



Child's Name: _____

Center/Program: _____

CHECKLIST

Please submit the following documents for your child's enrollment:

For Private Pay Students: items 1-5

For ABC Scholarship/Voucher students: items 1-10

(Please use black ink.)

- _____ 1. **WACD APPLICATION**
- _____ 2. **Food Program Form**
- _____ 3. **Immunization Record (up to date)**
- _____ 4. **Current Photo**
- _____ 5. **Insurance Card**
- _____ 6. ABC application
- _____ 7. Authorization for release of records
- _____ 8. Well Child Check up (Health Screening signed & dated by a doctor)
- _____ 9. Birth Certificate
- _____ 10. Social Security number _____ - _____ - _____
- _____ 11. Proof of income (last 4 check stubs, letter from employer, tax forms, or documentation of other qualifiers. If no income we will need a letter stating that fact also.)

For Office Use Only

Qualified as: _____ Spreadsheet: _____

ProCare: _____ COPA #: _____

Scanned: _____ Brigance: Date: _____ Score: _____

Notes: _____

Western Arkansas Child Development, Inc.
#14 West Cherry St., Alma, AR 72921
1-866-538-WACD(9223) Fax 479-430-7195
email: wacd@wacd.net website: www.wacd.net

Program _____
Parents Email _____
Start Date: _____

I am enrolling for :
 ABC (grant program 8 am-3 pm)
 ABC plus extended day
 Private Pay
 Other _____

Child's information

Child's name: _____ Birth Date: _____
Phone _____ Social Security _____ Drop off time _____ Pick up time _____
Address _____ City _____ State _____ Zip code _____
Mailing Address _____
Doctor _____ Phone _____ Dentist _____ Phone _____

Has your child had Chicken Pox? Yes _____ No _____ Date Vaccine Received _____
Has your child had previous day care, babysitter, preschool experience? _____
Are there any medical problems we should be aware of? _____

Known Allergies _____
Bowel/Bladder irregularities? _____ Sleeping/napping instructions? _____
Other important information or instructions? _____

Parent Information

Father's Name _____ Cell Phone _____
Employer _____ Employer's phone _____
Father's Birthdate _____
Address (if different from child's) _____
Mother's Name _____ Cell Phone _____
Employer _____ Employer's phone _____
Mother's Birthdate _____
Address (if different from child's) _____

Emergency Contact Information

Name of person to contact if parent is not available _____ relationship _____
Home Phone _____ work phone _____ cell phone _____

List all other people (besides emergency contact) that may pick up your child:

Name _____ relationship _____ phone _____
Name _____ relationship _____ phone _____
Name _____ relationship _____ phone _____

Family Information

Brothers and sisters (please indicate ages and whether they live with the child):

Please list any other person s living with the child and their relationship (if any) to the child:

Consent for emergency care:

I/we, _____, parent/s of _____ do hereby request and give consent to Western Arkansas Child Development, and the duly appointed representative for said child to receive such medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the director or duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached.

Parent _____ Date _____ Witness _____ Date _____

Video, Picture, Voice Disclosure:

WACD, Inc. has my permission to videotape, take pictures, or video record of my child for educational or marketing purposes. I understand that my child may have their picture included on educational or training videotapes, audiotapes, scrapbooks, yearbooks, bulletin boards, etc.

Parent _____ Date _____

Discipline Policy:

The following methods of discipline are used at WACD, Inc.

1. Redirection of child to a different activity
2. Calm Down Time—The child will be directed to a new activity or area of the room to calm down.

I have read and understand the discipline Policy of WACD Inc.

Parent _____ Date _____

Parental request for conference:

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

Parent _____ Date _____

Division of Children and Family Services:

200.3 Upon enrollment of your child they may be subject to interviews by licensing staff, child maltreatment investigators and/or law enforcement officials for the purpose of determining licensing compliance or for investigative purposes. (Child interviews do not require parental notice or consent)

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

Parent Signature _____ Date _____

*****Market Analysis*****

Please tell us how you heard about our program _____

Did one of our customers or staff refer you to us? If so who? _____

Remember...we give a \$25.00 professional courtesy credit to our customers. Thanks for referring your friends to us!

**Special Nutrition Programs
Child and Adult Care Food Program
Letter to Parents**

Dear Parent/Guardian:

The Western Arkansas Child Development, Inc. participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Please help us comply with the requirements of the CACFP by completing, signing, and returning the attached statement as soon as possible. This information is necessary so that we may receive CACFP reimbursement for the meals served to children in our program. This form will be placed in our files and treated as confidential information. All children in our program receive their meals free of charge, but the determination of eligibility category affects the amount of Federal funding received by us.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. Please contact us for additional information if you have a foster child enrolled in our program.

