A picture containing clipart

Description automatically generated

Thank you for your interest in our Early Intervention Day Treatment (EIDT/Summer) Program! Please fill out and return this packet as soon as possible. You may drop the completed packet off at 1310 Bradley Dr, email it to [leahcoleman@kidsmh.com](mailto:leahcoleman@kidsmh.com) or fax it to 870-424-4112. Please know that acceptance into this program is on a first come first serve basis and placement is determined by which classroom will best fit your child’s needs. If you have copies of your child’s current therapy evaluations to give us that will be very helpful in this process.

**Please note, your child must have full Medicaid, AR Kids A, SSI, Waiver, or TEFRA to participate in the preschool program.** If your child has private insurance or AR Kids B (you pay a small co-pay at the doctor) then they are ineligible for EIDT services but may be evaluated for our Outpatient therapy program.

**Please note, your child must have on of the following diagnosis to qualify for the summer program:**

1. Intellectual Disability
2. Spina Bifida
3. Cerebral Palsy
4. Autism Spectrum Disorder
5. Epilepsy/Seizure Disorder
6. Down Syndrome

If you have any questions about your child’s insurance or diagnosis, please call our office at 870-424-4021.

Kidspiration Pediatric Therapy Services, Inc.

EIDT Clinic and   
Developmental Preschool  
  
Right Side of Packet  
(parent copies to return)

* Daycare consents initialed and signed for enrollment
* Transportation Standing Order for emergency care
* Developmental Questionnaire for testing
* Food Program Sheet

**Parent**

**to provide social security card, birth certificate, and Medicaid card**

Dear Parents/Guardians,

Welcome to Kidspiration Pediatric Therapy Services! We are very excited to have your child in our facility for evaluation! The attached preschool enrollment packet contains important information about our program as well as required forms that will need to be filled out and returned to us. Please take the time to review the information included. The sooner you get this packet completed and returned to us the sooner we can get your child in for testing!

After we get this packet and a signed referral from your child’s doctor, we will contact you.

Please contact us if you have any questions or concerns regarding the information and forms provided. We look forward to meeting your child and watching them grow and learn in our program!

Leah Coleman, Owner/Director

Here at Kidspiration, we believe that all children are special! Here are some helpful hints and guidelines that will assist us in providing your child with the best care possible.

* The following items are required before your child can be enrolled in the current  
  1. Copy of your child’s current shot record. State law requires current immunizations and must be kept up to date.
  2. Copy of Birth Certificate
  3. Copy of Social Security Card
  4. Copy of Medicaid Card (if applicable)
* All children are required to bring a change of clothing to be kept at the center in case of an accident or emergency if this is appropriate for you child.
* All children should have a supply of diapers/pull-ups, bottles, milk or formula if needed. The caregivers will inform you when more is needed. All items brought in for your child must be clearly labeled with your child’s name.
* Breakfast is served at 8:00 am and lunch is served at 11:30 am, afternoon snack will be served at 2:00 pm.
* Please make sure your child is here between 7:30-8:00 am for breakfast and so that they do not miss any therapy or important classroom learning. If your child has an appointment and will arrive later than 8:00 am please call the office and let us know approximately what time they will arrive.
* Every child must be signed in by a parent/guardian upon arrival and signed out when they are leaving for the day.
* Please go through the carline in order to drop off and pick up your child.
* There are medication sheets in the nurse’s office that must be filled out and signed before medication can be administered to your child. The nurse will ONLY administer medications that are necessary and properly labeled. If the medication is only needed once or twice a day, please give your child the required doses at home.

Please fill out the attached information as it will help us provide appropriate care during the day while your child is with us. Once again, Welcome to KIDSPIRATION!  
  
Phone: (870) 424-4021 Fax: (870) 424-4112

Parents:

Kidspiration partners with Southeastrans to provide Medicaid funded transportation for our students enrolled in the preschool. In order to get transportation set up for your child, please contact Southeastrans directly.

**Call toll free: 1-888-833-4136**

When you call:

* Have your Medicaid ID ready.
* Provide your name, date of birth, address, and phone number.
* Provide the name, address, and phone number of your doctor.
* Any special transporting needs you might have.
* Your child’s hours at Kidspiration are 7:30-3:30 (this is the time the van will drop your child off at Kidspiration in the morning and pick them up from our center. The actual pick-up and drop-off times from your home may vary.)

If you have any questions, feel free to call us and we will do our best to help!

