Clarinda Community School District
Enrollment/ Emergency Form

Student Name: First_____ **Middle**_____ **Last**_____ **Date of Birth:**_____
Grade:_____ **Male/Female:**_____
Home Phone_____ **Address**_____ **City/State/Zip**_____

Family Information:

List name and relationship to student	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 __Relative/Friend Home __Hotel __ Other
New Residents of Clarinda: What brought you to Clarinda? __Employment __Relatives __Other:_____

Emergency Contact Information

Contact Information (please list LOCAL contacts only)

Child Care_____ Phone_____

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

Siblings in the District:

Name:_____Grade Level:_____

Name:_____Grade Level:_____

Name:_____Grade Level:_____

Student Dismissal

How will your Child be dismissed from school?

___Picked Up
___Rural Bus
___Walk

___Shuttle Bus To:
__McKinley
__High School
__Lied Center
__Lutheran School

School Medical Registration Form- Health History

Student Name:_____ Parent Name and Phone Number:_____

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 all 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: Y/N If yes, what medication?_____

***Note- All medications given at school must be supplied by the parent in the original container and a medication permission form must be completed and signed by the parent.**

1. Does your child have health insurance? Y/N Provider Name:_____
2. Do you have any concerns about your child's general health? (eating, sleeping,weight, etc.) Y/N
3. Does your child have any chronic illnesses or medical conditions? (seizures, asthma, heart condition, ADHD, etc.) Y/N
4. Has your child had any serious accidents? (burns, head/injury, broken bones, etc.) Y/N
5. Does your child have any problems with:
   Hearing Y/N Vision Y/N Does your child wear glasses Y/N
   Speech Y/N Physical Disabilities Y/N

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:**_____

Student Name: _____ Birth Date: _____ Sex: ☐ M ☐ F

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ Phone (W): _____ Phone (C): _____

School: _____ Grade: _____

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

If yes, in which state? _____

If not, in what other country? _____

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 _____

Name of School _____ State _____ Dates Attended _____

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

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

Home Language Survey Questions

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? _____

_____ _____

Parent/Guardian Signature Date

Nombre del/de la alumno(a): _____ Fecha de nacimiento: _____ Sexo: ☐ M ☐ F

Nombre del padre/madre/tutor: _____

Dirección: _____

Teléfono (casa): _____ Teléfono (trabajo): _____ Teléfono (celular): _____

Escuela: _____ Grado: _____

¿Nació su hijo(a) en los Estados Unidos? ☐ Sí ☐ No

Si la respuesta es "sí", ¿en qué estado? _____

Si la respuesta es "no", ¿en qué país? _____

¿Asistió su hijo(a) a alguna escuela en los Estados Unidos durante tres años a lo largo de su vida? ☐ Sí ☐ No

Si la respuesta es "sí", dé el nombre de la escuela/las escuelas, el estado y las fechas de asistencia:

Nombre de la escuela _____ Estado _____ Fechas de asistencia _____

Nombre de la escuela _____ Estado _____ Fechas de asistencia _____

Nombre de la escuela _____ Estado _____ Fechas de asistencia _____

¿En qué idioma prefiere recibir información escrita de la escuela? _____

¿En qué idioma prefiere recibir información oral de la escuela? _____

Preguntas de la encuesta sobre la lengua materna

1. ¿Cuál es el idioma principal que se usa en su casa, independientemente del idioma que hable el/la alumno(a)? _____
2. ¿Cuál es el idioma que habla con más frecuencia el/la alumno(a)? _____
3. ¿Cuál es el idioma que el/la alumno(a) adquirió por primera vez? _____

_____ Firma del padre/madre/tutor

_____ Fecha

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.

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: _____

IOWA
MIGRATORY
EDUCATION
PROGRAM

Revision Date: September 8, 2023

Parent Form

School District: _____ **Date Completed:** _____

Your children may be eligible to receive supplemental services, depending on the answers to this form.