If you receive food stamps then you need to only list your food stamp case number. In addition, you must complete Section 5 of the form including all required information with signature, Social Security Number of an adult household member, and date form was completed.

If a food stamp case number is not reported, you must complete Section 4 and Section 5 on the eligibility statement. Section 4 should include the names of all household members and the total current household income by source. Section 5 must include all required information with signature, Social Security Number of an adult household member, and date form was completed.

USDA defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e., sharing living expenses). The income you report must be last month's total gross household income listed by source, for each household member. If last month's income does not accurately reflect your circumstances, you may provide a projection of your annual income, and you may use last year's income as a basis for making this projection if no significant changes have occurred. If your household's income is equal to or less than the amounts indicated for your household's size on the chart below, the center will receive a higher level of reimbursement.

You are required to notify us if there is a change in household size or an increase in income that exceeds \$50 per month or \$600 per year. If you list a food stamp case number, you must notify us when you no longer receive food stamps. Similarly, you should notify us if you become unemployed and the loss of income during the period of unemployment causes your family to be within the eligibility standards.

All meals served to children under the Child and Adult Care Food Program are served free regardless of race, color, sex, age, disability, or national origin.

There is to be no discrimination in admissions policy, meal service, or the use of facilities. Any complaints of discrimination should be submitted in writing to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Thank you for your cooperation.

Institution Representative
(NPC-4 Rev. 6/06)

USDA CHILD NUTRITION PROGRAM INCOME GUIDELINES July 1, 2010 – June 30, 2011			
<u>Household Size</u>	Annual	Monthly	Weekly
1	\$20,036	\$1,670	\$386
2	26,955	2,247	519
3	33,874	2,823	652
4	40,793	3,400	785
5	47,712	3,976	918
6	54,631	4,553	1,051
7	61,550	5,130	1,184
8	68,469	5,706	1,317
each added household member	+6,919	+ 577	+ 134

APPLICATION INSTRUCTIONS

To allow this center to receive Federal Funds to subsidize the provision of nutritious meals, one application must be completed and on file for each child or adult participant. Complete the front using the instructions for your household. You must sign the application and return it to your center immediately.

Call # _____ if you need help

PART 1 - ALL HOUSEHOLDS COMPLETE PART 1.

1. Print the name of the child/participant you are applying for.
2. List the child/participant's age and the name of the center.

PART 2 - FOOD STAMPS HOUSEHOLDS COMPLETE PART 2 AND PART 5.

1. List a current Supplemental Nutrition Assistance Program (SNAP) case number for the child/participant. No SSN.
2. Skip Part 4. You do not have to list names of household members or income if you list a Supplemental Nutrition Assistance Program (SNAP) number for the child/participant. Sign the application in Part 5. An adult household member must sign.

PART 3 - FOSTER CHILD'S HOUSEHOLDS COMPLETE PART 3 AND PART 5. A foster child is the legal responsibility of a welfare agency or court.

1. List the foster child's monthly "personal use" income. Write "0" if the foster child does not get "personal use" income. Skip to Part 4. Do not list any other children, household members or income.
2. A foster parent or other official representing the child must sign the application in Part 5.
3. Personal Use income is (a) money given by the welfare office identified by category for the child's personal use, such as for clothing, school fees, and allowances; and (b) all other money the child gets, such as money from his/her family and money from the child's full or part-time jobs.

PART 4 - ALL OTHER HOUSEHOLDS COMPLETE PART 4 AND PART 5.

1. Write the name of everyone in your household, whether they get income or not; include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
2. Write the amount of income each household member got last month, before taxes or anything else is taken out, and where it came from, such as earnings, welfare, pensions, and other income. If any amount last month was more or less than usual, write that person's usual monthly income.
3. An adult household member must sign the application and give **the LAST 4 digits only** of his/her social security number in Part 5.

*To figure monthly income multiply: Weekly x 4.33, every 2 weeks x 2.15, twice a month x 2.

PART 5 - ALL HOUSEHOLDS COMPLETE PART 5. SIGNATURE AND SOCIAL SECURITY NUMBER.

1. All applications must have the signature of an adult household member.
2. The application must have the social security number of the adult who signs. If the adult does not have a social security number, write "none" or something else to show that the adult does not have a social security number. If you listed a food stamp number for each child or if you are applying for a foster child, the last 4 digits of a social security number is not needed.

