً؟ الطالب اكتسبها التي اللغة هي ما - 3

Vietnamese

1. Ngôn ngữ chính được sử dụng ở nhà, bắt kể ngôn ngữ nói của học sinh là gì? _____

2. Ngôn ngữ nói mà học sinh hay sử dụng nhất là gì? _____

3. Ngôn ngữ mà học sinh tiếp thu đầu tiên là gì? _____

Karen

1 ဂ်ဒိဉ်ထံးကျိဉ်တၢ်စံးကတိၤအီၤလၢဟံဉ် လၢတဘဉ်ထွဲကျိဉ်လၢပုၤကိၤဖိစံးကတိၤအီၤ
မ့ၢ်ကျိဉ်မနုၤလဲဉ် _____

2 ကျိဉ်လၢပုၤကိၤဖိညိန့ၢ်စံးကတိၤအီၤအါကတၢ်မ့ၢ်ကျိဉ်မနုၤလဲဉ် _____

3. ကျိဉ်လၢပုၤကိၤဖိစံးကတိၤအီၤဆိကတိၤမ့ၢ်ကျိဉ်မနုၤလဲဉ် _____

Bosnian

1. Koji je primarni jezik koji se koristi kod kuće, bez obzira na jezik kojim govori učenik?

2. Koji je jezik koji učenik najčešće govori? _____

3. Koji je jezik koji je učenik prvo usvojio? _____

Swahili

1. Ni lugha gani ya msingi inayotumiwa nyumbani, bila kujali lugha inayozungumzwa na mwanafunzi? _____

2. Ni lugha gani inayozungumzwa mara nyingi na mwanafunzi? _____

3. Ni lugha gani ambayo mwanafunzi alijifunza kwanza? _____

Chinese (Mandarin)

1. 不考虑这名学生说的语言，在家主要使用什么语言? _____

2. 这名学生最常说的是什么语言? _____

3. 这名学生首先学会的是什么语言? _____

Burmese

1. ကျောင်းသားက မည်သည့်ဘာသာစကားကို ပြောသည်ဖြစ်စေ အိမ်တွင် မည်သည့်ဘာသာစကားကို အဓိက ပြောဆိုပါသလဲ။ _____

2. ကျောင်းသားက မည်သည့်ဘာသာစကားကို အများဆုံး အသုံးပြု ပြောဆိုပါသလဲ။ _____

3. ကျောင်းသားက မည်သည့် ဘာသာစကားကို ပထမဆုံး လေ့လာသင်ယူခဲ့ပါသလဲ။ _____

French

1. Quelle est la principale langue de communication utilisée à la maison, indépendamment de la langue parlée par l'élève ? _____

2. Quelle est la langue parlée le plus souvent par l'élève ? _____

3. Quelle langue l'élève a-t-il acquise en premier ? _____

Nepali

1. विद्यार्थीले जुन भाषा बोलेतापनि घरमा बोलिने प्राथमिक भाषा कुन हो? _____

2. विद्यार्थीले प्रायः बोल्ने भाषा कुन हो? _____

3. विद्यार्थीले सुरुमा प्राप्त गरेको भाषा कुन हो? _____

Somalian

1. Waa maxay luuqada koowaad ee guriga laga isticmaalo, iyadoon loo eegayn luuqada ay ku hadlaan ardaygu? _____

2. Waa maxay luuqada uu badanka ku hadlo ardaygu? _____

3. Waa maxay luuqada uu ardaygu ugu horayntiiba helay? _____

Marshallese

1. Ta kajin eo kein kajuon kom ej kenono ilo mweo, jekdon ta kajin eo rijikuul eo ej kenono? _____

2. Ta kajin eo elab an rijikuul eo kōjerbale? _____

3. Ta kajin eo rijikuul eo ear jelā mōktata? _____

Additional Required Information

Please answer all of the following questions. Your responses may give us information about your student's knowledge and skills allowing us to better support your child's educational needs. All information collected is needed for district data and funding and is completely unrelated to immigration and citizenship.

Was your child born in the United States? ☐ Yes ☐ No

If yes, in which state? _____

If no, in what other country? _____

2. Has your child attended any school in the United States for *any three years* during their lifetime?

☐ Yes ☐ No

If yes, please provide school name(s), state, and dates attended:

Name of School _____ State _____

Dates Attended _____

Name of School _____ State _____

Dates Attended _____

Right to Translation and Interpretation Services

Your response will help the school provide communication in a language you prefer.

In which language do you prefer to receive written information from school? _____

In which language do you prefer to receive spoken information from school? _____

Have parent/guardian sign and date this document ensuring that the answers within are factual.

