# Mukilteo ECEAP Family Enrollment Questionnaire

We would like to get to know a little about your family. Your answers will help us to provide additional support or resources that will benefit you and your family.

| Child's Name | Parent/Guardian | Parent/Guardian |
|---|---|---|
| | | |

| What does your family enjoy doing together? | Which areas would you like to partner with your Family Support Specialist in? Check all that apply. |
|---|---|
| | ☐ Increase self-reliance |
| What changes, if any, have recently happened in your family? | ☐ Increase knowledge of child development and parenting skills |
| | ☐ Further my education and training |
| What is going well in your family right now? What makes your family strong? | ☐ Increase my ability to use needed services in the community |
| | ☐ Increase strategies to advance in my career |
| Does your family have immediate needs that we can help with right now? If yes, please explain. ☐ Yes ☐ No | ☐ Set and achieve goals |
| | ☐ Gain new cognitive and behavioral skills |
| | ☐ Navigate available networks of learning and Support |
| | ☐ Other: |

| Which community resources are you interested in? Check all that apply. | | | | |
|---|---|---|---|---|
| Family Stability | Well-Being | Finances | Education & training | Employment & Career Management |
| ☐ Child Medical Care | ☐ Adult medical care | ☐ Budgeting | ☐ College Education | ☐ Job Fairs |
| ☐ Child Dental Care | ☐ Adult Dental care | ☐ Savings plan | ☐ ESL Classes | ☐ Job Interviewing |
| ☐ Child Recreation | ☐ Counseling | ☐ Credit Reports | ☐ GED completion | ☐ Self-Employment |
| ☐ Library | ☐ Support Groups | ☐ Outstanding debt | ☐ Trade School | ☐ Work from home |
| ☐ Legal Assistance | ☐ Self-care | ☐ Spending plan | ☐ Job Training | ☐ Resumes |
| ☐ Basic Needs | ☐ Parenting | ☐ Reduce expenses | ☐ Paying for school | ☐ Skill Development |

| Please check topics that you are interested in for parent education | | | |
|---|---|---|---|
| | ☐ Financial Goals | ☐ Quick and Easy dinners | ☐ Parenting Skills |
| | ☐ School Readiness | ☐ Support at home learning | ☐ Positive Discipline |
| | ☐ Basic Health care at home | ☐ Mental Health | ☐ Kids and media |
| | ☐ Healthy lifestyle | ☐ School volunteering | ☐ Advocacy |

**Child Interest Survey – Getting to Know your child**

| **Child's Name** | | **Nickname** | | **DOB** | |
|---|---|---|---|---|---|
| **Parent/Guardian Names** | | | | | |

**Who lives in the home?**

**What is the primary language spoken in your home?**

**My Child's Favorite Things**

| | |
|---|---|
| Toys | |
| Book | |
| Color | |
| Other | |

**Things my child does not like**

| | |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |

**Medical Needs, Food allergies, Dietary Needs?**

**What skills has your child acquired?**

- ☐ Has been in preschool before
- ☐ Can dress/undress
- ☐ Can zip/button own clothing
- ☐ Uses scissors
- ☐ Uses crayons
- ☐ Feeds her/himself
- ☐ Speaks clearly
- ☐ Age-appropriate vocabulary
- ☐ Understand directions
- ☐ Toilet trained
- ☐ Just started toilet training
- ☐ Needs helps with toileting

**What comforts your child when he/she is upset?**

**My child likes to**

- ☐ Play with other children
- ☐ Play make-believe
- ☐ Draw pictures/stories
- ☐ Go to friend's houses
- ☐ Listen to stories
- ☐ Play quiet games
- ☐ Play alone
- ☐ Play outside
- ☐ Paint/color
- ☐ Build
- ☐ Play video games

**Family Holidays we celebrate**

**Which words below describe your child when interacting with others?**

- ☐ Easily Distracted
- ☐ Cries Easily
- ☐ Bossy
- ☐ Creative
- ☐ Shy
- ☐ Talkative
- ☐ Defiant
- ☐ Easily frustrated
- ☐ Cautious
- ☐ Flexible
- ☐ Friendly
- ☐ Strong-willed
- ☐ Cooperative
- ☐ Impulsive
- ☐ Inquisitive
- ☐ Patient
- ☐ Perfectionist
- ☐ Thoughtful