PART 6 - RACIAL/ETHNIC IDENTITY: Complete the racial/ethnic identity question if you wish. You are not required to answer this question to get meal benefits. We need this information to make sure that everyone is treated fairly.

INCOME TO REPORT

Earnings from Work

Wages/salaries/tips
Strike benefits
Unemployment compensation
Workers compensation
Net income from self-owned business or farm income

Pensions/Retirement/Social Security

Pensions
Supplemental Security Income
Retirement income
Veteran's payments
Regular contributions from persons not Social Security

Other Income

Disability benefits
Cash withdrawn from savings
Interest or Dividends
Income from estates/trusts investment living in the household
Net royalties/annuities/rental income
Any other income

FOR VERIFICATION PURPOSES ONLY. DO NOT WRITE BELOW THIS LINE.

DATE VERIFICATION NOTICE WAS SENT: _____ RESPONSE DUE FROM HOUSEHOLD: _____ SECOND NOTICE SENT: _____
VERIFICATION RESULT: NO CHANGE _____ FREE/REDUCED PRICE _____ FREE/PAID _____ REDUCED PRICE/FREE _____ REDUCED RICE/PAID _____

REASON FOR ELIGIBILITY CHANGE: INCOME _____ HOUSEHOLD SIZE _____ REFUSED TO COOPERATE _____ CHANGE IN FOOD STAMP/AFDC OTHER: _____

DATE NOTICE OF CHANGE SENT: _____ VERIFYING OFFICIALS SIGNATURE _____ Date _____

**CHILD CARE FOOD PROGRAM
ENROLLMENT FORM**
(to be completed by parent or guardian)

Provider's Initial: _____ Date: _____ (Form valid for one year from this date)
--

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information may be verified. The meal times, the meal pattern and the daily menus should be posted and available for parents at all times. If you have questions, or comments, or would like to learn more about the Child and Adult Care Food Program, contact our office.

Western Arkansas Child Development, Inc.
Name of Provider/Director _____

866-538-WACD (9223) _____
Telephone

Name of Day Care Facility

Address

I wish to enroll my child (ren), whose names and enrollment information are given below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious, well balanced meals/snacks to day care children.

My child (ren) will be served the following meals:

(PLEASE CIRCLE) BREAKFAST AM SNACK LUNCH PM SNACK OTHER _____

Child (ren) Information (please print)

First Name	Last Name	Age	Birthdate	Time of Care	Days of Week (circle)	Sex
			/ /		SAT - SUN <u>M</u> - <u>T</u> - <u>W</u> - <u>TH</u> - <u>FR</u>	M F
			/ /		SAT - SUN M - T - W - TH - FR	M F
			/ /		SAT - SUN M - T - W - TH - FR	M F
			/ /		SAT - SUN M - T - W - TH - FR	M F

Note here any food allergies or special needs your child(ren) have: _____

Doctor's Name: _____

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex, or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

In case of emergency, please call: HOME # _____ WORK # _____

Parent Address: _____

Parent Signature: _____ Date: _____
(Enroll-2007)

FREE AND REDUCED PRICE MEAL APPLICATION FOR CENTERS AND HOMES

Please see the instructions on the reverse side if you have questions, or you may call the center. #

1. PRINT: Child Information

> _____ Western Arkansas Child Development, Inc.
 CHILD/CHILDREN'S NAME(S) AGE NAME OF CENTER/PROVIDER

> _____

> _____ **Number of children claimed on this application** _____

> _____ **2. List the Supplemental Nutrition Assistance Program (SNAP) number, if any, then skip to #5**

> _____ **#** _____

3. FOSTER CHILD: List the child's monthly personal use income. Write "0" if the child has no personal income. \$ _____

4. HOUSEHOLD MEMBERS AND MONTHLY INCOME: If you gave a Food Stamp case number for the child PART 2, skip to PART 5.

NAMES OF HOUSEHOLD MEMBERS	Gross MONTHLY Earnings (before deductions)				
	JOB 1	JOB 2	Monthly Welfare Payments, Child Support, Alimony	Monthly Pension/Retirement Payments, SS Income	Any other Monthly Income
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

5. SIGNATURE AND SOCIAL SECURITY NUMBER: I certify that all the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of Federal Funds; that center officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

X _____ # _____
 Signature of Adult Household Member **LAST 4 DIGITS ONLY - Social Security Number***

Home telephone # _____ Work telephone # _____ Printed name _____
 Street/apt # _____ City/state/zip _____ Date _____

