Preschool Information Sheet

Child's Name: _____ Nickname: _____ Current age: _____ DOB: _____

Father's Name: _____ E-mail Address: _____

Mother's Name: _____ E-mail Address: _____

Siblings: _____

Does your child have any unusual fears? _____

Do you have any concerns with your child's speech? _____ Vision? _____ Hearing? _____

Is your child able (on his/her own) to button? _____ Snap? _____ Zipper? _____

Does your child have a pet/pets? _____ If so what are they and what are the pet's names? _____

_____

What form of discipline does your child respond to best? _____

_____

Does your child have any allergies? _____ If so what to and what is the reaction? _____

_____

_____

How would you describe your child's personality? _____

_____

What are some of your child's hobbies/interest? _____

_____

What would you like to see your child get out of this learning program? _____

_____

_____

Does your child have a normal rest/nap time? _____ If so when is it? _____

_____

CONFIDENTIAL

BELL SHOALS BAPTIST ACADEMY

BACKGROUND CHECK AUTHORIZATION

Bell Shoals Baptist Academy requires background checks for al] volunteers. You are asked to sign this release form authorizing such checks. These checks include verification of social security number as well as a criminal records check. If conviction is discovered, a determination will be made whether the conviction is related to working with children and would present a safety or security risk.

Any vqlunteer who provides misleading, erroneous or willfully deceptive information to the Academy will be eliminated from volunteering.

Print Name: _____

{First) (Middle) (Last) • (Malden)

Names of Children enrolled in the Academy: _____

Current Address: _____

(Street) (zip/State)

Social Security number: _____ Date of Birth: _____

Telephone Number: _____

Driver's License Number: _____

{PIease!3ttach a copy of License)

Are you a member of Bell Shoals Baptist Church? Y/N_ _

Have you previously volunteered with children or youth at Bell Shoals Baptist Church? Y/N___ _

Printed Name: _____

Signature: _____ Date: _____

Please include a check for $10.00 made payable to BSBA to cover the processing fee and a copy of your driver's license.
We will not be able to process this request unless both of these ar_e attached. Thank you!

(Admin Only) ___ paid ___ Shelby _ pending approval ___ approved

AdministrativeSignature: _____ Oate: _____

BSBA Allergy Action Plan

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Place Student's Picture Here

Please list all foods, medicines and/or environmental items that your child has a severe reaction to:

_____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely ingested/exposed.*

☐ If checked, give epinephrine immediately if the allergen was *definitely ingested/exposed*, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

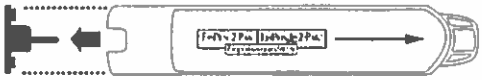
Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER

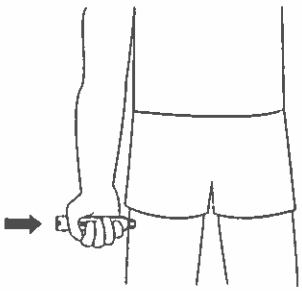
Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

EpiPen Auto-Injector and EpiPen Jr Auto-Injector Directions

- First, remove the EpiPen Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EpiPen Auto-Injector and massage the area for 10 more seconds

EpiPen 2-Pak® | EpiPen Jr 2-Pak®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

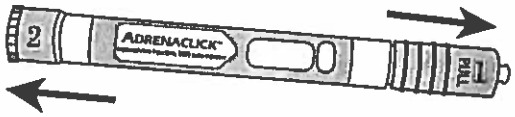
<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

An allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this BSBA Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___)_____-_____) Doctor:_____ Phone: (___)_____-_____

Parent/Guardian:_____ Phone: (___)_____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___)_____-_____

Name/Relationship: _____ Phone: (___)_____-_____

Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

Potty Training Policy

PLEASE READ CAREFULLY

It is BSBA's policy that your child be completely potty trained. **NO PULL-UPS, DIAPERS or TRAINING PANTS** of any kind are permitted in our 3 or 4 year old program. The following policy is from our handbook regarding potty training.

