



Rogers Public Schools Pre-Kindergarten Application

● Child Information

Student Full Name : _____

Birthdate: _____ Birth Country: _____

Gender: Male _____ Female _____ Race/Ethnicity: _____

Social Security: _____ Primary Language: _____

Secondary Language: _____ Speaks English at Home?: yes / no

Name of physician or emergency care provider: _____

Physician phone number: _____

Physician Address: _____

Child's birth weight: _____

List any allergies: _____

Does this child have any special dietary needs? _____

Does this child receive any special education services? _____

Does this child have medical insurance? Yes / No

Name of Medical Insurance Provider _____

List all siblings living in the household: *(Name, Age, School of children birth-18 years old)*

Child's name: _____ Age: _____ School: _____

Child's name: _____ Age: _____ School: _____

Child's name: _____ Age: _____ School: _____

Child's name: _____ Age: _____ School: _____

Child's name: _____ Age: _____ School: _____

I declare under the penalty of perjury and the rules and regulations of the Arkansas Better Chance program that the information supplied is true and correct. I understand that the information I supplied may be independently verified by the Arkansas Division of Child Care and Early Childhood Education and that any false statements may result in exclusion from DHS programs and criminal prosecution.

Signature of Primary Caregiver: _____ Date: _____

● **Parent Information- Primary Caregiver**

Parent Full Name : _____

Birthdate: _____ Birth Country: _____

Gender: Male _____ Female _____ Race/Ethnicity: _____

Relation to child: _____ Phone Number: _____

Current Address: _____

City/State: _____ Zip code: _____

Email Address: _____

Employment Status (FT,PT) _____ Employer Name: _____

Employer Number: _____

Parental Status:

_____ Two Parent, _____ Single Parent, _____ Other-Specify _____

Marital Status:

_____ Married _____ Single _____ Divorced

Number in Family: _____ Number in Household: _____

Primary Language: _____

Highest Education-(Please circle or write on line):

None, Grade: 1, 2, 3, 4, 5, 6, 7, 8, 9 10, 11, 12, high school diploma, GED,
some college, AA/AS, BA/BS, MA/MS _____

_____ Parent deployed military, _____ Child in custody of someone other than parent,
_____ Child in foster care, _____ Parent incarcerated, _____ No income

● **Parent Information- Secondary Caregiver**

Parent Full Name : _____

Birthdate: _____ Birth Country: _____

Gender: Male _____ Female _____ Race/Ethnicity: _____

Relation to child: _____ Phone Number: _____

Current Address: _____

City/State: _____ Zip code: _____

Email Address: _____

Employment Status (FT,PT) _____ Employer Name: _____

Employer Number: _____

Primary Language: _____

Highest Education-(Please circle or write on line):

None, Grade: 1, 2, 3, 4, 5, 6, 7, 8, 9 10, 11, 12, high school diploma, GED,
some college, AA/AS, BA/BS, MA/MS _____

● **Health History Questionnaire** *(Please answer yes or no)*

1. Does your child pay attention when being read to? _____
2. Can your child play independently for over a ½ hour? _____
3. Does your child follow instructions and obey adults? _____
4. Does your child speak clearly enough for others to understand? _____
5. Can your child dress without help? _____
6. Does your child have any speech problems (stuttering, delayed)? _____
7. Does your child object to being left with a sitter? _____
8. Does your child ever wet or soil him/herself during the day? _____
9. Do you have any concerns about your child's general health (eating and sleeping habits, bowel or bladder, posture, teeth, skin, weight, etc)? _____
10. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or
11. watery eyes, wear glasses or contact lenses)? _____
12. Does your child have any ear or hearing problems (frequent ear aches, difficulty hearing, draining ear, use of hearing aid, etc)? _____
13. Does your child have any allergies (food, insects, medications, pollens, etc.)? _____
14. Does your child have any specific sickness which might in your opinion affect his/her school performance? _____
15. Has your child received any medical or other evaluation, the findings of which could help school personnel in meeting his/her health or educational needs? _____
16. Does this problem require any health care in school? _____
17. Does your child take medications? _____
18. Do you have any concerns about your child's developmental behavior or emotional well-being of which the school should be aware? _____
19. Does the child receive any special services (speech, developmental, ot/pt ect.) _____
20. Has your child had a dental exam within the last 12 months? _____
21. Has your child experienced wheezing or coughing within the last 12 months? _____
22. Has your child ever had any hospitalizations, operations, or major illness or injury? _____

Please describe the problem or concern you have below:

Information on this form may be shared with appropriate personnel for health and educational purposes.

Signature of Primary Caregiver: _____ Date: _____