6. RACE: Please circle the racial or ethnic identity of your child. You are not required to answer this question.
 White Black or African American Hispanic or Latino Asian Hawaiian Native or Other Pacific Islander
 American Indian/ Alaskan Native Not Hispanic or Latino

* PRIVACY ACT STATEMENT: Section 9 of the National School Lunch Act requires that, unless your child's Supplemental Nutrition Assistance Program (SNAP) is provided, you must include the last 4 digits of the Social Security number of the adult household member signing the application or indicate that the household member does not have a Social Security number. Provision of a Social Security number is not mandatory, but if a Social Security number is not given or an indication is not made that the signer does not have such a number, the application cannot be approved. The Social Security number may be used to identify the household member in carrying out efforts to verify the correctness of the information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP benefits, contacting the state employment security office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss of reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The social security number may also be disclosed to programs as authorized under the National School Lunch Act and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain Federal, state and local education, health, and nutrition programs.

FOR CENTER/PROVIDER USE ONLY		DO NOT WRITE BELOW THIS LINE	
MONTHLY INCOME CONVERSION:	WEEKLY X 4.33	EVERY TWO WEEKS X 2.15	TWICE A MONTH X 2
TOTAL HOUSEHOLD SIZE _____	MONTHLY INCOME _____	CHECK IF SNAP PARTICIPANT _____	
Eligibility Determination: APPROVED FREE _____ APPROVED REDUCED PRICE _____ DENIED _____ Temporary: FROM _____ TO _____			
REASON FOR DENIAL: INCOME TOO HIGH _____ INCOMPLETE APPLICATION _____ OTHER: _____			
CHANGE IN STATUS: _____ REASON: _____ DATE: _____ DATE WITHDRAWN: _____			
SIGNATURE OF DETERMINING OFFICIAL: _____ DATE: _____			



#14 W. Cherry, Alma, AR 72921 Phone: 866-538-WACD Fax: 479-430-7195

Dear Parent,

Thank you for your interest in the Arkansas Better Chance programs offered by Western Arkansas Child Development, Inc.

Enclosed you will find the necessary information for our Center/Home Based ABC programs. Part of the eligibility criteria for our program is a copy of your child's birth certificate, up-to-date immunization record, social security card, well-child check up form (physical signed by a doctor), proof of income and a current picture. All completed forms must be turned in to our office before your child can be determined for eligibility or enrolled in the program.

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

If you have any questions or are in need of further information please contact our office at 866-538-9223.

Thank You,

Elizabeth Scudder
Program Director

CHILD INFORMATION

*Name(First/Middle/Last):		
*Date of Birth:	*Social Security Number:	
*Gender:	*Ethnicity:	*Primary Language:
Has this child attended a state-funded pre-K (ABC) program before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, where?	
Will this child be concurrently enrolled in an ABC center and HIPPPY or PAT program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, which HIPPPY or PAT?	
List any allergies:		
Does the child have any special dietary needs?		
Receiving any special education services?		
Primary Language:		

EMERGENCY CONTACT AND CONSENT INFORMATION

Name of emergency contact if parent/guardian cannot be reached:		
Address:	Phone:	
City:	State:	ZIP Code:
Relationship:		
Physician Name:		
Address	Phone:	
City:	State:	ZIP Code:
Consent for Emergency Medical Care		
I _____ of _____		
Parent/Guardian's name	Relationship	Child's name
Do hereby request and give consent to the Director/Caregiver of the Child Care Facility, or their duly appointed representative, for said child to receive such medical or surgical aid as may be deemed necessarily expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parent(s) cannot be reached. Consent is also given for the Director/Caregiver or their duly appointed representative to transport said child for emergency medical treatment, if parent(s) cannot be reached. I additionally give consent for my child to attend the above named field trip.		
Parent/guardian signature _____	Date _____	

SIGNATURE

I declare under the penalty of perjury and the rules and regulations of the Arkansas Better Chance program that the information supplied is true and correct at the time of application. I understand that the information I supplied may be independently verified by the Arkansas Division of Child Care and Early Childhood Education and that any false statements may result in exclusion from DHS programs and criminal prosecution.	
Signature of Primary Caregiver:	Date:

*Must be entered into COPA.

Western Arkansas Child Development, Inc
Arkansas Better Chance Program
#14 W. Cherry
Alma, AR 72921
Phone: 866-538-WACD (9223) Fax: 479-430-7195

Authorization for Release of Records

I hereby authorize Western Arkansas Child Development, Inc. to disclose any information necessary from my child's record. I understand that any subject matter obtained in connection with these services can be disclosed to any agency affiliated with WACD requesting such information.