**Does your child have any fears?**

**Do you have any concerns?** ☐ Speech ☐ Gross motor ☐ Behavior ☐ Hearing ☐ Vision ☐ None

| **Comments** | |
|---|---|

| **What are your expectations for Preschool? What would you like to see happen this year?** | **Please share something special about your child with me** |
|---|---|
| | |

**Teacher Notes:**

Washington State Department of CHILDREN, YOUTH & FAMILIES

# Snohomish County ECEAP

Snohomish County

## Health and Nutrition History Form

Child's name _____ Child's birthdate _____ Today's date _____

**CHILD'S HEALTH HISTORY**

1. Name of medical provider_____ Location _____Phone_____
2. Child's weight at birth: Pounds _____ Ounces _____
3. Were you told that your child was born early or premature? _____ If so, how early?_____
4. Were there any significant problems during pregnancy or birth? ☐ Yes ☐ No If yes, please explain:_____
5. Has your child had surgery or been hospitalized? ☐ Yes ☐ No Date/reason: _____

| **6. Has your child had any of the following?** | | | If yes, please describe: |
|---|---|---|---|
| ***a. Asthma or other breathing issues?*** | ☐ Yes | ☐ No | |
| ***b. Any life-threatening allergies?*** | ☐ Yes | ☐ No | |
| ***c. Seizures/other neurological issues?*** | ☐ Yes | ☐ No | |
| ***d. Heart/other cardiovascular issues?*** | ☐ Yes | ☐ No | |
| ***e. Diabetes or other endocrine concerns?*** | ☐ Yes | ☐ No | |
| f. Bone or joint issues? | ☐ Yes | ☐ No | |
| g. Eczema or skin issues? | ☐ Yes | ☐ No | |
| h. Frequent ear infections or tubes? | ☐ Yes | ☐ No | |
| i. Other ear, nose or throat concerns? | ☐ Yes | ☐ No | |
| j. Tuberculosis exposure? | ☐ Yes | ☐ No | |
| k. Bladder, bowel/urinary tract concerns? | ☐ Yes | ☐ No | |
| l. Frequent, heavy nosebleeds? | ☐ Yes | ☐ No | |
| m. Injury or abuse? | ☐ Yes | ☐ No | |
| n. Second-hand smoke exposure? | ☐ Yes | ☐ No | |
| o. Behavior concerns? | ☐ Yes | ☐ No | |

Other, please describe:

For ECEAP staff: Enter all chronic health conditions, allergies and medications into ELMS.

*Conditions in bold text above should be entered into ELMS as Life-Threatening.

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# Snohomish County ECEAP

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## MEDICATION

**9.** Does your child take medication on a regular basis? ☐ Yes ☐ No Reason(s)_____

**10.** Would any medications would be required at school? ☐ Yes ☐ No *Please note: Any medications given at school require a Licensed Healthcare Provider's signature on a completed Medication Authorization Form.*

Name of medication(s), dosage and when taken:_____

## ALLERGIES

**11.** Does your child have allergies or severe reactions (including intolerances) to food, medicine, insects, animals or other substances? ☐ Yes-- please answer questions 12-15. ☐ No-- please skip to Dental History

**If your child has a food or milk allergy that has been medically diagnosed, we will ask for documentation from your medical provider that includes a list of foods that can be substituted.*

