2024/2025

Little Badger Pre-Kindergarten Application Procedures

- WEDNESDAY, FEBRUARY 7, 2024 will be the FIRST day that we will accept applications for the 2024/2025 school year.
- Complete each page of the application
- Provide copies of all needed documents
- Applications and documents may be returned to Little Badger Pre-K's Office or Beebe Public Schools – Central Office (1201 West Center St. Beebe)

We have two different types of applications:

1. ABC – Arkansas Better Chance which is income based program. There's an income level guide to follow in order to qualify for this tuition free program. We have 80 spots for the ABC program.
2. Tuition – is a paid Pre-K program. Tuition for this program is $100.00 a week. We have 30 spots in our Tuition program.

All classes are filled on a first come/first served basis. When all spots are filled in both programs there will be a waiting list.

Tuition Student Application

Little Badger Pre-K

2024-2025

Bring this completed application, along with the items listed below, to the office at **Beebe Elementary or **Central Office.** Slots are first come, first served.

Additional Documents Needed at Registration:

1. Birth Certificate
2. Social Security Card
3. ARKids First Card (if applicable to your child)
4. 4 year old Health Screening

(If your child has not had his/her 4 yr. old health screening yet, bring in his/her 3 year old health screening.)

5. Shot Record (most updated)

IMPORTANT INFORMATION

Students are not guaranteed a slot in a pre-k classroom ***UNTIL:***

1. **ALL** documents are submitted (with a complete application)

AND

2. You receive a phone call from the pre-k office stating that the application process is completed.

Tuition Pre-K Information

(Please keep this page for your own reference)

*The weekly tuition fee is ***$100.00***

*Breakfast and lunch prices are not included in the ABC program. You will be given an application at orientation to fill out to determine if your child will qualify for free or reduced meal prices.

If your child qualifies for reduced meal prices, the daily fees are as follows:
Breakfast: $ .30
Lunch: $ .40
Extra Milk: $ .50

If your child does not qualify for free or reduced meal prices, the daily fees are as follows:
Breakfast: $1.00
Lunch: $ 2.25
Extra Milk: $ .50

*However, you may choose to serve your child breakfast at home and/or send a lunch with him/her each day. There will be no additional meal charges if you choose to provide your child's meals.

*Our pre-k day is from 7:30 am – 2:30 pm. If you require childcare outside of these times, we offer before and after school childcare. The rates for additional childcare services are as follows:

Before School Care: $20.00 (6:15 am – 7:30 am)
After School Care: $30.00 (2:30 pm – 6:00 pm)
Annual Registration Fee: $40.00

*Meal prices and before school/after school care prices are subject to change prior to the start of the 2024-2025 school year.

Tuition Application **2024-2025**

BEEBE SCHOOL DISTRICT

Tuition PRE-K Enrollment Form

GENERAL STUDENT INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:

Birthdate: ____-____-____ Gender: (Circle One) Female Male Social Security # ____-____-____

Ethnicity

☐ Hispanic ☐ Non-Hispanic

☐ Yes, Cuban

☐ Yes, Mexican, Mexican American, Chicano

☐ Yes, Other Spanish, Hispanic, Latino

☐ Yes, Puerto Rican

Race

☐ American Indian ☐ Asian Indian ☐ Black or African Am.

☐ Chinese ☐ Filipino ☐ Guaanian or Chammorro

☐ Immigrant ☐ Japanese ☐ Korean

☐ Migrant ☐ Multi-Racial ☐ Native Hawaiian

☐ Other ☐ Other Asian ☐ Other, Pacific Islander

☐ Samoan ☐ Unknown ☐ Vietnamese

☐ White

Primary Language

☐ English ☐ Spanish

☐ Other: _____

Secondary Language

☐ English ☐ Spanish

☐ Other: _____

Student's Physical/911 Address

Address: _____

City: _____ State: _____

Zip Code: _____

Phone #: _____ - _____ - _____

Student's Mailing Address

☐ *Mailing Address is same as Physical/911 Address*

Address: _____

City: _____ State: _____

Zip Code: _____

Is this child a dependent of an active or reserve member of a branch of the United States Armed Services? Yes No

If this child resides in a household with an active or reserve member of a branch of the United States Armed Services, please select the branch below.