All children 3 years and older enrolling in Bell Shoals Baptist Early Learning Center **MUST** be fully toilet-trained by the start of school. "Pull-Ups" are not appropriate undergarments during your child's school day. We are not licensed for diapering. We do recognize, however, that 2 1/2-,3-, and 4-year olds have accidents, and they are reminded often. Repeated "accidents" (three or more in a five day period) could result in a probationary period where the child is kept home until toilet training is successful.

Step 1: After three accidents occur within five school days, a note will go home to the parents to be signed and returned to school.

Step 2: A conference with parents will be scheduled if an additional two accidents occur within five school days.

Step 3: If an additional two accidents occur, the child will be placed on one-week probation (potty contract) where the child will not be allowed at school so they can work on potty training.

Step 4: If after the one-week probation has ended and the child is not potty trained then the student will be dismissed from the school.

(Potty – Trained means being self – sufficient in the bathroom, with little or no help from staff)

Please sign and return this policy to your student's teacher on your one-on-one. You may contact the office with any questions you may have regarding this policy.

_____ _____

Parent Signature Date

_____

Child's Name (Please Print)

During the 2009 legislative session, a new law was passed that requires child care facilities, family day care homes and large family child care homes provide parents with information detailing the causes, symptoms, and transmission of the influenza virus (the flu) every year during August and September.

My signature below verifies receipt of the brochure on *Influenza Virus, The Flu, A Guide to Parents:*

Name:_____

Child's Name: _____

Date Received:_____

Signature:_____

Please complete and return this portion of the brochure to your child care provider, in order for them to maintain it in their records.

What should I do if my child gets sick?

Consult your doctor and make sure your child gets plenty of rest and drinks a lot of fluids. Never give aspirin or medicine that has aspirin in it to children or teenagers who may have the flu.

CALL OR TAKE YOUR CHILD TO A DOCTOR RIGHT AWAY IF YOUR CHILD:

- Has a high fever or fever that lasts a long time
- Has trouble breathing or breathes fast
- Has skin that looks blue
- Is not drinking enough
- Seems confused, will not wake up, does not want to be held, or has seizures (uncontrolled shaking)
- Gets better but then worse again
- Has other conditions (like heart or lung disease, diabetes) that get worse

How can I protect my child from the flu?

A flu vaccine is the best way to protect against the flu. Because the flu virus changes year to year, annual vaccination against the flu is recommended. The CDC recommends that all children from the ages of 6 months up to their 19th birthday receive a flu vaccine every fall or winter (children receiving a vaccine for the first time require two doses). You also can protect your child by receiving a flu vaccine yourself.

What can I do to prevent the spread of germs?

The main way that the flu spreads is in respiratory droplets from coughing and sneezing. This can happen when droplets from a cough or sneeze of an infected person are propelled through the air and infect someone nearby. Though much less frequent, the flu may also spread through indirect contact with contaminated hands and articles soiled with nose and throat secretions. To prevent the spread of germs:

- Wash hands often with soap and water.
- Cover mouth/nose during coughs and sneezes. If you don't have a tissue, cough or sneeze into your upper sleeve, not your hands.
- Limit contact with people who show signs of illness.
- Keep hands away from the face. Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.

When should my child stay home from child care?

A person may be contagious and able to spread the virus from 1 day before showing symptoms to up to 5 days after getting sick. The time frame could be longer in children and in people who don't fight disease well (people with weakened immune systems). When sick, your child should stay at home to rest and to avoid giving the flu to other children and should not return to child care or other group setting until his or her temperature has been normal and has been sign and symptom free for a period of 24 hours.

For additional helpful information about the dangers of the flu and how to protect your child, visit: http://www.cdc.gov/flu/ **or** http://www.immunizeflorida.org/

What is the influenza (flu) virus?

Influenza ("the flu") is caused by a virus which infects the nose, throat, and lungs. According to the US Center for Disease Control and Prevention (CDC), the flu is more dangerous than the common cold for children. Unlike the common cold, the flu can cause severe illness and life threatening complications in many people. Children under 5 who have the flu commonly need medical care. Severe flu complications are most common in children younger than 2 years old. Flu season can begin as early as October and last as late as May.