Child's Name: _____

Date of Birth: _____ Social Security number: _____

Phone number: _____

Information to be disclosed to: _____
Address: _____

Signature of Caregiver/Legal Representative

Date

Printed name of Caregiver/Legal Representative

Relationship to child



**Arkansas Department of Human Services
Division of Child Care and Early Childhood Education**



**ARKANSAS BETTER CHANCE PROGRAM
WELL CHILD SCREENING (EPSDT) FORM**

To Parent or Guardian:

In order to provide the best learning experience for your child, teacher must understand your child's health needs. State regulations require any child enrolled in the Arkansas Better Chance Pre-K program to have a well child check-up. In addition, the child must be current on all required immunizations. Please complete this page of the form, sign it and give it to your child's physician or licensed nurse practitioner. Once form is completed and signed on both sides, return the form to your Pre-K program.

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

Address, City and Zip Code

Name of Pre-K Program Where Enrolled	Pre-K Program Phone Number

Type of Health Insurance

AR Kids A Private Insurance
 AR Kids B Other:

~~Parent - To be completed by parent or guardian before well child screening~~

Check answers to the following questions. Explain any "yes" answers in the space provided.

- | | | | |
|-----|--------------------------|--------------------------|---|
| | Yes | No | |
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease (such as asthma or diabetes)? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (like to food, medicine, dust)? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | In the past 12 months, has your child experienced any difficulty with wheezing or night coughing? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | In the past 12 months, has your child experienced excessive weight loss or weight gain? |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had a dental examination in the last 12 months? |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the health care provider? |

If you answered "yes" to any question, please explain below. For illnesses or injuries, include your child's age at the time.

Question #	Explanation

Parent/Guardian Permission and Release:
I give my permission for the information on this form to be used in meeting my child's health and educational needs while enrolled in the Arkansas Better Chance program.

Signature of Parent/Guardian _____

Date _____

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

To Health Care Professional:

This child is enrolled in the Arkansas Better Chance Pre-K program. State regulations require a comprehensive well child screening for all enrolled children. The Division of Child Care and Early Childhood Education recommends an Early Periodic Screening and Diagnostic Treatment (EPSDT) which is age-appropriate. For children enrolled in AR Kids, the cost of the EPSDT may be billed to AR Kids A or B using the procedure codes below:

Patient Type	AR KIDS A		AR KIDS B	
	1-4 years	5-11 years	1-4 years	5-11 years
New	99382 EP U1	99383 EP U1	99382	99383
Established	99382 EP U2	99383 EP U2	99382	99383

Parent to be completed by Health Care Provider. Complete all sections and sign at the bottom.

Weight		Height		BMI	Temp	Blood Pressure
lb.	%ile	in.	%ile	%		/

History Update

- Yes No Any changes in patient health since last visit? Explain: _____
- Yes No Any family history of heart disease for anyone under 55 years of age?
- Yes No Any family history of abnormal cholesterol?

Health

- Good appetite
- Drinks lowfat milk
- Encourage diet of fruit and vegetables
- Limits fast food
- Picky or variable eater
- Brushes teeth, sees dentist

Social and Behavioral

- Parents discipline appropriately
- Dresses self, helps at home
- TV and video games are limited
- Praised for good behavior
- Has friends and playmates

Screening and Laboratory Results

Test	Result	Date	Comments if abnormal
Vision	L _____ R _____		
Hearing			
TB			
Hemoglobin			
Cholesterol			

PHYSICAL EXAM		
	Norm	Abnormal
General	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>
Throat	<input type="checkbox"/>	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Femoral		
Pulses	<input type="checkbox"/>	<input type="checkbox"/>
Genitals	<input type="checkbox"/>	<input type="checkbox"/>
Extremities		
Gait	<input type="checkbox"/>	<input type="checkbox"/>
Spine	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Neuro	<input type="checkbox"/>	<input type="checkbox"/>

Immunizations

- Yes No All immunizations are current.
- Yes No Child has had all immunizations possible at this time.
- Child needs: DTaP IPV HepB HiB MMR Varivax PCV-7 at _____ years / _____ months

Referrals

- Follow up visit needed in _____ weeks / months
- Return check at _____ years _____ months
- Needs to see dentist. Referral to be made by physician or nurse practitioner.

Impressions

- Well child, normal growth and development
- _____

CLINIC INFORMATION (or stamp)	
Name	_____
Address	_____
City	_____
Zip Code	_____ Phone _____

_____, MD / DO / NP

Date _____