☐ Active Duty – US Army ☐ Active Duty – US Air Force ☐ Active Duty – US Navy ☐ Active Duty – US Marines
☐ Active Duty – US Coast Guard ☐ Reserves – US Army ☐ Reserves – US Air Force ☐ Reserves – US Navy
☐ Reserves-US Marines ☐ National Guard – US Army ☐ National Guard – US Air Force
☐ Parents serve in multiple branches

Is this student a twin (or triplet, quadruplet, etc.)? Yes No

Tuition Application *2024-2025*

PRIMARY CAREGIVER INFORMATION

(Parent or Guardian with the most contact with the child)

FIRST NAME:	MIDDLE NAME:	LAST NAME:

Birthdate: ____-____-____ Gender: (Circle One) Female Male Social Security # ____-____-____

Ethnicity:	Race:
☐ Hispanic ☐ Non-Hispanic	☐ American Indian ☐ Asian Indian ☐ Black or African Am.
☐ Yes, Cuban	☐ Chinese ☐ Filipino ☐ Guaanian or Chammorro
☐ Yes, Mexican, Mexican American, Chicano	☐ Immigrant ☐ Japanese ☐ Korean
☐ Yes, Other Spanish, Hispanic, Latino	☐ Migrant ☐ Multi-Racial ☐ Native Hawaiian
☐ Yes, Puerto Rican	☐ Other ☐ Other Asian ☐ Other, Pacific Islander
	☐ Samoan ☐ Unknown ☐ Vietnamese
	☐ White

Primary Language:	Secondary Language:
☐ English ☐ Spanish	☐ English ☐ Spanish
☐ Other: _____	☐ Other: _____

Education Level:	Employment Status:
☐ Bachelor or Advanced Degree	☐ Employed Full-Time
☐ College Degree or Training School Certificate	☐ Employed Part-Time
☐ GED	☐ Self-Employed
☐ High School Graduate	☐ Homemaker
☐ No High School	☐ In School
☐ Some College/Vocational/Associates Degree	☐ Retired or Disabled
☐ Some High School	☐ Unemployed
☐ Unknown	

Primary Caregiver's Physical/911 Address	Primary Caregiver's Mailing Address
How miles do you live from school? _____	☐ *Mailing Address is same as Physical/911 Address*
Address: _____	Address: _____
City: _____ State: _____	City: _____ State: _____
Zip Code: _____	Zip Code: _____
Cell Phone #: _____-_____-_____	
Work Phone #: _____-_____-_____	
Home Phone #: _____-_____-_____	

Tuition Application *2024-2025*

SECONDARY CAREGIVER INFORMATION

(2ND Parent or Guardian in the household with child and is used for determining eligibility)

FIRST NAME:	MIDDLE NAME:	LAST NAME:

Birthdate: _____-_____-_____ Gender: (Circle One) Female Male Social Security # _____-_____-_____

Ethnicity:

☐ Hispanic ☐ Non-Hispanic

☐ Yes, Cuban

☐ Yes, Mexican, Mexican American, Chicano

☐ Yes, Other Spanish, Hispanic, Latino

☐ Yes, Puerto Rican

Race:

☐ American Indian ☐ Asian Indian ☐ Black or African Am.