Parent Name:	
Parent Signature:	
Interpreter Name (if applicable)	

Student Race and Ethnicity Reporting

Student Name: _____ Date Form Completed: _____

Date of Birth: _____ ☐ Male ☐ Female

Person Completing This Form: ☐ Parent/Guardian ☐ Student ☐ Other: _____

The U.S. Department of Education has implemented new standards for school districts to report student race and ethnicity. Your answers to the following will be held strictly confidential and data will be used only in the aggregate.

1. Is your child of Hispanic, Latino, or Spanish ethnicity: ☐ Yes ☐ No
Includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

If you answered "Yes" to question #1, you may also check one or more of the racial categories in question #2. If you answered "No", please check one or more of the following racial categories.

2. Racial Categories:

- ☐ American Indian or Alaska Native
Origins in any of the original peoples of North, Central, and South America who maintain a tribal affiliation or community attachment.
- ☐ Asian
Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam.
- ☐ Black or African American
Origins in any of the black racial groups of Africa
- ☐ Native Hawaiian or Other Pacific Islander
Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ White
Origins in any of the original peoples of Europe, the Middle East, or North Africa.



IOWA MEP PARENT FORM

School District: _____ Date completed: _____

The answers to this form will help determine if your child (ren) is eligible to receive supplemental services

Name of Parent(s) or Legal Guardian(s): _____

Current Street Address: _____ Apt #: _____

City: State: _____ Zip Code: _____ Phone Number: _____

Best Time to be Contacted: _____

1. Have both parents lived in this town continuously for the past 3 years or more?
YES _____ NO _____

2. If YES you may stop filling out the form, if NO please continue to question 3.

3. Please select any of the following jobs that the family have done in the last 3 years?

- ☐ Tyson, JBS, Monsanto, Smithfield, Seaboard, Pineridge farm, Loffredo
- ☐ Feeding, Taking care of Cows, Goats (Dairy Farm), Milking
- ☐ Planting/ Detasseling- Corn, Soybeans (Monsanto, Syngenta, Stine)
- ☐ Pork, Chicken, Egg, Turkey Farms (Daybreak, Rembrand)
- ☐ Preparing farm fields
- ☐ Other agricultural work activity/Company _____

4. Name of student(s) Name of School Grade:

_____	_____
_____	_____
_____	_____
_____	_____

Disclaimer at bottom of the form-

Please return this form to the school, Note for the school/district: When both "No" to #1 and one or more of the boxes from #3 is/are checked, please give this form to the migrant liaison to scan and email to alex.johnson@iowa.gov. Please file original in student's records. For additional questions regarding this form, please contact Geri McMahon at 515-2813944 (geri.mcmahon@iowa.gov)

MILITARY CONNECTED STATUS

Revised 10/24/13

STUDENT NAME:

CHECK
ONE

- ☐ Neither Parent or Guardian is serving in any military service
- ☐ A Parent or Guardian is serving in the National Guard but is not deployed
- ☐ A Parent or Guardian is serving in the Reserves but is not deployed
- ☐ A Parent or Guardian is serving in the National Guard and is currently deployed
- ☐ A Parent or Guardian is serving in the Reserves and is currently deployed
- ☐ A Parent or Guardian is serving in the military on active duty but is not deployed
- ☐ A Parent or Guardian is serving in the military on active duty and is currently deployed
- ☐ The student's Parent or Guardian died while on active duty within the last year

COMMENTS: _____

State law requires that the school report specific data to the Department of Education. Please indicate whether or not your child attended preschool prior to attending Kindergarten.

____ Yes, my child attended preschool. If yes, please list preschool name: _____

____ No, my child did not attend preschool.

Childs Name: _____ Parent Signature: _____

2023-2024 Clarinda and West Central Community Action Head Start Partnership Application

Applicant/Prenatal									
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID	
Race		Hispanic		English Proficiency		Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little			
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate			
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None			
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient			
Primary Health Coverage		Other Coverage		Insurance #		Medicaid Eligibility		Medicaid #	
						<input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially			
Dental Coverage		Dental Coverage #				Dentist/Dental Home			

Document Used to verify date of birth

Primary Adult									
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID	
Race		Hispanic		English Proficiency		Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little			
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate			
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None			
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient			
Highest Grade Completed		Employment Status		Child's Relationship		Custody		Check all that apply:	
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Biological/Adopted/Step		<input type="checkbox"/> Yes		<input type="checkbox"/> Lives with Family	
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild		<input type="checkbox"/> No		<input type="checkbox"/> Provides Financial Support	
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Other Relative				<input type="checkbox"/> Teen Parent	
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster		<input type="checkbox"/> Poor			
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other _____					
<input type="checkbox"/> Master's									
Email Address: _____									