**Kidspiration Pediatric Therapy Services, Inc.**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents/guardians: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_

Persons authorized to pick child up and their phone numbers:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drug allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Authorization**In the case of an emergency we will contact the parent to notify you on need to transport your child to the hospital. In the case of a true emergency we will call 911 and a member of the staff will go with your child to seek medical attention and stay with them until a parent/guardian can get there.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent/ guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize an acting representative of the school to give consent for any and all necessary emergency medical care for my child. I hereby give my consent to Kidspiration to call Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ at the following number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or to take my child to a hospital emergency room should any emergency arise where such medical service is indicated.

**Medical Authorization**

I hereby authorize the following over the counter medications to be given to my child as needed. Please initial by any medications that can be given at school.

\_\_\_ Tylenol \_\_\_ Ibuprophen \_\_\_hydrocortisone (anti itch cream) \_\_\_Benadryl (antihistamine) \_\_\_antibiotic ointment \_\_\_sunscreen \_\_\_ diaper ointment \_\_Lice Treatment

I understand that any prescription medications will require a separate form to be filled out before the nurse can give it at school. I understand that no medications can be left in my child’s bag in the classroom regardless if it is given while at school. If medication is sent in their bag, then it will be kept in the nurse’s office until the end of the day. \_\_\_\_\_\_ (Initials)

**Kidspiration Pediatric Therapy Services, Inc.**

**Publicity Release Consent**

I hereby give consent for my child’s participation in the following forms of publicity releases. Please initial by the forms of publicity your child may participate in. Staff are trained and informed on the rules regarding posting of videos or pictures on the Kidspiration website. All pictures are screened to be sure the child’s parent has given consent prior to being posted on any website associated with Kidspiration.

**\_\_\_\_\_ My child CAN have Publicity** (Kidspiration Facebook Page and/or Website) **\_\_\_\_\_ NO PUBLICITY ALLOWED**

**HIPAA Release**

I hereby give permission for my child’s allergies/medical needs to be posted in their classroom, the kitchen and other areas as needed. I understand that this information will be posted to ensure all staff members are aware of my child’s allergies/medical needs, and that this information will be behind a cover page to protect the confidentiality of my child’s medical needs. \_\_\_\_\_\_ (Initials)

**Interviewing Children**

This is a statement of verification that I have been informed that my child may be interviewed by Child Care Licensing, DCFS Special Investigators or law enforcement officers for investigative purposes or for determining compliance with licensing requirements. \_\_\_\_\_\_ (Initials)

**Kindergarten Readiness Skills**

This is to acknowledge that I have received the Kindergarten Readiness Skills Calendar for my child in accordance with licensing requirements. \_\_\_\_\_ (Initials)

**Shaken Baby Syndrome Handout**

This is to acknowledge that I have received information on the prevention of Shaken Baby Syndrome in accordance with licensing requirements. \_\_\_\_\_ (Initials)

**Attendance Policy**

I understand that my child’s hours at Kidspiration are Monday through Friday from 7:30-3:30pm. I understand that I can meet with the director to arrange different days or times and provide a work/school schedule at the meeting. I understand that my child can be dropped from the program if they miss 10 days of school without any communication from me as to why they are absent. I understand that it is my responsibility to inform the school of any changes in the person’s authorized to pick my child up from school., any changes in the way they are getting to or from school (buses) and to report any changes in my address or phone numbers. I understand that this is for the safety of my child and so that the school can reach me in the case of any illness or emergency that may arise. \_\_\_\_\_ (Initials)

Kidspiration Pediatric Therapy Services, Inc.

Discipline Policy

I have read the discipline policy and understand that NO corporal punishment is used at Kidspiration. I understand that discipline is directed more towards behavior modification. I understand that all measures will be sued to communicate with me in regard to my child’s behavior at school and may consist of meeting with the director in order to address the individual needs of my child. \_\_\_\_\_ (Initials)  
  
  
Immunization Policy

I am aware that per the minimum licensing requirements for childcare centers that my child’s immunizations must be kept up to date for them to be enrolled in daycare. I understand that if I choose to waive immunization that it is my responsibility to obtain an Immunization Waiver from the state every year and to provide the school with a copy of this waiver. I am aware that if my child has received immunizations in another stat then it is my responsibility to provide the school with proof of their immunizations. \_\_\_\_\_ (Initials)

I give consent for the nurse at Kidspiration to obtain my child’s immunization record from the Arkansas WebIZ program to be used to track my child’s immunizations during their enrollment at Kidspiration. I am aware that I can request a copy of my child’s immunization record at any time while they are enrolled at Kidspiration. \_\_\_\_\_ (Initials)