☐ Chinese ☐ Filipino ☐ Guaanian or Chammorro

☐ Immigrant ☐ Japanese ☐ Korean

☐ Migrant ☐ Multi-Racial ☐ Native Hawaiian

☐ Other ☐ Other Asian ☐ Other, Pacific Islander

☐ Samoan ☐ Unknown ☐ Vietnamese

☐ White

Primary Language:

☐ English ☐ Spanish

☐ Other: _____

Secondary Language:

☐ English ☐ Spanish

☐ Other: _____

Education Level:

☐ Bachelor or Advanced Degree
☐ College Degree or Training School Certificate
☐ GED
☐ High School Graduate
☐ No High School
☐ Some College/Vocational/Associates Degree
☐ Some High School
☐ Unknown

Employment Status:

☐ Employed Full-Time
☐ Employed Part-Time
☐ Self-Employed
☐ Homemaker
☐ In School
☐ Retired or Disabled
☐ Unemployed

Secondary Caregiver's Physical/911 Address

Address: _____

City: _____ State: _____

Zip Code: _____

Cell Phone #: _____-_____-_____

Work Phone #: _____-_____-_____

Home Phone #: _____-_____-_____

Secondary Caregiver's Mailing Address

☐ *Mailing Address is same as Physical/911 Address*

Address: _____

City: _____ State: _____

Zip Code: _____

Tuition Application *2024-2025*

HOUSEHOLD INFORMATION

Number in Family (The # of immediate family members living in the house. Ex. Parent, Guardian, Siblings): _____

Number in Household (The total # of people living in the house): _____

List the names and relationship to the child enrolled of all family members in the household:

Name:	Relationship to Child Enrolled:

Emergency Contact

Name of emergency contact if parent/guardian cannot be reached: _____

Address (including city & zip code): _____

Phone #: _____ Relationship to Child: _____

Physician and Consent Information

Physician Name: _____ Clinic Name: _____

Phone #: _____

I _____ _____ of _____
(Parent/Guardian's name) (Relationship) (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

Parent/Guardian Signature

I declare under the penalty and the rules 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

Tuition Application *2024-2025*

Arkansas Department of Human Services
Division of Child Care and Early Childhood Education

WELL CHILD SCREENING FORM

To Parent or Guardian:
In order to provide the best learning experience for your child, teachers must understand your child's health needs. State regulations require any child enrolled in a Pre-K program to have a well-child check-up. In addition, the child must be current on all required immunizations. Please complete this page of the form, sign it and give the next page to your child's physician or licensed nurse practitioner. Once both forms are completed and signed, return them to your Pre-K program.

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

Address, City and Zip Code

Name of Pre-K Program Where Enrolled	Pre-K Program Phone Number
Little Badger Pre-K (Tuition)	501-882-5463 ext. 1118

Type of Health Insurance

D AR Kids A D Private Insurance
D AR Kids B D Other:

Part I – To be completed by parent or guardian before well child screening.

Check answers to the following questions. Explain any "yes" answers in the space provided.

	Yes	No	
1.	D	D	Do you have any concerns about your child's general health?
2.	D	D	Has your child been diagnosed with any chronic disease (such as asthma or diabetes)?
3.	D	D	Does your child have any allergies (like to food, medicine, dust)?
4.	D	D	Does your child take any medications (daily or occasionally)?
5.	D	D	Does your child have any problems with vision, hearing or speech?
6.	D	D	Has your child had any hospitalization, operation, major illness or injury?
7.	D	D	In the past 12 months, has your child experienced any difficulty with wheezing or night coughing?
8.	D	D	In the past 12 months, has your child experienced excessive weight loss or weight gain?
9.	D	D	Has your child had a dental examination in the last 12 months?
10.	D	D	Would you like to discuss anything about your child's health with the health care provider?

If you answered "yes" to any question, please explain below. For illnesses or injuries, include your child's age at the time.

Question #	Explanation

Parent/Guardian Permission and Release:
I give my permission for the information on this form to be used in meeting my child's health and educational needs while enrolled the Little Badger Pre-K program.

Signature of Parent/Guardian _____ Date _____

This form must be completed by a Doctor OR submit a current well-child checkup

2024-2025

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

To Health Care Professional:
This child is enrolled in the Little Badger Pre-K program. State regulations require a comprehensive well child screening for all enrolled children. The Division of Child Care and Early Childhood Education recommends an Early Periodic Screening and Diagnostic Treatment (EPSDT) which is age-appropriate. For children enrolled in AR Kids, the cost of the EPSDT may be billed to AR Kids A or B using the procedure codes below:

Patient Type	AR KIDS A		AR KIDS B	
	1-4 years	5-11 years	1-4 years	5-11 years
New	99382 EP U1	99383 EP U1	99382	99383
Established	99382 EP U2	99383 EP U2	99382	99383

Part II: To be completed by Health Care Provider. Complete all sections and sign at the bottom.