Secondary or Other Adult									
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID	
Race		Hispanic		English Proficiency		Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little			
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate			
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None			
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient			
Highest Grade Completed		Employment Status		Child's Relationship		Custody		Check all that apply:	
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Biological/Adopted/Step		<input type="checkbox"/> Yes		<input type="checkbox"/> Lives with Family	
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild		<input type="checkbox"/> No		<input type="checkbox"/> Provides Financial Support	
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Other Relative				<input type="checkbox"/> Teen Parent	
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster		<input type="checkbox"/> Poor			
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other _____					
<input type="checkbox"/> Master's									
Email Address: _____									

2 nd Applicant applying for services									
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID	
Race		Hispanic		English Proficiency		Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little			
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate			
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None			
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient			
Primary Health Coverage		Other Coverage		Insurance #		Medicaid Eligibility		Medicaid #	
						<input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially			
Dental Coverage		Dental Coverage #				Dentist/Dental Home			

Document used to verify date of birth

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix x	Nickname	Birthday	Gender	SSN
<div> <div> Race <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other: </div> <div> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial </div> <div> Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div> English Proficiency <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient </div> <div> Other Language </div> <div> Other Language Proficiency <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient </div> </div>							

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix x	Nickname	Birthday	Gender	SSN
<div> <div> Race <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other: </div> <div> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial </div> <div> Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div> English Proficiency <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient </div> <div> Other Language </div> <div> Other Language Proficiency <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient </div> </div>							

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix x	Nickname	Birthday	Gender	SSN
<div> <div> Race <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other: </div> <div> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial </div> <div> Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div> English Proficiency <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient </div> <div> Other Language </div> <div> Other Language Proficiency <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient </div> </div>							

Family Information, Income & Contacts

Family Information

Family Living Address									
Started Living at Date	Living Address	Address Line 2	ZIP	City	State	County			
<div> <div> Family Mailing Address Same as living? <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div> Started Using Date </div> <div> Mailing Address </div> <div> Address Line 2 </div> <div> ZIP </div> <div> City </div> <div> State </div> </div>									
Phone Number(s)		Type (check one)		Note (extension or best time to call)		Opt in for Text Messages			
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other				<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other				<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Parental Status (check one)	Primary Language at Home	Relationship to Participant(s)	Acquired/learning another language in addition to English	Homeless Family	Active Duty Military	Military Veteran	Referred by Child Welfare Agency	Receiving SNAP	WIC
<input type="checkbox"/> One <input type="checkbox"/> Two			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family Income

Income Verified by		Verification Date		TANF Status		SSI
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly on TANF/Not now		<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Member	Amount	Per (for example: week, month, year)	Annual Amount	Description (for example: SSI, Job, Child Support)	Verification (for example: W2, check stub)	Note
	\$		\$			
	\$		\$			
	\$		\$			

Income Notes

Eligibility Verification

Child eligible to	Total number in family	Type of eligibility interview	Income Status	Documentation used for verification: Circle all that apply	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> In-person <input type="checkbox"/> Telephone <input type="checkbox"/> Online	<input type="checkbox"/> Over Income <input type="checkbox"/> Public Assistance <input type="checkbox"/> Eligible (Below 100%) <input type="checkbox"/> Foster child <input type="checkbox"/> Homeless 101%-130%	<input type="checkbox"/> Tax Return <input type="checkbox"/> W-2 <input type="checkbox"/> FIP Documentation <input type="checkbox"/> Pay stub or pay envelopes <input type="checkbox"/> Education Grants/Awards Information confirmed by phone	<input type="checkbox"/> Unemployment <input type="checkbox"/> Written statements from employers <input type="checkbox"/> Foster care reimbursement <input type="checkbox"/> SSI Documentation <input type="checkbox"/> Child Support <input type="checkbox"/> Housing Questionnaire <input type="checkbox"/> Self-Declaration <input type="checkbox"/> SNAP Card/Notice of Decision Other _____
Enter Annual Income	Documentation of No Income (Write a detailed statement how the family met basic needs) Use additional paper if needed. Attach the Self-Declaration Form				
Income received and documentation is not available Write a clear explanation for the reasons documents cannot be provided					

