Sarah Kuhlemeier
Early Learning Academy
Program Coordinator

Family Screening Profile

Early Learning Academy

Child's Name: **First** **Middle** **Last**	Date of Birth:
Birth Place: **City** **State** **Country**	☐ Male ☐ Female
Home Address:	Residing School District:

Mother's Name:	**Father's Name**:
Employer:	**Employer:**
Primary Phone Number:	**Primary Phone Number:**
Legal Guardian?: Yes No	**Legal Guardian?: Yes No**
Marital Status? Single Married Divorced	**Marital Status? Single Married Divorced**
Highest Level of Education completed by mother: **Grades 1-8 9 10 11 High School Diploma GED Bachelor's Master's/ + Vocational**	**Highest Level of Education completed by father**: **Grades 1-8 9 10 11 High School Diploma GED Bachelor's Master's /+ Vocational**

People living in the household

Name	Age	How is this person related to child listed above?

According to the following income guidelines, would you consider your household low income for the past or current year: Yes No

Number in Family	Income	Number in Family	Income	Number in Family	Income
1	$12,060	4	$24,600	7	$37,140
2	$16,240	5	$28,780	8	$41,320
3	$20,420	6	$32,960		

Are you currently receiving:

WIC? Yes No

Link? Yes No

TANF? Yes No

Medicaid/All Kids? Yes No

Childcare subsidy payments? Yes No

Has your child received services through:

Child and Family Connections
If so, dates of service:

FHN Parent Enrichment Program
If so, dates of service:

FHN Pediatric Rehabilitation
If so, dates of service:

DCFS
If so, dates of service:

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Medical Information		If yes, please explain
1. **Is your child under a doctor's care**?	Yes No	
2. **Has your child taken medicine in the last 24 hours**?	Yes No	
3. **Has your child ever been hospitalized**?	Yes No	
4. **Has your child ever had a serious injury**?	Yes No	
5. **Has your child had seizures or fainting spells**?	Yes No	
6. **Has your child experienced lead poisoning**?	Yes No	Level:
7. **Has your child had a chronic illness**?	Yes No	
8. Does your child have a history of ear infections?	Yes No	
9. **Has your child experienced hearing loss**?	Yes No	
10. **Has your child ever been evaluated for ADD /ADHD**?	Yes No	
11. **Does your child wear glasses**?	Yes No	
12. **Do you have concerns about your child's health**?	Yes No	
13. **Was your child full term**?	Yes No	

Birth weight:	**Birth length**:	**Please describe any risk factors during pregnancy or the birth of your child**:

Developmental Information		
At what age did your child:	**Stand**?	**Sit?**
Dress?	**Use the toilet?**	**Walk without help?**
Speak first words?	**Speak in sentences?**	

Did an agency refer you to screening or our program?	Yes No	
Does anyone in your family have a history of drug or alcohol abuse?	Yes No	
Does your family have a history of physical violence?	Yes No	
Has your child ever lived outside the home for an extended time?	Yes No	
Does any household member have any serious illness or handicap?	Yes No	
Have any of your child's siblings had difficulty in school?	Yes No	

Has your family recently experienced Death Divorce Moving Adoption Unemployment Restraining Order

Other:____

Does your child currently have a chance to play with others his/her own age?

Yes No

How often? ____________________

Where?

With relatives
At Sunday School
A story hour or play group
Is enrolled at preschool:
(please list)_________________
Daycare