General Information

Name of Parent(s) or 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 longer? ___YES ___NO
   If YES, please stop completing the form. If NO, please continue.

2. Please select any of the following jobs that the family has done in the last 3 years:
   ___Slaughter, processing, meat locker (beef, poultry, pork) Tyson, JBS, Monsanto, Smithfield, Seaboard
   ___Feeding, milking, taking care of cows or goats (dairy farms)
   ___Planting or detasseling corn, soybeans, fruits, vegetables, nurseries, or greenhouses
   ___Hog farms, chicken farms, eggs, or turkey farms
   ___Preparing farm fields
   ___Other agricultural work. What was the activity or company? _____

Children's Information

Name of Child	Name of School	Grade

Please return this form to the school.

ATTN: School district migratory liaison, please scan and email completed forms to alex.johnson@iowa.gov before filing the original copy in the student's records. Please contact Rachel Pettigrew, Migratory Education Program Consultant, with any questions regarding this form: rachel.pettigrew@iowa.gov or 515-380-5115.

IOWA
MIGRATORY
EDUCATION
PROGRAM

Revision Date: September 8, 2023

Formulario Para Padres

Distrito Escolar: _____ **Fecha:** _____

Sus hijos pueden ser elegibles para recibir servicios suplementarios, dependiendo de sus respuestas.

Información General

Nombres de los padres o tutores: _____

Dirección actual: _____ Número de apartamento: _____

Ciudad: _____ Estado: _____ Código postal: _____ Número de teléfono: _____

Mejor horario para ser contactado: _____

1. ¿Ambos padres han vivido en esta ciudad continuamente durante los últimos 3 años? SÍ NO
   Si marcó SÍ, puede dejar de completer el formulario. Si marcó NO, por favor continúe.

2. Seleccione cualquiera de los siguentes trabajos que la familia ha realizado en los últimos 3 años:
   ___ Matanza o procesamiento de animales/carnes (res, aves, cerdo) Tyson, JBS, Monsanto, Seabpard
   ___ Alimentación, ordeño, cuidado de vacas, cabras (granja lechera)
   ___ Siembra o desespiga maíz, soja, frutas, hortalizas, viveros, invernaderos
   ___ Granjas de cerdos, granjas de pollos, huevos, granjas de pavos
   ___ Preparación de campos de cultivo
   ___ Otra actividad laboral agrícola/Empresa_____

Información Infantil

Nombre del Niño	Nombre de Escuela	Grado

Por favor devuelva este formulario a la escuela.

ATTN: School district migratory liaison, please scan and email completed forms to alex.johnson@iowa.gov before filing the original copy in the student's records. Please contact Rachel Pettigrew, Migratory Education Program Consultant, with any questions regarding this form: rachel.pettigrew@iowa.gov or 515-380-5115.

Community Schools and West Central Community Action Head Start
Partnership Application

Documentation that can be used for Preschool Partnership Application Verification

2024 Tax Return

2024 W-2

FIP Documentation (Notice of Decision)

SNAP Benefits (Copy of SNAP Card or 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 2024 year)

Child Support (Last 12 months or 2024 year)

Self Declaration

Housing Questionnaire

Other_____

Clarinda
Community School District
423 East Nodaway St.
Clarinda, Iowa 51632
7-12 Building 712-542-5167 Central Office: 712-542-5165 PK-6 Building: 712-542-4510

To Parents & Guardians:

At Clarinda Community School District, we use Google Workspace for Education, and we are seeking your permission to provide and manage a Google Workspace for Education account for your child. Google Workspace for Education is a set of education productivity tools from Google including Gmail, Calendar, Docs, Classroom and more used by tens of millions of students and teachers around the world. At Clarinda Community School District, students will use their Google Workspace for Education accounts to complete assignments, communicate with their teachers, and learn 21st century digital citizenship skills.

Answers to common questions can be found at https://workspace.google.com/terms/education_privacy/. CCSD may authorize third party apps to access Google information for educational purposes.