Additional Family Information for Consideration

Moved once in the past year? Moved 2 or more times in the past year? Can you provide transportation to and from school for your child(ren)? Are there any custody issues we need to be aware of? Please explain (e.g. Dual/shared custody, no contact order, etc.) Please provide a copy of the court order	Circle One YES NO YES NO YES NO	Does your child have any special needs we need to be aware of? Currently is your child on? Has your immediate family experienced any of the following; Circle all that apply	Circle One YES NO IFSP IEP YES NO
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> Terminal Illness High Risk Pregnancy (EHS Home based Only) Death of Parent/Guardian/Sibling Abuse (Physical, Emotional, Neglect) Neglect (Physical, Emotional) Mental Illness Divorce Alcohol/Substance Misuse Incarceration </div> <div style="width: 35%;"></div> </div>			

How did you hear about the WCCA Head Start program? Parent Flyer Post Card Newspaper Social Media Agency School

Other: _____

Please note: Your child's application will NOT be processed until all required income documents are received and processed.

Certification: I certify that the information I provided in person, by telephone or electronically is true and correct to the best of my knowledge. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency.

Parent/Guardian Signature _____

Date _____

Staff Signature _____

Date _____



HEAD START/EARLY HEAD START Child Health & Nutrition Questionnaire (13 months-5 years)

Child's Name: _____ Date of Birth: _____

Center: _____

I give permission for the Health & Nutrition Questionnaire to be reviewed by a licensed dietician for the purpose of providing and sharing nutritional recommendations as applicable for my child with me.

Parent/Guardian Signature: _____ Date: _____

Well Child Questions

Is your child current with well-child exams? Yes No Date of last physical exam: _____

Does your child have a diagnosed medical health condition? Yes No

Diagnosis: _____

Do you have any health concerns regarding your child? _____

Doctor(s) your child sees and reason: _____

Does your child currently wear glasses: Yes No Date of last eye exam: _____

Eye Doctor: _____

Eye Problems: _____

Does your child have an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)? Yes No

Does your child take prescribed medicine? Yes No Name: _____

Will your child be required to take this medicine at school? Yes No How often: _____

Does your child take a multi-vitamin or mineral? Yes No Tablet or Gummy

Does your child brush his or her teeth?		Yes	No	Independently	or	With Support
How many times a day?		None	Once	Twice	Three	
Dentist: _____		Date of last dental exam: _____				
Concerns? _____		Is treatment needed?		Yes	No	
What does your child drink from?		Regular Cup	Sippy Cup	Bottle		
Is this bottle/sippy cup taken to bed?		Yes	No			

Does your child have any difficulty with toileting? _____	
Does your child use diapers or pull-ups? Yes No	

Nutrition Questions							
Does your child drink milk?		Yes	No	Type: Whole/Vitamin D	2%	1%	Fat-Free
Soy	Almond	Lactaid	Other: _____		How much daily?		

Does your child have any food allergies?		Yes	No	List: _____
What are your child's favorite foods or beverages? Example: milk, juice, chicken nuggets, soda/pop, veggies/fruit etc.				
Are there any new foods you would like to see your child eat more or less of?				
Is there anything you would like to see different about your child's eating?				
Is there any difficulties in your child eating? Example: allergies, patterns, frequency, refusal etc.				

What are mealtimes like? Examples-environment, tone of mealtime, where, with whom, etc?	
---	--

Home Environment	
How many hours is your child on computer, Cellular Phone, IPAD, Tablet or watch TV daily?	
Does anyone in the home or vehicle smoke or vape? Yes No	

Child's Name _____

Center _____

What type of activities does your child enjoy?

Does your child live currently live in or visit a home built before 1960? Yes No

Is there peeling or chipping paint or remodeling of this home? Yes No

Does your child eat dirt or candy from Mexico? Yes No

Does a sibling or playmate have a high lead level >15 ug/dl? Yes No

Does your child have frequent contact with an adult that works with lead or do you live near a battery manufacturing or recycling plant or lead smelter? Yes No

Do you give your child any home or folk remedies? Yes No

Has your child lived in Mexico, Central or South America, Africa, Asia, Eastern Europe or visited one of these countries for longer than 2 months? Yes No

If yes or you don't know to any of these questions request a blood test at your child's next exam if it has been a year since your child last had a blood lead test. ALL children in Iowa must have at least one blood lead test before entering kindergarten.



PERMISSION FOR PROGRAM ACTIVITIES SCHOOL PARTNER

Child's Name _____ Classroom: _____

Your child's school partners with staff from the West Central Community Action Head Start program to assist in keeping children current with health and developmental screenings. These screenings are provided in the child's classroom at no cost to you.

