Thank you for your interest in Kidspiration!

Please select the location you are interested in!

☐Mountain Home

☐Marion County (Yellville)

Kidspiration is an Early Intervention Day Treatment (EIDT) Preschool. Your child must have Medicaid and a developmental delay to enroll. Our highly qualified therapists will complete an array of developmental evaluations to determine eligibility.

Please complete the following forms and email to info@kidsmh.com.

Make sure you fill-in or select all answers to the best of your ability. If it does not apply to your child, please put N/A.

"What is the enrollment process?"

1. First, fill it out this enrollment packet as completely and accurately as possible!

2. As soon as possible, call your child's doctor and schedule an appointment for a developmental screening.

3. Once we receive this packet back from you and your child has had the developmental screening performed by their doctor, we will put your child in our computer system and send a referral form for your child's doctor to fill out and sign. We cannot schedule your child for evaluations until we have the referral form back from the doctor! (This is required by Arkansas Medicaid.)

4. We typically schedule children to come to the preschool and be in a classroom for 1-2 full days for evaluations. While they are here, Kidspiration therapists will perform physical therapy, speech therapy, occupational therapy, and developmental evaluations. If your child qualifies based on Medicaid guidelines, we will let you know when you pick your child up on testing day and schedule a start date!

If you have any questions about the process, please let us know!

Developmental Questionnaire

PLEASE FILL IN THE BLANKS OR CIRCLE THE CORRECT ANSWERS FOR EACH QUESTION.
ALL INFORMATION PROVIDED IN THIS FORM IS CONFIDENTIAL & USED ONLY FOR THE EVALUATION AND TREATMENT OF YOUR CHILD.

1. CHILD BASIC INFORMATION

Child's Full Name: _____ **DOB:** _____

Sex: _____ **Race:** _____ **City & State of Birth:** _____

Physical Address:

_____
STREET CITY STATE ZIP CODE

Mailing Address (if different from physical):

_____
STREET CITY STATE ZIP CODE

Physician: _____ **Clinic Name and location:** _____

Medicaid Number: _____ **Social Security Number:** _____

If your child is on a PASSE or has private insurance coverage please fill out that info below. You must provide us with a copy of your child's PASSE ID card and/or private insurance ID card

PASSE TYPE: SELECT ONE: **PASSE ID #:** _____

PRIVATE INSURANCE TYPE: SELECT ONE **Policy #:** _____

Group #: _____

2. PARENT/GUARDIAN INFORMATION

Mother/Guardian Name: _____ **DOB:** _____ **Last 4 of SS#:** _____

Phone: _____ **Email Address:** _____

Physical Address: ☐ Check box if same as child's

_____

Employer: _____ **Work Phone:** _____

Work Hours/Days: _____

Father/Guardian Name: _____ **DOB:** _____ **Last 4 of SS#:** _____

Phone: _____ **Email Address:** _____

Physical Address: ☐ Check box if same as child's

_____

Employer: _____ **Work Phone:** _____

Work Hours/Days: _____

3. FAMILY/HOME INFORMATION

Child Lives with:

☐ Both Parents ☐ Father ☐ Mother ☐ Guardian

Custody:

☐ Parent Live Together ☐ Shared Custody ☐ Parent/s Not Involved

Please Explain:

_____

Is there a court ordered custody arrangement? ☐ NO ☐ YES

If yes, please provide a copy of the court order for your child's file.

SIBLINGS:

Name:	Sex:	DOB:	Relationship

WHO LIVES IN THE HOME WITH YOUR CHILD?

Name:	Age:	Relationship to Child:

4. BIRTH HISTORY

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

Birth Weight: _____ Lbs. _____ Oz's.

