ECARE FULL DAY KINDERGARTEN SCHOLARSHIP APPLICATION
2014 – 2015

Date:_____ Grade:_____ School:_____

Student Full *Legal* Name: (Last Name)_____(First Name)_____

(Full Middle Name):_____ (Nickname)_____

Birth Date:_____ Gender ☐ M ☐ F

Student Cell Phone #:_____ Student Email address:_____

Mailing Address:_____ Apt #_____

Mailing City:_____ Mailing State:_____ Mailing Zip Code:_____

Physical Address:_____
Street City State Zip

Home Phone:_____ County of Residence:_____

Date student entered **school** in: RFSD_____ Colorado_____ US_____

Please list other siblings living at home:

Name	Date of Birth	Gender	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent/Legal Guardian Information (address information if different from student):

Name:_____ Employer:_____

Relationship to student: ☐Father ☐Mother ☐Stepfather ☐Stepmother ☐Grandfather
☐ Grandmother ☐other _____ (please specify)

Custodial Parent: ☐Yes ☐No

Mailing Address:_____ City & State_____ Zip Code_____

Physical Address:_____ Student resides here:☐Yes ☐No

Home Phone #:_____ Email Address:_____

Work Phone #:_____ Ext._____ Cell Phone #:_____

Name:_____ Employer:_____

Relationship to student: ☐Father ☐Mother ☐Stepfather ☐Stepmother ☐Grandfather
☐ Grandmother ☐Other_____ (please specify)

Custodial Parent: ☐Yes ☐No

Mailing Address:_____ City & State_____ Zip Code_____

Physical Address:_____ Student resides here:☐Yes ☐No

Home Phone #:_____ Email Address:_____

Work Phone #:_____ Ext._____ Cell Phone #:_____

We prefer to receive correspondence in: ☐English ☐Spanish

_____ _____
Parent/Legal Guardian Signature Date

Social Security Number/ _____ Medicaid Number/_____

What does your child like to be called? _____ Place of Birth/ _____

Number of moves in last 3 years: _____

Others living in the home (not immediate family):

Name: _____ Relation to Child: _____
Name: _____ Relation to Child: _____
Name: _____ Relation to Child: _____

Programs your child is or has been involved with (circle all that apply):

Childcare Center Family Childcare Home Preschool WIC

Early Childhood Connections Public Health Family Visitor Program

Mountain Valley Developmental Services Other: _____

COMPLETE THIS FOR PRESCHOOL ENROLLMENT ONLY:

Where will parents be while child is attending school?
Mom _____ Phone # _____
Father _____ Phone # _____

Will Your Child go to a Sitter Regularly? _____ If yes, Sitter's Name _____
Address: _____ Phone:_____

Name of Persons Your Child May be Released To
Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Person to Contact In case of an Emergency (List in the order we should call.)
Name _____ Phone: _____

Name _____ Phone: _____

Name _____ Phone: _____

Health and Developmental History

Pregnancy and Birth:

Length of pregnancy: _____ (weeks)

Age when first pregnancy occurred? Mother _____ Married_____ Father _____ Married____

Describe any illnesses, bleeding, x-rays, or medications taken during pregnancy:

_____

Smoking or alcohol use/ _____ Child's birth weight/ _____

Problems with labor or birth: _____

_____

Has there ever been a concern about the age at which your child began?
Crawling _____ Walking _____ Talking _____

Illnesses: (If none of these apply to your child please circle NO)

Mumps _____ Chicken Pox, _____ Ear Infections _____
Rubella _____ Pnuemonia/Bronchitis/Strep Throat _____
Meningitis _____ Epilepsy/Seizures _____ Heart Condition _____
Other _____

Injuries: (If none of these apply to your child please circle NO)

Fractures _____ Head Injuries _____ Stitches _____

Conditions: (If none of these apply to your child please circle NO)

Birth Defects Bathroom Urgency Shortness of breath
Frequent Headaches Frequent Nosebleeds Frequent Upset Stomach
Toothaches Fever (104 over 2 days

Operations/Hospitalizations (If none of these apply to your child please circle NO)

Tubes in ears _____ Other _____

Allergies

Drug _____ Asthma _____ Insect _____
Foods _____ Pollen _____ Eczema _____
Other _____
Describe the reactions: _____
Does it require immediate medical attention? _____