Weight	Height	BMI	Temp	Blood Pressure
lb. %ile	in. %ile	%		/

History Update

D Yes D No Any changes in patient health since last visit? Explain:_____
D Yes D No Any family history of heart disease for anyone under 55 years of age?
D Yes D No Any family history of abnormal cholesterol?

Health

D Good appetite
D Drinks lowfat milk
D Encourage diet of fruit and vegetables
D Limits fast food
D Picky or variable eater
D Brushes teeth, sees dentist

Social and Behavioral

D Parents discipline appropriately
D Dresses self, helps at home
D TV and video games are limited
D Praised for good behavior
D Has friends and playmates

PHYSICAL EXAM

	Norm	Abnormal
General	D	D
Head	D	D
Neck	D	D
Eyes	D	D
Ears	D	D
Nose	D	D
Throat	D	D
Mouth	D	D
Teeth	D	D
Lungs	D	D
Heart	D	D
Femoral Pulses	D	D
Genitals	D	D
Extremities	D	D
Gait	D	D
Spine	D	D
Skin	D	D
Neuro	D	D

Screening and Laboratory Results

Test	Result	Date	Comments if abnormal
Vision Test type:	L_____ R		
Hearing Test type:			
TB Risk: Yes / No			
Hemoglobin Risk: Yes / No			
Cholesterol Risk: Yes / No	mg/dL		

Immunizations

D Yes D No All immunizations are current.
D Yes D No Child has had all immunizations possible at this time.
Child needs: D DTaP D IPV D HepB D HiB D MMR D Varivax D PCV-7 at_____years/_____months

Referrals

D Follow up visit needed in _____ weeks / months
D Return check at_____years_____months
D Needs to see dentist. Referral to be made by physician or nurse practitioner.

Impressions

D Well child, normal growth and development
D _____

_____, MD / DO / NP
Date_____

CLINIC INFORMATION (or stamp)

Name_____
Address_____
City_____
Zip Code_____Phone_____

Beebe Public Schools
Student Health History

Student Name: _____

Grade: _____ DOB: _____ Age: _____ Sex: _____

Primary Contact: _____

Relationship: _____ Phone: _____

If parents or the emergency contact listed cannot be reached, does the school have the parents' consent to take the child to a doctor or hospital for treatment? It is understood that the parent is responsible for all medical expenses involved.
Please Circle One: Yes No

Physician_____ Phone: _____

Preferred Hospital_____

Does your child have a medical condition of which we should be aware? Yes No

Please Check all that apply: _____Asthma _____ADHD _____Diabetes _____Seizures

If others, please explain: _____

List other condition(s): _____

List all current medications: _____

_____

Will medication be required during school hours? (Circle One) Yes No
(*If yes, please complete medication request form available from your school nurse)

Allergies (food & drug): Y or N circle one
If your child has food allergies that affect what he/she eats in the cafeteria, please have your child's doctor complete the "Certification of Special Dietary Needs." You can pick this form up from the school nurse.

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Written permission must be received from the parent/guardian in order for a child to receive medicine at school. Listed below are over-the-counter medications that our school keeps in stock for administration to students. Licensed school nurses will supervise administration of medications. All medications will be given according to label directions on the container. Indication(s) for the administration of medicine will be determined on an individual basis. This authorization is valid ONLY for the school year indicated on the date below.