Pregnancy Complications:

☐ Bed Rest ☐ Anemia ☐ Gestational Diabetes ☐ Early Labor ☐ None

Other: _____

Were any prescriptions, drugs, alcohol, or tobacco products used? ☐ NO ☐ YES

If yes, explain: _____

Birth Complications:

☐ Cord Around Neck ☐ Emergency C-Section ☐ Meconium Aspiration ☐ None

Other: _____

Delivery Type: ☐ Vaginal ☐ C-Section ☐ Hospital Birth ☐ Home Birth

Health at Birth: ☐ GOOD ☐ Complications: _____

NICU: ☐ NO ☐ YES Name of Hospital: _____

Length of Stay: _____ Reason: _____

5. MEDICAL HISTORY

Hospitalizations:

Reason: _____ Date: _____ Length of Stay: _____

Reason: _____ Date: _____ Length of Stay: _____

Surgeries:

Type: _____ Date: _____

Type: _____ Date: _____

Serious Illnesses:

Type: _____ Date: _____

Type: _____ Date: _____

Medications:

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Diagnoses:

☐ Autism/ASD ☐ ADHD ☐ CP ☐ Down Syndrome ☐ CF ☐ Asthma

Other: _____

What doctor/clinic gave the diagnosis: _____ Date of Dx: _____

Has your child seen a specialist (ex. ENT, Neurologist, Cardiologist, Allergist, etc.)?
☐ NO ☐ YES If yes, please explain: _____

Allergies?: ☐ NO ☐ YES *If yes, please provide written documentation from your child's doctor.*

Food: _____

Medications: _____

Environmental/Seasonal: _____

Does your child have an EpiPen or other emergency medication? ☐ NO ☐ YES

What happens when your child comes in contact with or consumes their allergen?

_____

Hearing Screening: ☐ NO ☐ YES SELECT ONE Hearing Aids: ☐ Y ☐ N

Vision Screening: ☐ NO ☐ YES SELECT ONE Glasses: ☐ Y ☐ N

Has your child received the following evaluations?

Speech? ☐ NO ☐ YES

Physical? ☐ NO ☐ YES

Occupational? ☐ NO ☐ YES

Developmental? ☐ NO ☐ YES

If yes, what facility/therapist did the evaluation/s and what was the date of the evaluation/s?

_____

6. CHILD'S GROWTH AND DEVELOPMENT

What are your biggest developmental concerns for your child? (ex. Walking, speech, social interaction, behavior, feeding, sensory, etc.) Why do you want him/her to come to Kidspiration?

Milestones: Please put the age your child mastered the following milestones. If they have not yet achieved something, please put an X:

Milestone:	Age Mastered:
Rolled Over	
Sat Independently	
Crawled	
Pulled to Stand	
Walked	
Weaned from Bottle	
Finger Feed	
Potty Trained	

7. LANGUAGE AND HEARING

How well do you feel your child hears? SELECT ONE

Does your child have a history of ear infections? ☐ NO ☐ YES

Has your child had P.E. tubes placed in his/her ears? ☐ NO ☐ YES Date: _____

How does your child mostly communicate:

☐ Gestures/Pointing ☐ Crying ☐ Sentences ☐ Words

If your child primarily communicates by gestures/pointing please answer the following questions:

a. Does your child try to talk in combination with pointing? _____

b. Does anyone in the family talk for your child or interpret his/her gestures? _____

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

What was his/her first word? _____

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

When did your child begin to use more complete sentences? _____

Approximately how many different words is your child saying now? _____

Do you consider your child to be talkative or quiet? _____

Did your child's speech/language development seem to stop for some time? ☐ NO ☐ YES

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

a. When and why do you think it stopped?
_____

b. How did your child communicate with you during this time?
_____

Do you think your child's speech is normal for his/her age? ☐ NO ☐ YES

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

a. **Do you have trouble understanding your child's speech?** ☐ NO ☐ YES

b. **Do people outside the family have trouble understanding your child's speech?** ☐ NO ☐ YES

c. **Does your child get frustrated if he/she is not understood by others?** ☐ NO ☐ YES

Do you have any concerns about the way your child's tongue or mouth works for speech or for eating? ☐ NO ☐ YES

If "yes" to this question, please describe: _____

Does anyone in the family have a history of any speech or language problems? ☐ NO ☐ YES

☐ Sibling ☐ Mom ☐ Dad ☐ Grandparent ☐ Aunt/Uncle ☐ Cousin

8. FEEDING

For his/her age is your child: SELECT ONE

Has your child had frequent or severe problems with:

☐ Feeding ☐ Chewing ☐ Teeth ☐ Swallowing

When eating does your child: ☐ Gag ☐ Throw-up ☐ Spit-out ☐ Refuse

Is your child a picky eater? ☐ NO ☐ YES

What are your child's favorite foods and snacks?

