CHILD DEMOGRAPHICS

Agency Program: _____ **KIDS Child ID#** _____

Legal First Name _____ **Legal Middle Name** _____

Legal Last Name _____**Generation Code** _____

Gender _____ **Date of Birth** ____/_____/_____
MM DD YYYY

Child's Race (Choose one or more.)

- O American Indian or Alaska Native (Origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
- O Asian (Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- O Black or African American (Origins in any of the black racial groups of Africa.)
- O Native Hawaiian or other Pacific Islander (Origins in any of the original peoples of Hawaii, Guan, Samoa or other Pacific Islands.)
- O White (Origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Child's ethnicity:

- O Hispanic/Latino (Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.)
- O Not Hispanic/Latino

Date Child Demographics Completed ____/____/_____
MM DD YYYY

MEDICAL HISTORY

1. **Birth Weight:** _____ **lbs.** _____ **ozs.**

2. **Premature?**
   O Yes O No
3. **Any Illness or complications during pregnancy or delivery?**
   O Yes O No
4. **Is/Was this child breast fed for at least 3 months during the baby's first 6 months?**
   O Yes O No

5. **During this program year, does this child have a doctor he/she sees regularly?**
   O Yes O No

6. **During this program year, has this child had any chronic (reoccurring over more than 3 months) medical conditions with the potential for negatively influencing development?**
   O Yes O No

7. **In the last 12 months, was the child taken to the dentist or received dental care?**
   O Yes O No

8. As of the date of this screening, are immunizations current for this child? (If yes, skip question 9)

○ Yes ○ No

9. If the immunizations are not current, check all that apply:

- ○ Family opts out for religious or medical reasons.
- ○ Family lacks access to services (i.e. transportation).
- ○ Immunization is not available at this time due to shortage of supply.
- ○ Other _____

PROGRAM PARTICIPATION

1. Number of visits scheduled _____

2. Number of visits completed _____

3. List of Early Childhood Programs the child was enrolled in during the past 12 months (select any that apply):

- ○ Parents as Teachers
- ○ Early Head Start
- ○ Head Start
- ○ Family Child Care Home
- ○ Early Childhood Special Education
- ○ Community Preschool or Center
- ○ Healthy Families
- ○ Part C Infant/Toddler Early Intervention
- ○ Other District Sponsored Preschools such as 4 Year Old At-Risk Preschool

4. Start Date: ____/___/_____ MM/DD/YYYY

5. Exit Date: ___/___/_____ MM/DD/YYYY

6. Exit Reason (check one):

- ○ Child is too old to participate or the family completed the service cycle.
- ○ The family or child transitioned to another early childhood or family support program.
- ○ The child/family moved out of the service area.
- ○ The family regularly missed scheduled personal visits.
- ○ Family could not be located.
- ○ Family was dissatisfied with the program.
- ○ Left program for other reasons/unknown.