Consent for Enrollment

I have been provided with a copy of the Kidspiration Pediatric Therapy Services, Inc. Parent Information and Policy Guide. I am aware that any concerns with these policies can be addressed in a meeting with the director. By signing below, I am agreeing to the enrollment of my child at Kidspriration Pediatric Therapy Services, Inc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Kidspiration Staff Signature Date

**Allergies:**

**\_\_\_\_ My Child has no known allergies**

**Please list any known allergies and reactions:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please provide information on how to treat your child’s allergic reaction:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications prescribed for allergy and date prescribed:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_  
Parent/Guardian Signature Date**



**Classroom Information Form**

**Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Is your child potty trained?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Is your child a picky eater? Explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What kind of milk does your child drink?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a naptime routine, or do you do anything special to help your child go sleep (sing, rub back, etc.)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Who lives in the home with your child?**

|  |  |
| --- | --- |
| Name: | Relationship: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Is there anything else you think your child’s teacher may need/like to know about your child (sensory concerns, behaviors, ?**  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Good to Know!**

* Toys are not allowed to be brought from home. This includes cars, dolls, balls, tiaras, sunglasses, tablets, etc. When items are brought from home, they cause disruptions in the classroom and tend to come up missing or broken. Please check your child’s pockets and backpack before coming to school to ensure they do not have anything on them they are not supposed to have.
* Please make sure you bring adequate diapers for your child if appropriate. Licensing requires that we change any wet or soiled diapers immediately and that we at least check diapers every hour. If your child is potty training, they must be accident free *at Kidspiration* for two weeks before they can wear underwear instead of diapers/pull ups.
* Your child is always required to have at least one change of clothes in their cubby if appropriate. If they have an accident, please make sure to send another set of clothes the next day. If your child is newly potty trained please send 2-3 sets of clothes to keep at school (shirt, pants, underwear, socks). Please make sure extra clothes and jackets are labeled with your child’s name.
* Please make sure your child is here by 8:00 every day. Breakfast is served at 8:00am and if there are any leftovers, they are thrown out at 8:30am to make room for lunch preparations. Also, therapists check attendance shortly after breakfast and may mark your child absent for the day if they are late.
* All children are to be picked up by 4:00pm every day. Exceptions are only made when a therapist requests to see a child past 4:00pm or if a parent has met with administration and turned in a work or school schedule that prohibits them from picking their child up prior to 4:00pm. Staff is very limited in the afternoons so please work with us to make sure your child is picked up on time. **ALL children must be picked up by 4:30pm. No exceptions.**

**Pick-up and Drop Off Times**

Morning Drop-Off: 7:30-8:00am  
Afternoon Pick-Up: 3:00-4:00pm

**CONSENT for Tylenol**

I hereby give \_\_\_\_\_\_ do not give \_\_\_\_\_\_\_ the Director of the Child Care Facility or their appointed representative permission to give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Child’s name) Tylenol. I understand I will be notified that Tylenol has been administered.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**CONSENT for Emergency Treatment**

Child’s Physician or emergency facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for medical care:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Father, Mother, Guardian ( circle the one that applies) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Child’s Name) do hereby give my consent to the Director of the Child Care Facility, or their duly appointed representative, for said child to receive 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 their duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Choice Explanation Letter

Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Parent/Guardian

Attached you will find a provider choice form. Federal law requires that you be made aware of other services possibly available to you and your child. A referral to First Connections, Arkansas Infant and Toddler program, or to your local school districts Education Services Cooperative will be made by us upon your child’s enrollment in our program. Services available through these programs are listed on the attached provider choice form. You may be contacted by a member of one of the above facilities for further explanation of services.

Early Intervention Day Treatment Programs are covered by Medicaid and/or private insurance. There are other state programs which issue Medicaid Waiver Services should your child become Medicaid ineligible. Your caseworker can refer you to these programs should you so desire.

Thank you.

I have read and understand the above.

Signature of Parent/Guardian Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHMS Program Staff Member Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Informed Consent

Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization is hereby granted to Kidspiration to (check those that apply):

1. \_X\_To conduct a comprehensive screening or evaluation and provide necessary treatment as indicated in the following areas:

\_\_\_ Medical \_\_\_ Substance Abuse  
\_\_\_ Psychological \_\_\_ Counseling  
\_X\_ Speech and Language \_\_\_ Nutrition  
\_X\_ Occupational Therapy \_\_\_ Neuropsychological  
\_X\_ Physical Therapy \_\_\_ Speech Therapy  
\_\_\_ Behavior \_\_\_ Psychiatric  
\_\_\_ Audiology \_\_\_ Social Services  
\_\_\_ Early Intervention (<2 years) \_X\_ Developmental Preschool  
\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Financial Screening for Services

1. \_\_\_ Conduct a specialized evaluation of my child.

