FIRST THINGS FIRST

THE UNIVERSITY OF ARIZONA Cooperative Extension

DEVELOPMENTAL & SENSORY || CHILD

Child's Name: ______________________________ **Child's Birth Date:** ______________ **Gender:** ☐ M ☐ F
(First) (Last)

Birth Hospital: ______________________ **Located in (State):** ______________ **If Premature, # of weeks:** ________

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

Primary Language: ☐ English ☐ Spanish ☐ Other
Ethnicity is Hispanic/Latino: ☐ Yes ☐ No

Parent/Guardian Name: ______________________________ **Relationship to the child:** ______________
(First) (Last)

Street Address: ____
(Address) (City) (State) (Zip)

Parent's Email: ______________________________ **Phone Number:** ______________

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 your 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)

Issued in furtherance of Cooperative Extension work, acts of May 8 and June 30, 1914, in cooperation with the U.S. Department of Agriculture, Jeffrey C. Silvertooth, Associate Dean & Director, Economic Development & Extension, College of Agriculture and Life Sciences, The University of Arizona.
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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
‖ Chrisann Dawson ‖ (928) 595-0655, phone ‖

OFFICIAL USE ONLY: ID #: ______________________

Screener: __________________________ Screening Site: __________________________ Screening Date: _____________

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