CHILD SURVEY

Agency Program Name: _______________________________ 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.)
○ 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.)
○ 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.)
○ Black or African American (Origins in any of the black racial groups of Africa.)
○ Native Hawaiian or other Pacific Islander (Origins in any of the original peoples of Hawaii, Guan, Samoa or other Pacific Islands.)
○ White (Origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Child’s ethnicity:
○ Hispanic/Latino (Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.)
○ Not Hispanic/Latino

Date Child Demographics Completed ______/_____/_______ MM   DD   YYYY

Primary Funding Source for this child (At least 30% funding. Check up to three sources that apply to this child.):
○ KSDE Parents as Teachers
○ KSDE Kansas Preschool Program
○ Children’s Cabinet Early Childhood Block Grant
○ Children’s Cabinet CBCAP
○ KDHE MIECHV
○ DCF Kansas Early Head Start
○ Federal Early Head Start
○ Federal Head Start
○ Federal Early Childhood Special Education
○ KDHE Early Childhood Special Education
○ Private
○ Other: _________________________________

Zip Code of Child’s Primary Residence: ________________

MEDICAL HISTORY

Questions 1 through 4 to be answered only by programs serving the child prior to age 3. If this child is 3 or older when beginning services, skip to Question 5:

1. Birth Weight: _______ lbs. _______ ozs.

2. Premature?
   ○ Yes
   ○ No
3. Any Illness or complications during pregnancy or delivery?
   ○ Yes  ○ No

4. Is/Was this child breast fed for at least 3 months during the baby’s first 6 months?
   ○ Yes  ○ No

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

7. In the last 12 months, was the child taken to the dentist or received dental care?
   ○ Yes  ○ 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

Home Visiting Program complete:
1. a. Number of visits scheduled ________
   b. Number of visits completed ________

Preschool, Center or School classroom based program or group based service complete:
1. a. Maximum number of Days in the year that a child can attend this program: ________
   b. Number of Program Hours within a Day __________
   c. Number of days this child has attended this program ________

2. List of Early Childhood Programs this child was enrolled in during the past 12 months (select any that apply):
   ○ Parents as Teachers
   ○ Early Head Start
   ○ Head Start
   ○ Part C Infant Toddler Early Intervention
   ○ Early Childhood Special Education
   ○ Family Child Care Home
   ○ Community or Private Preschool or Child Care Center
   ○ School based Preschool (such as 4 Year Old At Risk Preschool) or Child Care Center
   ○ Healthy Families
   ○ Other ________________________________
3. Start Date: _____/_____/______
   MM/DD/YYYY

4. Exit Date: _____/_____/______
   MM/DD/YYYY

5. 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.