As the parent/guardian of the above child, I give permission to West Central Community Action Head Start to provide the following services for my child to participate in the activity stated below. I understand that by circling the "Yes" answer, permission is granted for that specific service to be completed. By circling the "No" answer, permission has NOT been granted.

I give permission for my child to have growth (height and weight measurements), blood pressure, vision and hearing screens completed by Head Start staff. Public Health requirements will be followed reporting any otoacoustic emissions (OAE) screens to the state representative.

Yes or No

I give permission for my child to have, speech, developmental, social/emotional, behavior and mental health screens and/or observations as needed by qualified specialists and/or Head Start staff. This may include individual, group or pull out session and share necessary information with each other as needed. (Essex Community School Only)

Yes or No or NA

Valid through _____ school year.

Parent Signature: _____ Date: _____

Clarinda Public Schools and West Central Community Action Head Start
Partnership Application

Documentation that can be used for Preschool Partnership Application Verification

2022 Tax Return Line 9

2022 W-2 Box 1

FIP Documentation (Last 12 months or the 2022 year) or a Notice of Decision Letter

Social Security Disability or Death Benefits (Last 12 months or the 2022 year) or a Notice of Decision

Pay stub or pay envelopes (Last 12 months)

Education Grants/Awards (Last 12 months)

Unemployment (from when unemployment begun to present)

Written statements from employers (last 12 months)

Foster care reimbursement or Letter from DHS Social Worker stating child in Foster Care

SSI Documentation (Last 12 months or 2022 year) or Notice of Decision Letter

Child Support (Last 12 months or 2022 year)

Other _____



Ages & Stages Questionnaires®

48 Month Questionnaire

45 months 0 days through 50 months 30 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____



Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender:

☐ Male ☐ Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child:

☐ Parent ☐ Guardian ☐ Teacher ☐ Child care provider
☐ Grandparent or other relative ☐ Foster parent ☐ Other: _____

Street address: _____

City: _____ State/Province: _____ ZIP/Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____



48 Month Questionnaire

45 months 0 days
through 50 months 30 days

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☒ Try each activity with your child before marking a response.
- ☒ Make completing this questionnaire a game that is fun for you and your child.
- ☒ Make sure your child is rested and fed.
- ☒ Please return this questionnaire by _____.

Notes:

COMMUNICATION

1. Does your child name at least three items from a common category? For example, if you say to your child, "Tell me some things that you can eat," does your child answer with something like "cookies, eggs, and cereal"? Or if you say, "Tell me the names of some animals," does your child answer with something like "cow, dog, and elephant"?

YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

2. Does your child answer the following questions? (Mark "sometimes" if your child answers only one question.)

YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

"What do you do when you are hungry?" (Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.") Please write your child's response:

"What do you do when you are tired?" (Acceptable answers include "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.") Please write your child's response:

3. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does she say something like, "It's round. I throw it. It's big"?

YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

4. Does your child use endings of words, such as "-s," "-ed," and "-ing"? For example, does your child say things like, "I see two cats," "I am playing," or "I kicked the ball"?

YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

COMMUNICATION

(continued)

5. Without your giving help by pointing or repeating, does your child follow three directions that are *unrelated* to one another? Give all three directions before your child starts. For example, you may ask your child, "Clap your hands, walk to the door, and sit down," or "Give me the pen, open the book, and stand up."
6. Does your child use all of the words in a sentence (for example, "a," "the," "am," "is," and "are") to make complete sentences, such as "I am going to the park," or "Is there a toy to play with?" or "Are you coming, too?"

YES

SOMETIMES

NOT YET

☐☐☐

—

☐☐☐

—

COMMUNICATION TOTAL

—

GROSS MOTOR

YES

SOMETIMES

NOT YET

1. Does your child catch a large ball with both hands? (You should stand about 5 feet away and give your child two or three tries before you mark the answer.)

☐☐☐

—

2. Does your child climb the rungs of a ladder of a playground slide and slide down without help?

☐☐☐

—

3. While standing, does your child throw a ball *overhand* in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. (Dropping the ball or throwing the ball underhand should be scored as "not yet.")

☐☐☐

—

4. Does your child hop up and down on either the right or left foot at least one time without losing her balance or falling?

☐☐☐

—

5. Does your child jump forward a distance of 20 inches from a standing position, starting with his feet together?

☐☐☐

—

6. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? (You may give your child two or three tries before you mark the answer.)

