

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 _____ Shuttle Bus To:

____ Rural Bus _____ McKinley

____ Walk _____ 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: _____ | Y/N |
| 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 _____

<p>Right to Translation and Interpretation Services</p> <p>Your response will help the school provide communication in a language you prefer:</p>	<p>In which language do you prefer to receive written information from school? _____</p> <p>In which language do you prefer to receive spoken information from school? _____</p>
--	--

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, Latinó, 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 detasselling 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 Department of Education





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? SI NO
Si marcó SI, puede dejar de completar el formulario. Si marcó NO, por favor continúe.

2. Seleccione cualquiera de los siguientes trabajos que la familia ha realizado en los últimos 3 años:
☐ Matanza o procesamiento de animales/carne (res, aves, cerdo) Tyson, JBS, Monsanto, Seaboard
☐ 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.

Iowa Department of Education



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 _____

2025-2026 Clarinda and West Central Community Action Head Start Partnership Application

Applicant/Prenatal						
First	Middle	Last	Suffix	Nickname	Birthday	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		Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home	
			<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	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"/> 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	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"/> 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	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		Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home	
			<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	Suffi	Nickname	Birthday	Gender	
			X				
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient			<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient	
<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial							

Additional Child (Non-Applicant) *							
First	Middle	Last	Suffi	Nickname	Birthday	Gender	SSN
			X				
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient			<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient	
<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial							

Additional Child (Non-Applicant) *							
First	Middle	Last	Suffi	Nickname	Birthday	Gender	
			X				
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient			<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient	
<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Racial							

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			
<input type="checkbox"/> Yes <input type="checkbox"/> No										
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	Experiencing Homelessness	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	Income Status	Documentation used for verification: Circle all that apply
<input type="checkbox"/> Yes <input type="checkbox"/> No		Interview: <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 <input type="checkbox"/> Documentation <input type="checkbox"/> Pay stub or pay envelopes <input type="checkbox"/> Education Grants/Awards <input type="checkbox"/> 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)? Families' primary language? _____ 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 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)

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 _____



Clarinda

Community School District

423 East Nodaway St.

Clarinda, Iowa 51632

Central Office: 712-542-5165

7-12 Building 712-542-5167

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: _____



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

Ages & Stages Questionnaires®: Social-Emotional, Second Edition (ASQ:SE-2™), Squires, Bricker, & Twombly.
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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 your child 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

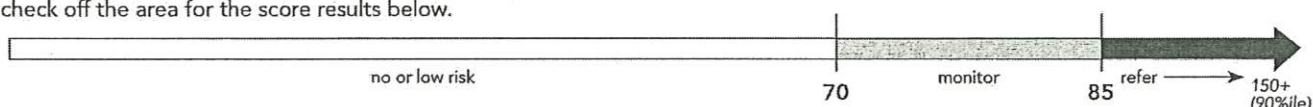
1. ASQ:SE-2 SCORING CHART:

- 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: _____

P201480600



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

Ages & Stages Questionnaires®, Third Edition (ASQ-3™), Squires & Bricker
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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"?

☐ ☐ ☐ _____

COMMUNICATION

(continued)

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 5. Without your giving help by pointing or repeating, does your child follow three directions that are <i>unrelated</i> 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." | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 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?" | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| COMMUNICATION TOTAL | | | | — |

GROSS MOTOR

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|---|
| 1. Does your child catch a large ball with both hands? <i>(You should stand about 5 feet away and give your child two or three tries before you mark the answer.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your child climb the rungs of a ladder of a playground slide and slide down without help? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. While standing, does your child throw a ball <i>overhand</i> 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. <i>(Dropping the ball or throwing the ball underhand should be scored as "not yet.")</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your child jump forward a distance of 20 inches from a standing position, starting with his feet together? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 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? <i>(You may give your child two or three tries before you mark the answer.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| GROSS MOTOR TOTAL | | | | — |

FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|---|
| 1. Does your child put together a five- to seven-piece interlocking puzzle? <i>(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?)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |

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.)



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.)

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"/>	—
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.)
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.)

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"/>	—

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 ☐ 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)?

☐ ☐ ☐ —

☐ ☐ ☐ —

☐ ☐ ☐ —

☐ ☐ ☐ —

☐ ☐ ☐ —

☐ ☐ ☐ —

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		<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"/>
Gross Motor	32.78		<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"/>
Fine Motor	15.81		<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"/>
Problem Solving	31.30		<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	26.60		<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"/>

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						