Type of Evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of evaluator or agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_ Release the following information to a third party:

Information to be released: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name of third party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Purpose of release: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_ Use the following information for other purposes:

Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read and I understand the information regarding parent’s consent. I understand the purpose(s) for which my consent is requested. I understand that giving consent for the above-stated purpose(s) is voluntary on my part and may be revoked at any time.

Signature of Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidspiration Pediatric Therapy Services

Consent to Release

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Parent:

As part of your child’s evaluation, he/she will be seen by one or more of the Kidspiration Pediatric Therapy Services, Inc. clinic professionals:

If you have any questions concerning the services that you and your child receive, you should ask any of the professionals who are providing care to your child.

Consent to Treat

I hereby give consent for the examination/evaluation of my child at Kidspiration Pediatric Therapy Services, Inc, including the diagnostic test ordered by my child’s physician.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARKANSAS INFANT & TODDLER PROGRAM

Provider Choice Form

Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been informed of all services available and would like to access the following choices.

SERVICES

\_\_ Certified Case Management \_\_ E.I-Home Based

\_X Occupational Therapy/Eval \_\_Transportation

\_X\_ Physical Therapy/Eval \_\_Home Based Parent Training

\_X\_Speech Therapy/Eval \_\_Evaluation

\_X\_ Preschool-Center Based \_\_Consultation

\_\_ Preschool-Comm. Based \_\_Adaptive Equipment

\_\_ Family Support \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ E.I- Center Based

I have been informed of all authorized providers for the services I have requested. I am choosing the following providers:

Sharon Dibble \_\_\_\_\_\_\_\_\_\_\_Developmental \_\_\_\_\_\_\_\_\_\_

(Provider) (Service)

\_\_\_\_Molly Lischeron & Kelly Carter \_\_\_\_\_\_\_\_\_\_\_\_Physical Therapy\_\_\_\_\_\_\_\_\_

(Provider) (Service)

\_\_\_\_Derek Hinson & Melissa Bassham\_\_ \_\_\_\_\_\_\_\_\_\_Occupational Therapy\_\_\_\_\_\_\_

(Provider) (Service)

Sarah Dewey, Allyson Woods, Ruth Wilson \_\_\_\_\_\_\_\_\_\_\_Speech Therapy\_\_\_\_\_\_\_\_\_\_\_\_

(Provider) (Service)

I understand that I have the option to change this choice at any time. I also understand that if the chosen provider is unable to provide services, I may then choose another provider.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Date

Child Health Management Clinic

CONSENT TO RELEASE TO MEDICAID

AUTORIZATION TO PAY BENEFITS TO PHYSICIAN:

*I hereby authorize payment directly to the signed Physician to the Medicaid Benefits, if any, otherwise payable to me for his/her services as described but not to exceed the reasonable and customary charge for those services.*

ALL PATIENTS:

*This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all diagnostic, assessment, and/or such medical treatment, which in the judgement of the clinical physician or his authorized agent may consider necessary or advisable. No guarantee has been made as a result of assessment or treatment.*

*Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Relationship to child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Kidspiration Pediatric Therapy Services

1310 Bradley Dr.

Mountain Home, AR. 72653

Phone: 870-424-4021

Fax: 870-424-4112

Kidspiration Pediatric Therapy Services, Inc.

I have been provided a copy of the Patient’s Rights and Responsibilities of Kidspiration Pediatric Therapy Services, Inc.

Signature Date



Kidspiration has created a parent networking group on Facebook for all current parents of our facility to communicate and stay in touch. This is a private group set up just for parents/guardians and will NOT take the place of our regular Facebook page where we post events, newsletters, and fun pictures of the children. You may post birthday invites, ask for advice, set up play groups, etc. This group is strictly monitored by our Admin and will not tolerate any negative comments or bashing of ANYONE. You will immediately be removed if this becomes a problem. Thank you guys, for all you do!

\_\_\_\_ Yes, I would like to be added to the Parent Networking Group.

\_\_\_\_ No, I do not want to be added to the Parent Networking Group.

My Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Social Media Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental Questionnaire**

1. ALL THE INFORMATION ON THIS FORM WILL BE CONFIDENTIAL AND USED ONLY FOR THE EVALUATION AND TREATMENT OF YOUR CHILD.

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET CITY STATE ZIP CODE

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Main Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred the child to this clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **FAMILY DATA**

School District \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother/Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Lives with: Father\_\_\_\_\_\_\_ Mother\_\_\_\_\_\_\_ Both\_\_\_\_\_\_\_\_ Guardian\_\_\_\_\_\_\_\_\_\_

BROTHERS AND SISTERS

NAME AGE GRADE SEX FULL, 1/2, STEP

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

1. **BEHAVIOR**

Do you think your child has a behavioral problem? YES\_\_\_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe behavioral problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do parents agree on methods of discipline? YES \_\_\_\_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_\_\_

Describe each of your methods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is anyone else (ex. School, sitter) having problems with your child’s behavior?

YES \_\_\_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_

If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you like best about your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **PRENATAL INFORMATION**

Nutrition during pregnancy: GOOD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were any prescriptions, drugs, alcohol, or tobacco products used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you begin prenatal care?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complications during pregnancy? \_If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Gestation Age at birth: \_\_\_\_weeks (We must know this for testing purposes.)***

Type of birth: C-Section\_\_\_\_\_\_\_ Vaginally\_\_\_\_\_\_\_\_

Labor induced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Length\_\_\_\_\_\_\_ Complications at delivery/after birth? Explain if yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **CHILD’S GROWTH AND DEVELOPMENT**

Has your child ever had developmental evaluations (Occupational, Physical, Speech)?\_\_\_\_\_\_\_\_\_\_\_\_  
 If so, when and where were the test completed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been tested for vision? Yes\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_ If yes, when? \_\_\_\_\_\_\_\_\_\_\_

Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What were you told? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has child been tested for hearing? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_ If yes, when?\_\_\_\_\_\_\_\_\_\_\_

As compared with other children, describe your child’s development.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did your child…..

Sat alone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Toilet Trained: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

Crawled\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bowel: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

Walked Alone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bladder: Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Made sound, coo/babble\_\_\_\_\_\_\_\_\_\_\_\_\_ Dry at night: Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

**ANSWER APPROPRIATELY**:

Single Words Yes\_\_\_\_ No\_\_\_\_\_ Age weaned from bottle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phrases/Sentences Yes\_\_\_\_ No\_\_\_\_\_ Temper Tantrums Yes\_\_\_\_ No\_\_\_\_\_

Says words clearly Yes\_\_\_\_ No\_\_\_\_\_ Describe Tantrums \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Understood by Mother Yes\_\_\_\_ No\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Understood by Others Yes\_\_\_\_ No\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child get along with other children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adults?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **LANGUAGE AND HEARING**

Do you feel your child hears?

Well \_\_\_\_\_\_ Poorly or not at all \_\_\_\_\_\_\_\_ Inconsistently \_\_\_\_\_\_\_\_\_ Uncertain \_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a history of ear infections? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had p.e. tubes placed in his/her ears?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child communicate mostly by: Gestures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Crying\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sentences \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Words\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phrases\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did your child: (write “not yet” when appropriate)

\_\_\_\_\_\_\_\_\_\_\_Make single sounds \_\_\_\_\_\_\_\_\_\_\_\_ Use words\_\_\_\_\_\_\_\_\_\_ Combine words in short sentences

What concerns do you have about your child’s speech, language, or hearing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the kinds of sounds your child made before one year of age---- cooing, prolonged vowel sounds, babbling, repeated syllables, squealing, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your child say his/her first real word? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child’s speech or language development seem to stop for some time?\_\_\_\_\_\_\_\_\_\_\_\_\_

If you answer “yes” to this question, please respond to a and b below.

1. When and why do you think it stopped?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How did your child communicate with you during this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your child first put two or three words together? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your child begin to use more complete sentences? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many different words is your child saying now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consider your child to be talkative or quiet?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child usually let you know what he/she wants\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you answer with “pointing” or “gesturing” to this question, please respond to a and b below.

1. Does your child try to talk in combination with pointing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does anyone in the family talk for your child or interpret his/her gestures?\_\_\_\_\_\_

Do you think your child’s speech is normal for his/her age? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***IF you answer “no” to this question, please respond to a, b, and c below***.