☐☐☐

—

GROSS MOTOR TOTAL

—

FINE MOTOR

YES

SOMETIMES

NOT YET

1. Does your child put together a five- to seven-piece interlocking puzzle? (If one is not available, take a full-page picture from a magazine or catalog and cut it into six pieces. Does your child put it back together correctly?)

☐☐☐

—

FINE MOTOR (continued)

2. Using child-safe scissors, does your child cut a paper in half on a more or less straight line, making the blades go up and down? (Carefully watch your child's use of scissors for safety reasons.)



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

3. Using the shapes below to look at, does your child copy at least three shapes onto a large piece of paper using a pencil, crayon, or pen, without tracing? (Your child's drawings should look similar to the design of the shapes below, but they may be different in size.)



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
-----------------------	-----------------------	-----------------------	---

4. Does your child unbutton one or more buttons? (Your child may use his own clothing or a doll's clothing.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
-----------------------	-----------------------	-----------------------	---

5. Does your child draw pictures of people that have at least three of the following features: head, eyes, nose, mouth, neck, hair, trunk, arms, hands, legs, or feet?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
-----------------------	-----------------------	-----------------------	---

6. Does your child color mostly within the lines in a coloring book or within the lines of a 2-inch circle that you draw? (Your child should not go more than 1/4 inch outside the lines on most of the picture.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
-----------------------	-----------------------	-----------------------	---

FINE MOTOR TOTAL —

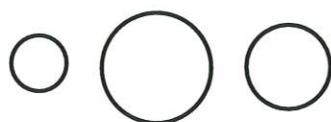
PROBLEM SOLVING

1. When you say, "Say 'five eight three,'" does your child repeat just the three numbers in the same order? Do not repeat the numbers. If necessary, try another series of numbers and say, "Say 'six nine two.'" (Your child must repeat just one series of three numbers to answer "yes" to this question.)

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

2. When asked, "Which circle is the smallest?" does your child point to the smallest circle? (Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
-----------------------	-----------------------	-----------------------	---



3. Without your giving help by pointing, does your child follow three different directions using the words "under," "between," and "middle"? For example, ask your child to put the shoe "under the couch." Then ask her to put the ball "between the chairs" and the book "in the middle of the table."

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
-----------------------	-----------------------	-----------------------	---

4. When shown objects and asked, "What color is this?" does your child name five different colors, like red, blue, yellow, orange, black, white, or pink? (Mark "yes" only if your child answers the question correctly using five colors.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
-----------------------	-----------------------	-----------------------	---

PROBLEM SOLVING (continued)

5. Does your child dress up and "play-act," pretending to be someone or something else? For example, your child may dress up in different clothes and pretend to be a mommy, daddy, brother, or sister, or an imaginary animal or figure.
6. If you place five objects in front of your child, can he count them by saying, "one, two, three, four, five," in order? (Ask this question without providing help by pointing, gesturing, or naming.)

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PROBLEM SOLVING TOTAL —

PERSONAL-SOCIAL

1. Does your child serve herself, taking food from one container to another using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl?
2. Does your child tell you at least four of the following? Please mark the items your child knows.
- ☐ a. First name ☐ d. Last name
- ☐ b. Age ☐ e. Boy or girl
- ☐ c. City she lives in ☐ f. Telephone number
3. Does your child wash his hands using soap and water and dry off with a towel without help?
4. Does your child tell you the names of two or more playmates, not including brothers and sisters? (Ask this question without providing help by suggesting names of playmates or friends.)
5. Does your child brush her teeth by putting toothpaste on the toothbrush and brushing all of her teeth without help? (You may still need to check and rebrush your child's teeth.)
6. Does your child dress or undress himself without help (except for snaps, buttons, and zippers)?

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

PERSONAL-SOCIAL TOTAL —

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain:

☐ YES ☐ NO

OVERALL (continued)

2. Do you think your child talks like other children her age? If no, explain:

☐ YES☐ NO

3. Can you understand most of what your child says? If no, explain:

☐ YES☐ NO

4. Can other people understand most of what your child says? If no, explain:

☐ YES☐ NO

5. Do you think your child walks, runs, and climbs like other children his age?
If no, explain:

☐ YES☐ NO

6. Does either parent have a family history of childhood deafness or hearing
impairment? If yes, explain:

☐ YES☐ NO

7. Do you have any concerns about your child's vision? If yes, explain:

☐ YES☐ NO

OVERALL (continued)

8. Has your child had any medical problems in the last several months? If yes, explain:

☐ YES

☐ NO

9. Do you have any concerns about your child's behavior? If yes, explain:

☐ YES

☐ NO

10. Does anything about your child worry you? If yes, explain:

☐ YES

☐ NO



48 Month ASQ-3 Information Summary

45 months 0 days through
50 months 30 days

Child's name: _____ Date ASQ completed: _____
Child's ID #: _____ Date of birth: _____
Administering program/provider: _____

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.


Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	30.72		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	32.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	15.81		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	31.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	26.60		●	●	●	●	●	●	○	○	○	○	○	○	○


2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | | | |
|---|-----|-----------|---|------------|----|
| 1. Hears well?
Comments: | Yes | NO | 6. Family history of hearing impairment?
Comments: | YES | No |
| 2. Talks like other children his age?
Comments: | Yes | NO | 7. Concerns about vision?
Comments: | YES | No |
| 3. Understand most of what your child says?
Comments: | Yes | NO | 8. Any medical problems?
Comments: | YES | No |
| 4. Others understand most of what your child says?
Comments: | Yes | NO | 9. Concerns about behavior?
Comments: | YES | No |
| 5. Walks, runs, and climbs like other children?
Comments: | Yes | NO | 10. Other concerns?
Comments: | YES | No |

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the  area, it is above the cutoff, and the child's development appears to be on schedule.

If the child's total score is in the  area, it is close to the cutoff. Provide learning activities and monitor.

If the child's total score is in the  area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

- _____ Provide activities and rescreen in _____ months.
_____ Share results with primary health care provider.
_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
_____ Refer to primary health care provider or other community agency (specify reason): _____
_____ Refer to early intervention/early childhood special education.
_____ No further action taken at this time
_____ Other (specify): _____

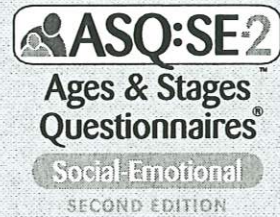
5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						



48 Month Questionnaire

42 months 0 days through 53 months 30 days



Date ASQ:SE-2 completed: _____

Child's information

Child's first name: _____ Child's middle initial: _____ Child's last name: _____

Child's date of birth: _____

Child's gender: ☐ Male ☐ Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____

City: _____ State/province: _____ ZIP/postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Relationship to child: ☐ Parent ☐ Guardian ☐ Teacher ☐ Other: _____
☐ Grandparent/other relative ☐ Foster parent ☐ Child care provider

People assisting in questionnaire completion: _____

Program information

(For program use only.)

Child's ID #:	Age at administration in months and days:
Program ID #:	
Program name:	

48 Month Questionnaire 42 months 0 days through 53 months 30 days



Questions about behaviors children may have are listed on the following pages. Please read each question carefully and check the box ☒ that best describes your child's behavior. Also, check the circle ☒ if the behavior is a concern.

Important Points to Remember:

- ☐ Answer questions based on what you know about your child's behavior.
- ☐ Answer questions based on your child's *usual* behavior, not behavior when your child is sick, very tired, or hungry.
- ☐ Caregivers who know the child well and spend more than 15–20 hours per week with the child should complete ASQ:SE-2.
- ☐ Please return this questionnaire by: _____
- ☐ If you have any questions or concerns about your child or about this questionnaire, contact: _____
- ☐ Thank you and please look forward to filling out another ASQ:SE-2 in _____ months.


	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
1. Does your child look at you when you talk to him?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
2. Does your child cling to you more than you expect?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
3. Does your child talk or play with adults she knows well?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
4. When upset, can your child calm down within 15 minutes?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
5. Does your child like to be hugged or cuddled?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
6. Does your child seem too friendly with strangers?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
7. Does your child settle himself down after exciting activities?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
8. Does your child cry, scream, or have tantrums for long periods of time?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE _____

48 Month Questionnaire



Check the box ☒ that best describes your child's behavior. Also, check the circle ☒ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
9. Is your child interested in things around her, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
					
10. Does your child stay dry during the day?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
11. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____


12. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
13. Does your child do what you ask her to do?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
14. Does your child seem happy?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
15. Does your child sleep at least 8 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
16. Does your child seem more active than other children his age?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
17. Does your child use words to tell you what she wants or needs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
18. Does your child stay with activities he enjoys for at least 10 minutes (other than watching shows or videos, or playing with electronics)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
19. Does your child use words to describe her feelings and the feelings of others? For example, does she say, "I'm happy," "I don't like that," or "She's sad?"	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE _____

48 Month Questionnaire



Check the box ☒ that best describes your child's behavior. Also, check the circle ☒ if the behavior is a concern.