_____

9. Social/Emotional/Self-Help

How does your child interact with other children? SELECT ONE

How does your child interact with adults? SELECT ONE

Does your child have trouble separating from you? ☐ NO ☐ YES

Is your child overly sensitive to:

☐ Lights ☐ Sounds ☐ Touch ☐ Smells ☐ Food Textures ☐ Clothing ☐ Textures

Does your child dislike being touched or held? ☐ NO ☐ YES

Does your child avoid eye contact? ☐ NO ☐ YES

Does your child pinch, bite, or hurt self or others? ☐ NO ☐ YES

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

If YES, describe behavioral problem:

_____

Methods of Discipline: ☐ Time-Out ☐ Spanking ☐ Positive Reinforcement

☐ Redirection ☐ Yelling ☐ Ignoring ☐ None

Other: _____

Do parents agree on methods of discipline? ☐ NO ☐ YES

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

☐ NO ☐ YES

Does your child understand common dangers? (ex. stove, roads, heights) ☐ NO ☐ YES

Can your child dress him/herself? ☐ NO ☐ YES

Can your child UNdress him/herself? ☐ NO ☐ YES

Is your child potty trained? ☐ NO ☐ YES ☐ Partially

Does your child let you know when they need to go potty? ☐ NO ☐ YES

Can your child feed him/herself with a spoon/fork? ☐ NO ☐ YES

Will your child stay seated at the table to eat? ☐ NO ☐ YES

10. FAMILY HISTORY

Does anyone in the family (parent or child) have a history of:

physical or sexual abuse? ☐ NO ☐ YES _____

Drug use? ☐ NO ☐ YES _____

Alcohol abuse? ☐ NO ☐ YES _____

Has your child ever been in foster care? ☐ NO ☐ YES When? _____

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

Autism: _____

ADHD: _____

Seizures: _____

Hearing Loss: _____

Severe Visual Impairment_____

Birth Defects: _____

Genetic Disorders: _____

Intellectual Disability: _____

Mental Health Problems: _____

School Difficulties/Special Ed: _____

Other: _____

Please list any additional information about your child that might be helpful for our therapists, teachers, and staff to know:

_____ _____

Completed By **Date Completed**

Classroom Information Form

This form is given to your child's teacher to help make your child's transition as smooth as possible!

Child's Name: _____ **DOB:** _____

Has your child ever been to daycare/preschool? ☐ NO ☐ YES

If yes, what is the name of the center? _____

Allergies: _____

Is your child potty trained? ☐ NO ☐ YES

Is your child a picky eater? ☐ NO ☐ YES

What are his/her favorite foods and snacks? _____

What kind of milk does your child drink?

☐ Whole ☐ 1% ☐ Lactose Free ☐ Other: _____

What does your child drink out of at home?

☐ Bottle ☐ Soft Spout Sippy ☐ Hard Spout Sippy ☐ Straw Cup ☐ Open Cup

Can your child feed him/herself independently? ☐ NO ☐ YES

How do you get your child to sleep (sing, rub back, etc.)? _____

Interests (toys, characters, shows, activities, etc.)? _____

Sensory Likes (spinning, chewing, jumping, etc.)? _____

Sensory Dislikes (noise, lights, touch, etc.)? _____

Challenging Behaviors (hitting, kicking, biting, etc.)? _____

Who lives in the home with your child?

Name:	Age:	Relationship to Child:

Is there anything else you think your child's teacher may need/like to know about your child?

Pick-Up List

The Following Individuals are Authorized to Pick-Up (Please also include parents/guardians)

Child's Name: _____

1. Name: _____
   Phone Number: _____
   Relationship: _____
   Can we give them info? ☐ Yes ☐ No

2. Name: _____
   Phone Number: _____
   Relationship: _____
   Can we give them info? ☐ Yes ☐ No

3. Name: _____
   Phone Number: _____
   Relationship: _____
   Can we give them info? ☐ Yes ☐ No

4. Name: _____
   Phone Number: _____
   Relationship: _____
   Can we give them info? ☐ Yes ☐ No

5. Name: _____
   Phone Number: _____
   Relationship: _____
   Can we give them info? ☐ Yes ☐ No

6. Name: _____
   Phone Number: _____
   Relationship: _____
   Can we give them info? ☐ Yes ☐ No

You may update your child's pick-up list at any time during your child's enrollment at Kidspiration!