1. How well do you understand your child’s speech? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How well do people outside the family understand your child’s speech? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How does your child react if he/she is not understood by others? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about the way your child’s tongue or mouth works for speech or for eating?\_\_\_\_\_\_\_\_

If “yes” to this question, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in the family have a history of any speech or language problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If “yes” to this question, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **FEEDING**

For his/her age is your child: Average weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Underweight\_\_\_\_\_\_\_\_\_\_\_\_

Overweight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child had frequent or severe problems with: Feeding\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chewing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teeth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Swallowing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What eating problems, diet problems or unusual food habits does the child have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **MEDICAL HISTORY**

List all medical diagnoses that your child has/had (ex. Down Syndrome, Autism, Asthma, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been seriously ill? YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, with what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any of the following? (circle all that apply): x-ray, MRI, CT Scan, Other medical tests. Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all medications your child currently takes, amount, and reason for taking:

|  |  |  |
| --- | --- | --- |
| MEDICINE | AMOUNT | REASON |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Check any of the following which pertain to your child, indication age and complication:**

|  |  |  |
| --- | --- | --- |
|  | AGE | COMPLICATIONS |
| Meningitis and/or Encephalitis |  |  |
| Convulsions/Seizures |  |  |
| Fainting Spells |  |  |
| Headaches and/or Migraines |  |  |
| Frequent Falls |  |  |
| Ear Infections |  |  |
| Diarrhea or constipation |  |  |
| Head Injury |  |  |
| Rheumatic Fever |  |  |
| Diabetes |  |  |
| Allergies |  |  |
| Eyes or Visual Problems |  |  |

1. **FAMILY HISTORY**

Complete the following table for all of the mother’s pregnancies in chronological order including any miscarriages or stillbirths:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Date of Birth** | **Birth Weight** | **Problems at birth** | **Any physical, emotional, behavioral, or educational problems** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Does anyone in the family (parent or child) have a history of physical or sexual abuse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note below if any of the child’s relatives have had any of the following conditions (for example: brother, aunt, etc.)**

Convulsions (seizures) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hyperactivity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing Loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deformations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Retardation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Severe Visual Impairment\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speech Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcoholism\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Difficulties\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emotional Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any of the above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Parent/Guardian Signature Date Completed

Please answer the following questions compared to other children your child’s age.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does your child: | Almost Always  (75% of the time or more) | Sometimes  (50% of the time) | Occasionally  (25% of the time or less) | Never or Not Applicable |
| Dislike being held or cuddled? |  |  |  |  |
| Seem easily irritated or enraged when touched by others? |  |  |  |  |
| Pinch, bite, or otherwise hurt self or others? |  |  |  |  |
| Dislike the feeling of certain clothing? |  |  |  |  |
| Seem overly sensitive to textures of food? |  |  |  |  |
| Seem overly sensitive to the temperature of food? |  |  |  |  |
| Mouth objects or clothes excessively? |  |  |  |  |
| Arch back when being held or moved? |  |  |  |  |
| Spin or whirl more than other children? |  |  |  |  |
| Rock/bounce while sitting? |  |  |  |  |
| Get nauseous from movement? |  |  |  |  |
| Jump a lot? |  |  |  |  |
| Lose balance easily? |  |  |  |  |
| Fear of space (stairs, heights, changing table, etc.)? |  |  |  |  |
| Walk on toes? |  |  |  |  |
| Seem sensitive to light? |  |  |  |  |
| Avoid eye contact? |  |  |  |  |
| Have trouble with shapes, colors, and sizes? |  |  |  |  |
| Chew on nonfood items? |  |  |  |  |
| Gag or throw up easily? |  |  |  |  |
| Trouble changing textures of foods? |  |  |  |  |
| Explore with taste? |  |  |  |  |
| Taste/smell toys, clothes or foods more than usual? |  |  |  |  |
| Have hearing loss? (yes or no?) |  |  |  |  |
| Have or had PE tubes? (yes or no?) |  |  |  |  |
| Hypersensitive to sound? (Fearful or avoidance) |  |  |  |  |
| Frequent ear infections? |  |  |  |  |
| Unable to follow 2-3 step directions? |  |  |  |  |
| Fear of unexpected noises? |  |  |  |  |
| Bump into things? |  |  |  |  |

**Behavior Plan for Summer Program**

We will try to manage and redirect all behavior in the clinic to the best of our ability. However, if a child’s behavior warrants, the consequences will be as follows:

1. Classroom consequences, Ex. Missing recess time, cleaning up a mess made, etc.
2. Call to the parent
3. Meeting with parent
4. Child sent home

These consequences will start over daily. If a child is sent home 3 times during the summer, then he/she will be discharged from the summer program.

I have read and understand this policy.

Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_