Please review it carefully and then sign below to indicate that you've read the notice and give your consent. If you don't provide your consent, we will not create (or disable) a Google Workspace for Education account for your child.

I give permission for Clarinda Community School District to create/maintain a Google Workspace for education account for my child. I consent for Google to collect, use and disclose information about my child solely for the purposes in this link: https://workspace.google.com/terms/education_privacy/.

Thank you,
Clarinda Community School District

Full name of student: _____

Signature of parent/guardian: _____

Printed name of parent/guardian: _____ Date: _____

Preschool

Student Name: _____

Health Requirements

Please use the checklist below to ensure you have all the paperwork required for students entering Preschool. Please initial one option under each requirement and return all forms and supporting documentation together. **Immunizations are due prior to the start of school.** Please contact the school nurse with any questions. Thank you.

Amy Steeve, BSN, RN, School Nurse
Phone: 712-542-4510 Fax: 712-542-3802
asteeve@clarindacsd.org

Current Physical or Student Health History Form: *Please contact the nurse if your child has food allergies, medications to be given at school, or health conditions requiring extra attention such as asthma, seizures, etc.*

_____ Current Physical Form (within past 12 months) **and** Student Health History Form (online registration)
OR
_____Will have doctor's office fax physical form or recent office note

Immunizations: Iowa law requires specific vaccinations prior to preschool entrance. Please contact your provider to ensure immunizations are up to date. If you do not receive immunizations, you must have an Exemption Form filled out.

_____Certificate of Immunization – signed copy from doctor's office
OR
_____Certificate of Exemption – religious exemption signed by parent, medical exemption must be signed by a physician

Dental Exam: Any screening done after age 3 is considered valid. I-Smile will do a dental screening exam during the school year but a consent form must be signed and returned prior to the screening. The I-Smile screening does not include dental cleaning, it is only a visual screening exam.

_____Certificate of Dental Exam – completed by dentist (located on CCSD website)
OR
_____ Will participate in school I-Smile dental exam

Vision Exam: A vision screening is recommended before the start of school by an eye doctor or healthcare provider. If you are screened by an eye doctor or a family physician, have them fill out the Certificate of Vision Screening. Our local Lions Club will provide a FREE screening during the school year if a consent is signed.

_____Certificate of Vision Screening – completed by eye doctor or family doctor (located on CCSD website)
OR
_____Will Participate in Lions Club screening

Nursing Services provided by: Clarinda Regional Health Center

Partnership Application

Applicant – Child's Name

First	Middle	Last	Birthday	Gender

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Primary Health Coverage	Other Coverage	Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home
			☐ Not Eligible ☐ On Medicaid ☐ Potentially		

Dental Coverage	Dental Coverage #	Dentist/Dental Home

Primary Adult

First	Middle	Last	Birthday	Gender

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's ☐ Bachelor's ☐ Col Deg/Train ☐ Col or Adv Train ☐ GED	☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ < Grade 9 ☐ HS Graduate ☐ Master's	☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed	☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled	☐ Biological/Adopted/Step ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other_____	☐ Yes ☐ No	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent

Email Address:

Secondary or Other Adult

First	Middle	Last	Birthday	Gender

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's ☐ Bachelor's ☐ Col Deg/Train ☐ Col or Adv Train ☐ GED	☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ < Grade 9 ☐ HS Graduate ☐ Master's	☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed	☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled	☐ Biological/Adopted/Step ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other _____	☐ Yes ☐ No	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent

Email Address:

Additional Child

Are you interested in this child receiving Head Start or Early Head Start Services?
☐ **Yes**
☐ **No**

First	Middle	Last	Birthday	Gender

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

☐ Yes
☐ No

First	Middle	Last	Birthday	Gender

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: _____			☐ Proficient		☐ Proficient

Additional Child **Are you interested in this child receiving Head Start or Early Head Start Service**
☐ Yes
☐ No

First	Middle	Last	Birthday	Gender

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: _____			☐ Proficient		☐ Proficient