Physical Development

Do you have questions or concerns about your child's physical development in any of these areas?
(If none of these apply to your child please circle NO)

Holding head up	Running	Rolling over	Eating
Sitting up	Climbing	Creeping	Balance
Crawling	Activity level	Standing	Using hands w/ small objects
Walking	Sleeping	Using Stairs	Riding trike or bike

Other _____

Speech & Language Development

Do you have questions or concerns about your child's speech or language development in any of these areas? **(If none of these apply to your child please circle NO)**

Babbling Talking Forming sounds correctly Other_____
Eating/swallowing

Sensory Development

Do you have questions regarding your child's sensory development in any of these areas?
(If none of these apply to your child please circle NO)

Enjoying cuddling/physical contact
Tolerating moderate noises
Liking variety of foods
Tolerating variety of fabrics on clothing
Tolerating light
Tolerating messy hands
Enjoying water play
Enjoying playdough
Vision Hearing
Other _____

Social Emotional Development

Do you have questions regarding your child's social emotional development in any of these areas?
(If none of these apply to your child please circle NO)

Smiling
Laughing
Talking
Being held/cuddled
Enjoying other children
Separating from parents
Following parent requests (most of the time
Others _____

Handling frustration
Activity level
Handling disappointment
Handling anger

Any history of emotional or physical abuse or neglect _____ (Yes) _____ (No)

Any history of substance abuse in home _____ (Yes) _____ (No)

Any history of domestic violence? _____ (Yes) _____ (No)

Educational Development

Do you have questions or concerns about your child's educational development in any of these areas?
(If none of these apply to your child please circle NO)

Using age appropriate toys
Playing games like Patty-Cake, Peek-a-Boo
Enjoying short picture booksRemembering things
Solving simple challenges
Other _____
Any close family with history of learning or school challenges? ___ (Yes) ____ (No)
Who _____ Type of challenge: _____

Other Information

Has your child and family been experiencing any unusual stress recently? (For example: moving, family health problems, death of family members, divorce, etc.)

_____

Does your child use any medication daily? Please explain: _____ (Yes) _____ (No)

_____

Does your child have any physical restrictions? Please explain: ____ (Yes) ____ (No)

Vision

Have your child's eyes ever been checked by an eye doctor or family doctor? _____ (Yes) _____ (No)

Who was the doctor _____ Date _____

Were the results Satisfactory Unsatisfactory

Do you have concerns about your child's vision at this time? ____ (Yes) _____ (No)

Below is a checklist of signs and behaviors that may indicate possible vision problems. Please check any items that describe your child.

___Sensitive to Light ___Rubs Eyes Frequently
___Looks Cross-Eyed ___Shuts or Covers One Eye
___Brushes At Eyes Frequently
___Blinks More Than Usual
___Tilts Head To One Side
___One or Both Eyes Wander
___Holds Book Close to Face or Stands Close to TV
___Squints or Makes Faces When Trying to See Distant Object

Comments:

_____

_____

Hearing

Do you feel your child has a hearing problem? _____ (Yes) _____ (No)
If so, why_____

Is your child currently or has he/she been seen by an ear specialist? _____ (Yes) _____ (No)

If so, whom? _____ Date _____

Has your child's hearing been tested before? _____ (Yes) _____ (No)
Check any that describe your child
___Jumps or startles at loud sounds
___Turns toward a sound
___Notices sounds in the environment such as an airplane overhead or a dog barking
___Responds to questions when you have their attention
___Imitates words or sounds

Comments: _____

_____

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CPP applications only

Total Gross Annual Household Income (circle one)
Less than 21,256 21,257 to 28,693 28,694 to 36,130 36,131 to 43,567 43,568 to 51,004

More than 51,005 - how much $_____

History of unemployment? Yes No Seasonal employment?/ Yes No

How long is your commute to work? _____

Last year of school completed: Mother _____ Father _____

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Tell us about your child

Describe things about your child that you are happy about and things that you worry about.

_____

_____

_____

What are your family's priorities right now?

_____

_____

_____

What else might be important for us to consider?

_____

_____ _____

Parent/Guardian Signature Date

Thank you for completing this form.

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For office use only **Agency Referrals:**

Advocate Safehouse Project Child Find Colorado West Family Visitors
Dept. of Social Services Healthy Beginnings Gateway (job training) Lift Up
Head Start Colorado Preschool Program Valley Settlement Project Raising A Reader