**12.** Please name what your child is allergic to and describe your child's allergic reaction:_____

**13.** How do you treat your child's allergy? Please list any over-the-counter medications you use at home, if any.

**14.** Has this allergy been diagnosed by a licensed healthcare provider? ☐ Yes ☐ No

**15.** Do you have epinephrine or any prescription medication at home to treat your child's allergy? ☐ Yes ☐ No

Additional information about allergies: _____

## DENTAL HISTORY

**16.** Name of Dentist_____ Phone_____ Date of last Dental Exam _____

**17.** How would you rate your child's dental health? ☐ Very good ☐ Somewhat Good ☐ Fair ☐ Somewhat bad ☐ Very bad

**18.** Has your child ever had an injury to the teeth and/or mouth? ☐ Yes ☐ No

**19.** Does your child complain about tooth or mouth pain? ☐ Yes ☐ No

**20.** Other dental concerns?

## PARENT/FAMILY

22. Do you have any concerns about your child's vision? ☐ Yes ☐ No If yes, describe _____
23. Do you have any concerns about your child's hearing? ☐ Yes ☐ No If yes, describe _____
24. Do you have any concerns about your child's speech? ☐ Yes ☐ No If yes, describe _____
25. Do you have any concerns about your child's behavior? ☐ Yes ☐ No If yes, describe _____
26. Do you have any concerns about your child's development? ☐ Yes ☐ No If yes, describe _____
27. Do you have any other concerns about your child/family? ☐ Yes ☐ No If yes, describe _____
28. Are cigarettes/other tobaccos used in your home or car? ☐ Yes ☐ No If yes, describe _____
29. Is there anything that gets in the way of going to the doctor or dentist? For example: Time, transportation, no insurance, etc. ☐ Yes ☐ No If yes, describe _____

Additional information regarding concerns: _____

Washington State Department of CHILDREN, YOUTH & FAMILIES

# Snohomish County ECEAP

Snohomish County

## NUTRITIONAL INFORMATION

| Yes | No | Please answer the following |
|---|---|---|
| ☐ | ☐ | Is there any food or drink that your child should not eat for cultural, religious or medical reasons (other than allergies)? If yes, please explain. |
| ☐ | ☐ | Do you have any concerns about your child's eating habits? If yes, please explain. |
| ☐ | ☐ | Has there been a change in your child's appetite in the past month? If yes, please explain. |
| ☐ | ☐ | Is your child on a special diet? If yes, please explain. |
| ☐ | ☐ | Does your child have any problems with chewing or swallowing? If yes, please explain. |
| ☐ | ☐ | Do you have any concerns about your child's growth? Please explain. |
| ☐ | ☐ | Do you have any concerns about your child's weight? Please explain. |
| ☐ | ☐ | Do you share meals together as a family? |
| ☐ | ☐ | Does your child take a vitamin? How often? |
| ☐ | ☐ | Does your child take a prescribed iron supplement? Why? How often? |
| ☐ | ☐ | Does your child currently use any nutritional supplements (Pediasure, Ensure, herbs, etc.)? If yes, what, how often, for what reason? |
| ☐ | ☐ | Does your child eat non-food items? Please list: _____ |

## WOULD YOU LIKE MORE INFORMATION ABOUT

| | | |
|---|---|---|
| ☐ Picky eater | ☐ Healthy eating on a budget | ☐ Feeding young children |
| ☐ Eating for a healthy weight | ☐ Healthy snack ideas | ☐ Healthy portion sizes |
| ☐ Physical activity ideas | ☐ Eating vegetables | ☐ Eating meals as a family |
| ☐ Limiting TV, video games, screen time | ☐ Healthy beverages | ☐ Food resources for your family |

Parent/Guardian Signature:_____ Date:_____

**Home Language Survey**

- The Home Language Survey determines whether the GOLD® English language acquisition objectives, Objective 37, "Demonstrates progress in listening to and understanding English," and Objective 38, "Demonstrates progress in speaking English" will be included in a child's record in MyTeachingStrategies®.

| | |
|---|---|
| Survey completion Date | |
| Child's Name | |
| Parent/Guardian Name | |
| What is the home language? | |

☐ I decline to provide information for this survey

**A. What Language do family members use when speaking to the child in the home?**

| N/A | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| ☐ Not applicable | ☐ Only English | ☐ Mostly English but sometimes home language | ☐ Both Equally | ☐ Mostly home language but some English | ☐ Only home language (not English) |

**B. What language does the child use when speaking to family members I the home?**

| N/A | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| ☐ Not applicable | ☐ Only English | ☐ Mostly English but sometimes home language | ☐ Both Equally | ☐ Mostly home language but some English | ☐ Only home language (not English) |

**C. What language does the child use when speaking to other children in the classroom?**

| N/A | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| ☐ Not applicable | ☐ Only English | ☐ Mostly English but sometimes home language | ☐ Both Equally | ☐ Mostly home language but some English | ☐ Only home language (not English) |

**D. What language does the child use when speaking to the teachers?**

| N/A | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| ☐ Not applicable | ☐ Only English | ☐ Mostly English but sometimes home language | ☐ Both Equally | ☐ Mostly home language but some English | ☐ Only home language (not English) |

Teacher Use only (If this value is 2 or greater use Objectives 37 and 38)

| Sum of checked numbers | | Number of questions answered | | |
|---|---|---|---|---|
| | / | | = | |