How can I tell if my child has a cold, or the flu?

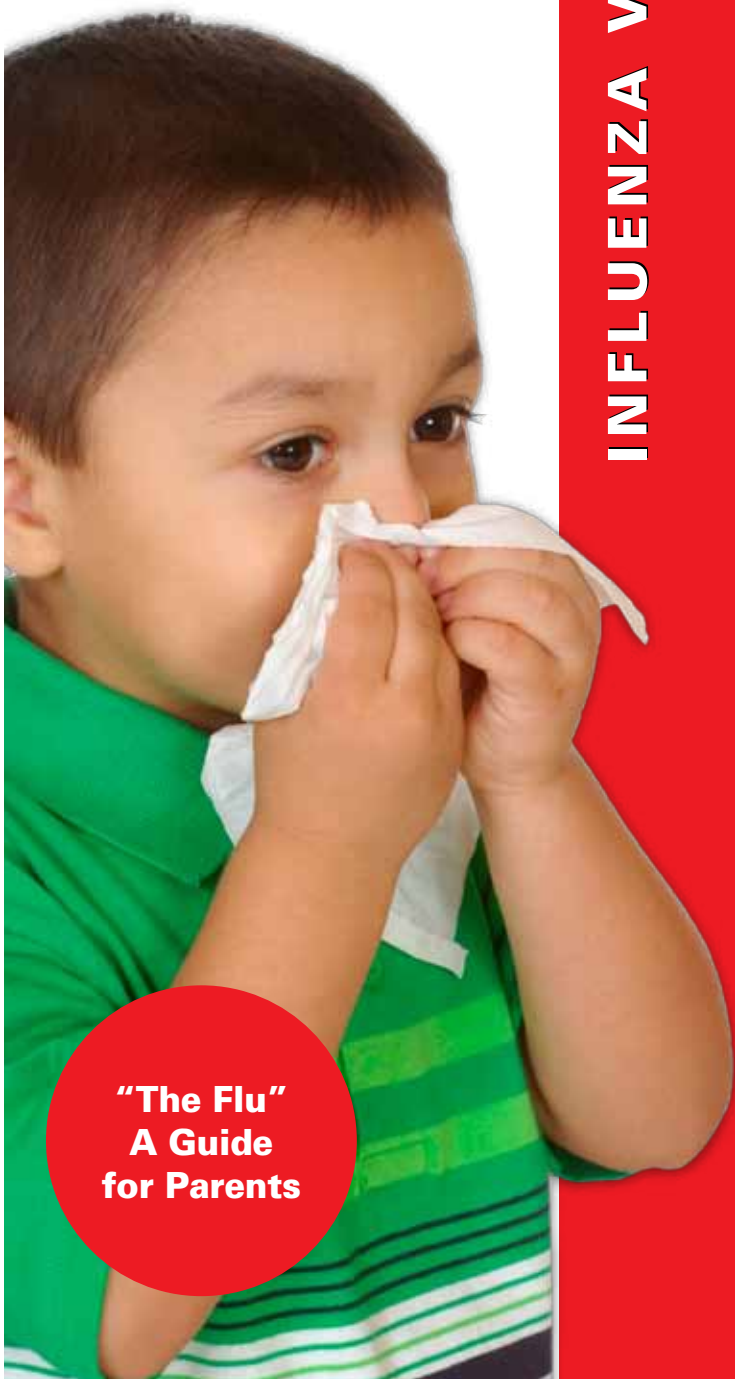
Most people with the flu feel tired and have fever, headache, dry cough, sore throat, runny or stuffy nose, and sore muscles. Some people, especially children, may also have stomach problems and diarrhea. Because the flu and colds have similar symptoms, it can be difficult to tell the difference between them based on symptoms alone. In general, the flu is worse than the common cold, and symptoms such as fever, body aches, extreme tiredness, and dry cough are more common and intense. People with colds are more likely to have a runny or stuffy nose. Colds generally do not result in serious health problems, such as pneumonia, bacterial infections, or hospitalizations.