Additional Child **Are you interested in this child receiving Head Start or Early Head Start Service**
☐ Yes
☐ No

First	Middle	Last	Birthday	Gender

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: _____			☐ Proficient		☐ Proficient

Family Information, Income & Contacts

Family Information

Family Living Address

Living Address	Address Line 2	ZIP	City	State	County

Family Mailing Address

Same as living?	Mailing Address	Address Line 2	ZIP	City	State
☐ Yes ☐ No					

Adults Name	Type (*check one*)	Phone Number(s)

Parental Status (*check one*)	Primary Language at Home	Acquired/learning another language in addition to English	Active Duty or Military Veteran	Experiencing Homelessness	SNAP	WIC	TANF	SSI	Referred by Child Welfare Agency
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Moved once in the past year?	Circle One YES NO	Does your child have any special needs we need to be aware of?	Circle One YES NO
Moved 2 or more times in the past year?	YES NO	Currently is your child on?	IFSP IEP
Can you provide transportation to and from school for your child(ren)?	YES NO		
Families' primary language?	_____	Has your immediate family experienced any of the following? Circle all that apply -	YES NO
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	_____ _____ _____ _____ _____ _____		Abuse (Physical, Emotional, Sexual) Neglect (Physical or Emotional) Terminal or Chronic Illness Death of a parent or sibling Mental Illness Incarceration Domestic Violence Alcohol/Substance Abuse Divorce/Separated Natural Disaster (flood, tornado, fire)

Please bring one of the following documents to verify family's income:

- 2025 Tax Return (1040)
- 2025 W-2
- Pay stub or Pay envelopes (last 12 months)
- FIP/TANF Documentation (Notice of Decision, Letter from DHS, Screenshot of online statement)
- SNAP Benefits (Copy of SNAP Card, Notice of Decision, Screenshot of online statement)
- SSI (A letter from social security or a bank deposit)
- Education Stipends (Last 12 months)
- Written statements from employers (last 12 months)
- Foster care reimbursement or Letter from DHS Social Worker stating child in Foster Care

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 _____

WEST CENTRAL
COMMUNITY ACTION

Head Start
Early Head Start

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 screenings completed by Head Start staff. Public Health requirements will be followed reporting any otoacoustic emissions (OAE) screens to the state representative.	Yes or No

Valid through_____school year.

Parent Signature:_____Date:_____

48 Month Questionnaire

42 months 0 days through 53 months 30 days

ASQ:SE-2 Ages & Stages Questionnaires® Social-Emotional SECOND EDITION

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: _____

P201480000

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

ASQ:SE-2

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?	☐z	☐v	☐x	ⓥ	____
2. Does your child cling to you more than you expect? 	☐x	☐v	☐z	ⓥ	____
3. Does your child talk or play with adults she knows well?	☐z	☐v	☐x	ⓥ	____
4. When upset, can your child calm down within 15 minutes?	☐z	☐v	☐x	ⓥ	____
5. Does your child like to be hugged or cuddled? 	☐z	☐v	☐x	ⓥ	____
6. Does your child seem too friendly with strangers?	☐x	☐v	☐z	ⓥ	____
7. Does your child settle himself down after exciting activities?	☐z	☐v	☐x	ⓥ	____
8. Does your child cry, scream, or have tantrums for long periods of time?	☐x	☐v	☐z	ⓥ	____

TOTAL POINTS ON PAGE _____

48 Month Questionnaire

ASQ:SE-2™

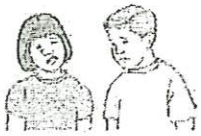
Check the box ☑ that best describes your child's behavior.
Also, check the circle ◯ if the behavior is a concern.