	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
20. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
21. Does your child explore new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
22. Does your child do things over and over and get upset when you try to stop him? For example, does he rock, flap his hands, spin, or _____? (Please describe.) _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
23. Does your child hurt herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
24. Does your child follow rules at home or at child care?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
25. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
26. Does your child stay away from dangerous things, such as fire and moving cars?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
27. Can your child name a friend?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
28. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt? 	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
29. Do other children like to play with your child?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE _____

48 Month Questionnaire



Check the box ☒ that best describes your child's behavior. Also, check the circle ☒ if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
30. Does <i>your child</i> like to play with other children? 	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
31. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
32. Does your child show an unusual interest in or knowledge of sexual language and activity?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
33. Does your child wake three or more times during the night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
34. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
35. Does your child have simple back-and-forth conversations with you? For example, Parent: "It's raining!" Child: "And cold outside." Parent: "Let's get your coat." Child: "I got it!"	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
36. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE _____

OVERALL Use the space below for additional comments.

37. Do you have concerns about your child's eating, sleeping, or toileting habits?
If yes, please explain:

☐ YES ☐ NO

38. Does anything about your child worry you? If yes, please explain:

☐ YES ☐ NO

39. What do you enjoy about your child?

48 Month Information Summary 42 months 0 days through 53 months 30 days



Child's name: _____ Date ASQ:SE-2 completed: _____
 Child's ID #: _____ Child's date of birth: _____
 Person who completed ASQ:SE-2: _____ Child's age in months and days: _____
 Administering program/provider: _____ Child's gender: ☐ Male ☐ Female

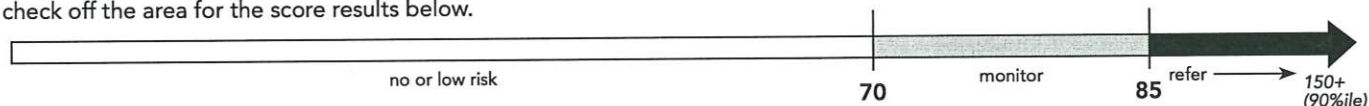
1. ASQ:SE-2 SCORING CHART:

- Score items (Z = 0, V = 5, X = 10, Concern = 5).
- Transfer the page totals and add them for the total score.
- Record the child's total score next to the cutoff.

TOTAL POINTS ON PAGE 1	
TOTAL POINTS ON PAGE 2	
TOTAL POINTS ON PAGE 3	
TOTAL POINTS ON PAGE 4	
Total score	

Cutoff	Total score
85	

2. ASQ:SE-2 SCORE INTERPRETATION: Review the approximate location of the child's total score on the scoring graphic. Then, check off the area for the score results below.



- ___ The child's total score is in the ☐ area. It is below the cutoff. Social-emotional development appears to be on schedule.
 ___ The child's total score is in the ☐ area. It is close to the cutoff. Review behaviors of concern and monitor.
 ___ The child's total score is in the ☐ area. It is above the cutoff. Further assessment with a professional may be needed.

3. OVERALL RESPONSES AND CONCERNS: Record responses and transfer parent/caregiver comments. YES responses require follow-up.

1-36. Any Concerns marked on scored items? **YES** no Comments: _____

37. Eating/sleeping/toileting concerns? **YES** no Comments: _____

38. Other worries? **YES** no Comments: _____

4. FOLLOW-UP REFERRAL CONSIDERATIONS: Mark all as Yes, No, or Unsure (Y, N, U). See pages 98-103 in the ASQ:SE-2 User's Guide:

- ___ **Setting/time factors** (e.g., Is the child's behavior the same at home as at school?)
 ___ **Developmental factors** (e.g., Is the child's behavior related to a developmental stage or delay?)
 ___ **Health factors** (e.g., Is the child's behavior related to health or biological factors?)
 ___ **Family/cultural factors** (e.g., Is the child's behavior acceptable given the child's cultural or family context? Have there been any stressful events in the child's life recently?)
 ___ **Parent concerns** (e.g., Did the parent/caregiver express any concerns about the child's behavior?)

5. FOLLOW-UP ACTION: Check all that apply.

- ___ Provide activities and rescreen in _____ months.
 ___ Share results with primary health care provider.
 ___ Provide parent education materials.
 ___ Provide information about available parenting classes or support groups.
 ___ Have another caregiver complete ASQ:SE-2. List caregiver here (e.g., grandparent, teacher): _____
 ___ Administer developmental screening (e.g., ASQ-3).
 ___ Refer to early intervention/early childhood special education.
 ___ Refer for social-emotional, behavioral, or mental health evaluation.
 ___ Other: _____