# FIRST THINGS FIRST

**DEVELOPMENTAL & SENSORY \| CHILD**

**Medical Insurance Information: This child has (check all that apply)**

- ☐ AHCCCS or KidsCare:
- ☐ Other Medical Insurance: (Name) ____________________________
- ☐ Employer
- ☐ No Medical Insurance
- ☐ Indian Health Service (IHS)
- ☐ Private
- ☐ Military

**Medical History**

Does this child have Dental Insurance? ☐ No ☐ Yes

Does this child have a primary healthcare provider? ☐ No ☐ Yes Dr./Practice ____________________________ Number: __________________

Does this child have any of the following: Individualized Service Plan (IEP), Individualized Family Service Plan (IFSP), 504, Individualized Health Plan (IHP) or any medically diagnosed special healthcare needs? ☐ No ☐ Yes

**Does this child have any of the following?**

- Glasses ☐ No ☐ Yes If yes, please list date of last exam: ____________________________
- PE Tubes ☐ No ☐ Yes If yes: ☐ Right ☐ Left
- Allergies ☐ No ☐ Yes If yes, please list: ____________________________
- Medical or developmental condition ☐ No ☐ Yes If yes, please list: ____________________________
- Taking any medication ☐ No ☐ Yes If yes, please list: ____________________________

Please indicate any additional information/concerns: ____________________________

**Consent: Your child can only receive these Early Childhood Screenings if you sign and return this form. Thank you.**

"YES, I give consent for my child to have a vision and hearing and/or ASQ developmental screening performed by the University of Arizona, Cooperative Extension, Gila County for the purposes of evaluating my child’s developmental growth. I understand the results of the screenings may be shared with my child’s AHCCCS plan, First Things First, County and its partners.

A summary of the screening results will also be provided to the program representative where my child(ren) are enrolled. I understand the screenings performed are not a medical diagnosis, but a tool utilized to detect if there is a need for further follow-up with a licensed medical professional. In addition, I understand that I am responsible for following up with a licensed medical professional.

☐ By checking, I authorize the University of Arizona, Cooperative Extension to provide screening results to my child’s doctors/providers, to receive diagnosis/treatment from doctors/providers and to provide hearing screening results to the AZ Dept. of Health Services - Hearing Screening Program."

**Check all that apply and sign below:**

- ☐ Yes, please perform a Vision Screening for my child.
- ☐ Yes, please perform a Hearing Screening for my child.
- ☐ Yes, please perform a Developmental Screening for my child.
- ☐ No, please do not provide any screenings.

**Parent/Guardian Signature:** ____________________________ **Date:** ____________________________

(Please Complete Other Side)
First Things First

Parent/Guardian

Thank you for taking time to answer the following questions - this will help us provide better care and support for families with young children like yours!

Parent/Guardian Demographic Information

Parent/Guardian Date of Birth (DOB): ___________________________ Gender: □ M □ F  Primary Language: □ English □ Spanish □ Other

Race: □ Alaska Native □ American Indian □ Asian □ Black/African American □ Native Hawaiian/Pacific Islander □ White □ Other

Ethnicity is Hispanic/Latino: □ Yes □ No

Your Medical Insurance Type:

□ Employer □ Private insurance □ AHCCCS/Medicare □ Indian Health Services (IHS) □ Military □ None □ Other __________

Do you have Dental Insurance? □ No □ Yes

Do you have a regular doctor or primary care physician? □ No □ Yes

Your education:

□ Less than high school □ High school graduate/GED □ Some college
□ Technical/vocational degree □ Bachelor’s degree or higher

Are you currently employed? □ Yes □ No

Are any of the other adults in your household (check all that apply):

□ Employed □ Active military □ Military Veteran

What is your annual household income?

□ Less than $15,000 □ $15,000 - $30,000 □ $31,000 - $45,000 □ $46,000 - $60,000
□ $61,000 - $75,000 □ $76,000 - $90,000 □ $91,000 - $105,000 □ Over $105,000

Are you the legal guardian? □ No □ Yes

How many adults (18 and over) are in your household, including you? __________

How many children live with you? Under 1 year old: _______ 1 – 2 years old: _______ 3 – 5 years old: _______ 6 – 17 years old: _______

Are there any children under age 6 in your household who have Individualized Service Plan (IEP), Individualized Family Service Plan (IFSP), 504, Individualized Health Plan (IHP) or any medically diagnosed special healthcare needs? □ Yes □ No

Where do you usually take the child(ren) in your household who are not yet in kindergarten to be cared for during the day?

□ An adult in my home □ Child care center/preschool □ Family child care home □ Relative, neighbor or babysitter □ Head Start

Do any of these programs currently serve you or another family member in your household? (check all that apply)

□ WIC □ Food stamps/EBT/SNAP □ Cash assistance/TANF □ DES child care subsidy □ Quality First scholarship □ Other __________

University of Arizona, Cooperative Extension, Gila County

ǁ Chrisann Dawson ǁ (928) 595-0655, phone ǁ

OFFICIAL USE ONLY:

ID #: ____________________________

Screener: ___________________________ Screening Site: ___________________________ Screening Date: _____________