	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? 	☐z	☐v	☐x	◯v	____
10. Does your child stay dry during the day?	☐z	☐v	☐x	◯v	____
11. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.) _____ _____	☐x	☐v	☐z	◯v	____
12. Do you and your child enjoy mealtimes together?	☐z	☐v	☐x	◯v	____
13. Does your child do what you ask her to do?	☐z	☐v	☐x	◯v	____
14. Does your child seem happy?	☐z	☐v	☐x	◯v	____
15. Does your child sleep at least 8 hours in a 24-hour period?	☐z	☐v	☐x	◯v	____
16. Does your child seem more active than other children his age?	☐x	☐v	☐z	◯v	____
17. Does your child use words to tell you what she wants or needs?	☐z	☐v	☐x	◯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)?	☐z	☐v	☐x	◯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?"	☐z	☐v	☐x	◯v	____

TOTAL POINTS ON PAGE ____

ASQ:SE-2

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)?	☐z	☐v	☐x	ⓥ	____
21. Does your child explore new places, such as a park or a friend's home?	☐z	☐v	☐x	ⓥ	____
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.) _____ _____	☐x	☐v	☐z	ⓥ	____
23. Does your child hurt herself on purpose?	☐x	☐v	☐z	ⓥ	____
24. Does your child follow rules at home or at child care?	☐z	☐v	☐x	ⓥ	____
25. Does your child destroy or damage things on purpose?	☐x	☐v	☐z	ⓥ	____
26. Does your child stay away from dangerous things, such as fire and moving cars?	☐z	☐v	☐x	ⓥ	____
27. Can your child name a friend?	☐z	☐v	☐x	ⓥ	____
28. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt? 	☐z	☐v	☐x	ⓥ	____
29. Do other children like to play with your child?	☐z	☐v	☐x	ⓥ	____

TOTAL POINTS ON PAGE ____

48 Month Questionnaire

ASQ:SE-2

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 *your child* like to play with other children? 	☐ z	☐ v	☐ x	◯ v	____
31. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	☐ x	☐ v	☐ z	◯ v	____
32. Does your child show an unusual interest in or knowledge of sexual language and activity?	☐ x	☐ v	☐ z	◯ v	____
33. Does your child wake three or more times during the night?	☐ x	☐ v	☐ z	◯ v	____
34. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____	☐ x	☐ v	☐ z	◯ 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!"	☐ z	☐ v	☐ x	◯ v	____
36. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: _____ _____ _____	☐ x	☐ v	☐ z	◯ 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*

ASQ:SE-2

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

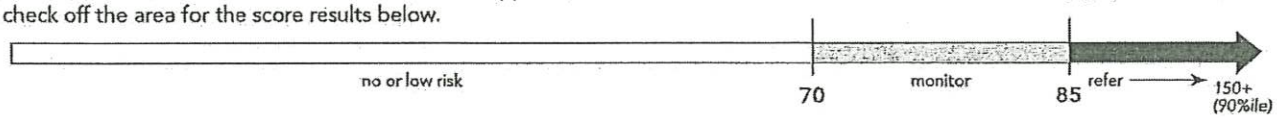
1. ASQ:SE-2 SCORING CHART:

- 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: _____

P201480600

ASQ-3 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: _____

P101480100

ASQ-3™

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

	YES	SOMETIMES	NOT YET	
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"?	○	○	○	___
2. Does your child answer the following questions? *(Mark "sometimes" if your child answers only one question.)*	○	○	○	___

"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"?	○	○	○	___
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"?	○	○	○	___

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COMMUNICATION *(continued)*

	YES	SOMETIMES	NOT YET	
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?"	○	○	○	___
		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)*

	YES	SOMETIMES	NOT YET	
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.)* 	○	○	○	___
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.)* 	○	○	○	___
4. Does your child unbutton one or more buttons? *(Your child may use his own clothing or a doll's clothing.)*	○	○	○	___
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?	○	○	○	___
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.)*	○	○	○	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
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.)*	○	○	○	___
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.)* 	○	○	○	___
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."	○	○	○	___
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.)*	○	○	○	___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
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.)*	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
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
- ○ b. Age
- ○ c. City she lives in
- ○ d. Last name
- ○ e. Boy or girl
- ○ 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)?	○	○	○	___

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

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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

E101480700

ASQ-3 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						

P101480800