ARKANSAS BETTER CHANCE FOR SCHOOL SUCCESS
CHILD APPLICATION

Application Date:	Enrollment Date:	

PRIMARY CAREGIVER INFORMATION
(Parent or guardian with most contact with child)

*Name(First/Middle/Last):		Gender: Male Female
*Date of Birth:	Day Phone:	Evening Phone:
*Current address:		E-Mail:
*City:	*State:	*ZIP Code:
*County:	Disabled: Yes No	Race:
Language (primary):	Other Language:	*Marital Status:
Child Medical Insurance: Yes No	Specify Insurance:	
*Employment Status (FT, PT):	Employer Name:	
Employment City:	State:	Employment Zip Code:
*# of hrs per week:	*Education Level (high school, college, etc.)	
If attending school, where:		# of semester hours:
Annual Income From Work Sources or Unemployment:		*Food Stamps/SNAP: Y N

SECONDARY CAREGIVER INFORMATION
(2nd Parent or guardian in household with child and is used for determining eligibility)

*Name(First/Middle/Last):		Gender: Male Female
*Date of Birth:	Day Phone:	Evening Phone:
*Current address:		E-Mail:
*City:	*State:	*ZIP Code:
*County:	Disabled: Yes No	Race:
Language (primary):	Other Language:	*Marital Status:
Child Medical Insurance: Yes No	Specify Insurance:	
*Employment Status (FT, PT):	Employer Name:	
Employment City:	State:	Employment Zip Code:
*# of hrs per week:	*Education Level (high school, college, etc.)	
If attending school, where:		# of semester hours:
Annual Income From Work Sources or Unemployment:		*Food Stamps/SNAP: Y N

HOUSEHOLD INFORMATION

*Current Housing: Rent Own Other *Start Date:	Moved in last 24 months: Y N
*Number in Family (The number of immediate family members living in house. (Parent, Guardian, Siblings):	
*Number in Household (The total number of people living in the house):	
List the name and relationship to the child enrolled of all family members in the household:	
Name:	Relationship:

***Must be entered into COPA.**

CHILD INFORMATION

*Name(First/Middle/Last):		Gender: Male Female
*Date of Birth:	*Social Security Number:	
*Race:	*US Citizen Yes No	
Has this child attended a state-funded pre-K (ABC) program before? Yes No	If so, where?	
Will this child be concurrently enrolled in an ABC center and HIPPY or PAT program? Yes No	If so, which HIPPY or PAT?	
List any allergies:		
Does the child have any special dietary needs?		
Receiving any special education services?		
*Previously in Foster Care: Yes No	Birth Weight:	
Primary Language:	Secondary Language:	
Speak English at Home: Yes No	School District child lives in:	

EMERGENCY CONTACT AND CONSENT INFORMATION

Name of emergency contact if parent/guardian cannot be reached:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		
Physician Name:		
Address		Phone:
City:	State:	ZIP Code:
Hospital Preference:		Phone:

Consent for Emergency Medical Care

I , of

Parent/Guardian's Name | Relationship to Child | Child's Name

Do hereby request and give consent to the Director/Caregiver of the Child Care Facility, or their duly appointed representative, for said child to receive such medical or surgical aid as may be deemed necessarily expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parent(s) cannot be reached. Consent is also given for the Director/Caregiver or their duly appointed representative to transport said child for emergency medical treatment, if parent(s) cannot be reached.

Parent/guardian signature	Date

SIGNATURE

I declare under the penalty of perjury and the rules and regulations of the Arkansas Better Chance program that the information supplied is true and correct at the time of application. I understand that the information I supplied may be independently verified by the Arkansas Division of Child Care and Early Childhood Education and that any false statements may result in exclusion from DHS programs and criminal prosecution.

Signature of Primary Caregiver:	Date

***Must be entered into COPA.**