Florida Department of Children & Families

For additional information, please visit www.myflorida.com/childcare or contact your local licensing office below:

CF/PI 175-70, June 2009

This brochure was created by the Department of Children and Families in consultation with the Department of Health.



INFLUENZA VIRUS

"The Flu" A Guide for Parents

Getting In; Getting Out...

Out: Check the Back Seat

- In just **10 minutes**, a car's temperature can increase by **19°**
- Before getting out of your car, check the back seat ... **Don't forget your child!**
- **Never** leave your child alone in a car and **call 911 if you see any child locked in a car!**
- Place something in the back seat that you will need at work, school, or home (your laptop; your lunch).

Developed by:
PREVENTION UNIT
Office of Family and Community Services

Getting In; Getting Out...

In: Check Behind The Car

- **Before getting in the car and starting the engine,** walk around the car and **check for kids, toys, and pets!**
- Make sure there is **nothing under or behind your car** that could attract a young child.
- **Pick up toys, bikes, chalk, or any type of equipment** around the driveway so that these items don't entice kids to play.

Developed by:
PREVENTION UNIT
Office of Family and Community Services

ASQ-3 Ages & Stages Questionnaires®

36 Month Questionnaire

34 months 16 days through 38 months 30 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Child's information

Child's first name: _____ Middle initial: _____ Child's last name: _____

Child's gender: ◯ Male ◯ Female

Child's date of birth: _____

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

Street address: _____

City: _____ State/ Province: _____ ZIP/ Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Parent Signature: _____

Program Information

Child ID #: _____

Program ID #: _____

Program name: _____

P101360100

ASQ-3

36 Month Questionnaire

34 months 16 days through 38 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least *seven* body parts? *(She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.)*	○	○	○	___
2. Does your child make sentences that are three or four words long? Please give an example:	○	○	○	___
3. Without giving your child help by pointing or using gestures, ask him to "put the book *on* the table" and "put the shoe *under* the chair." Does your child carry out both of these directions correctly?	○	○	○	___
4. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture (for example, "barking," "running," "eating," or "crying")? You may ask, "What is the dog (or boy) doing?"	○	○	○	___
5. Show your child how a zipper on a coat moves up and down, and say, "See, this goes up and down." Put the zipper to the middle and ask your child to move the zipper *down*. Return the zipper to the middle and ask your child to move the zipper *up*. Do this several times, placing the zipper in the middle before asking your child to move it up or down. Does your child consistently move the zipper up when you say "up" and down when you say "down"?	○	○	○	___
6. When you ask, "What is your name?" does your child say both her first and last names?	○	○	○	___

COMMUNICATION TOTAL ___

E101360200

GROSS MOTOR

		YES	SOMETIMES	NOT YET	
1. Without holding onto anything for support, does your child kick a ball by swinging his leg forward?		○	○	○	___
2. Does your child jump with both feet leaving the floor at the same time?		○	○	○	___
3. Does your child walk up stairs, using only one foot on each stair? *(The left foot is on one step, and the right foot is on the next.)* She may hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*		○	○	○	___
4. Does your child stand on one foot for about 1 second without holding onto anything?		○	○	○	___
5. While standing, does your child throw a ball *overhand* by raising his arm to shoulder height and throwing the ball forward? *(Dropping the ball or throwing the ball underhand should be scored as "not yet.")*		○	○	○	___
6. Does your child jump forward at least 6 inches with both feet leaving the ground at the same time?		○	○	○	___

GROSS MOTOR TOTAL ___

FINE MOTOR

		YES	SOMETIMES	NOT YET	
1. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction?	Count as "yes" 1 1 1 / Count as "not yet" 2 3	○	○	○	___

FINE MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	

2. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace?

○ ○ ○ ___

3. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle?

Count as "yes"

Count as "not yet"

○ ○ ○ ___

4. After your child watches you draw a line from one side of the paper to the other side, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction?

Count as "yes"

Count as "not yet"

○ ○ ○ ___

5. Does your child try to cut paper with child-safe scissors? He does not need to cut the paper but must get the blades to open and close while holding the paper with the other hand. *(You may show your child how to use scissors. Carefully watch your child's use of scissors for safety reasons.)*

○ ○ ○ ___

6. When drawing, does your child hold a pencil, crayon, or pen between her fingers and thumb like an adult does?

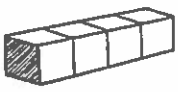
○ ○ ○ ___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	

1. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? *(You can also use spools of thread, small boxes, or other toys.)*

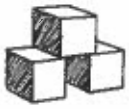


○ ○ ○ ___

2. If your child wants something he cannot reach, does he find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?

○ ○ ○ ___

PROBLEM SOLVING (continued)

	YES	SOMETIMES	NOT YET	
3. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? *(Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.")* Please write your child's response here: 	○	○	○	___
4. When you say, "Say 'seven three,'" does your child repeat *just* the two numbers in the same order? *Do not repeat the numbers.* If necessary, try another pair of numbers and say, "Say 'eight two.'" *(Your child must repeat just one series of two numbers for you to answer "yes" to this question.)*	○	○	○	___
5. Show your child how to make a bridge with blocks, boxes, or cans, like the example. Does your child copy you by making one like it? 	○	○	○	___
6. When you say, "Say 'five eight three,'" does your child repeat *just* the three numbers in the same order? *Do not repeat the numbers.* If necessary, try another series of numbers and say, "Say 'six nine two.'" *(Your child must repeat just one series of three numbers for you to answer "yes" to this question.)*	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child use a spoon to feed herself with little spilling?	○	○	○	___
2. Does your child push a little wagon, stroller, or toy on wheels, steering it around objects and backing out of corners if he cannot turn?	○	○	○	___
3. When your child is looking in a mirror and you ask, "Who is in the mirror?" does she say either "me" or her own name?	○	○	○	___
4. Does your child put on a coat, jacket, or shirt by himself?	○	○	○	___
5. Using these exact words, ask your child, "Are you a girl or a boy?" Does your child answer correctly?	○	○	○	___
6. Does your child take turns by waiting while another child or adult takes a turn?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain: ○ YES ○ NO

2. Do you think your child talks like other children her age? If no, explain: ○ YES ○ NO

3. Can you understand most of what your child says? If no, explain: ○ YES ○ NO

4. Can other people understand most of what your child says? If no, explain: ○ YES ○ NO

5. Do you think your child walks, runs, and climbs like other children his age? If no, explain: ○ YES ○ NO

6. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

OVERALL *(continued)*

7. Do you have any concerns about your child's vision? If yes, explain: ○ YES ○ NO

8. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

9. Do you have any concerns about your child's behavior? If yes, explain: ○ YES ○ NO

10. Does anything about your child worry you? If yes, explain: ○ YES ○ NO

ASQ-3 36 Month ASQ-3 Information Summary

34 months 16 days through 38 months 30 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	30.99		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	36.99		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	18.07		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	30.29		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	35.33		●	●	●	●	●	●	●	●	○	○	○	○	○

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Hears well? Yes **NO**
   Comments:
2. Talks like other children his age? Yes **NO**
   Comments:
3. Understand most of what your child says? Yes **NO**
   Comments:
4. Others understand most of what your child says? Yes **NO**
   Comments:
5. Walks, runs, and climbs like other children? Yes **NO**
   Comments:
6. Family history of hearing impairment? **YES** No
   Comments:
7. Concerns about vision? **YES** No
   Comments:
8. Any medical problems? **YES** No
   Comments:
9. Concerns about behavior? **YES** No
   Comments:
10. Other concerns? **YES** No
    Comments:

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ▭ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

_____ No further action taken at this time

_____ Other (specify): _____

5. Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

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