- Acetaminophen / Ibuprofen (regular strength) **WILL NOT BE GIVEN BEFORE 10:00am OR AFTER 2:00pm**
  *may be given for fever over 102 degrees, and headaches and/or other pains not relieved by other means such as ice, heat, food, rest, etc.
- Antacid
- Cough Drops
- Benadryl – given in case of allergic reaction (indication for administration to be determined by the school nurse)
- Over The Counter Medications (ex: oral pain reliever, eye drops, topical ointment/cream/spray, throat spray, etc.)

_____ _____
Parent/Guardian Signature Date

updated 3/2022

➢ Required Information
(Form will be returned if not complete)

Wilbur D. Mills Education Service Cooperative
EARLY CHILDHOOD SPECIAL EDUCATION
P.O. Box 850 Beebe, AR 72012 / 501.882.8852

Parent Consent for Screening

➢ Name of Child _____ ➢ Sex _____

➢ Race *[check all that apply]* ☐ Hispanic ☐ Amer.Indian/Alaskan ☐ Asian ☐ Black ☐ Hawaiian/Pacific Islander ☐ White

➢ Check if Interpreter needed ☐Parent ☐Child

➢ Date of Birth _____ ➢ Age _____ ➢ School District of Residence _____

➢ SSN _____ ArKids Number: _____

➢ Physical Address _____
Street Address City Zip

➢ Mailing Address _____
P.O. Box City Zip

➢ Names of Parents/Guardians _____

➢ Phone Nos.

	Home	Cell	Work
Mother's Info:			
Father's Info:			

➢ Service Location: (Please fill in school name) _____

➢ Consent: I give the Wilbur D. Mills Early Childhood Special Education Program permission to screen my child.

➢ _____ ➢ _____
Signature of Parent/Guardian Date

➢Services child is currently receiving or has recently received:
☐ Speech ☐ OT ☐ PT ☐ Counseling ☐ HIPPY *Attach copy of latest Evaluation(s)

DO NOT WRITE BELOW THIS LINE

The following area(s) have been screened:

Areas	Screened		Result		Rescreen		Area(s) of Referral
	By *[Person]*	Date	Passed	Failed	Date	Result	
Developmental Areas							
Vision							
Speech/Language							
Hearing							

By signing below, I verify that the results of the DIAL-4 screen conducted on my child were discussed with me.

_____ _____
Signature of Parent/Guardian Date

Parent/Guardian was not in attendance. Letter explaining screening results was:
☐ Mailed to parent/guardian on this date ☐ Left at center for pickup. _____ Date

Child failed: ☐ Vision ☐Hearing Letter mailed to parent/guardian on: _____

A Referral was made to the WDMESC Early Childhood Special Education Program on: _____

W.D.M.E.S.C. EARLY CHILDHOOD SPECIAL EDUCATION

Child's Name _____ Location _____

➢ Part 1 - Self-Help Development

Directions: Place an X in the box that best describes how your child can do each task. A young child's behavior is not the same from day to day. Think of your child's average ability at home, not his or her very best or worst day. Mark each item by putting an X in one of the boxes.

	Task	Most of the time	Sometimes or if I help	Rarely or Never	Not allowed to or not asked
1	Buttons clothing without help	*			
2	Puts toys or books away when asked	*			
3	Spills food or drink when eating			*	
4	Unscrews bottle caps without help	*			
5	Wets or soils pants			*	
6	Washes and dries hands when needed	*			
7	Puts clothes or shoes where they belong when asked	*			
8	Brushes teeth without help	*			
9	Blows and wipes nose without being asked	*			
10	Puts clothes on *backward*			*	
11	Puts each shoe on correct foot	*			
12	Gets dressed without help	*			
13	Wets bed			*	
14	Picks up after self without being asked	*			
15	Brushes or combs hair without being asked	*			
16	Washes self during bath or shower	*			
17	Pours from a small can or carton without spilling	*			
18	Uses a fork, a spoon, or chopsticks correctly	*			
19	Pours dry cereal and milk into bowl without spilling	*			
20	Uses the toilet without help.	*			
21	Wakes up and needs help going back to sleep			*	
22	Follows safety rules (stays away from hot oven, etc.)	*			

➢ Part 2 - Social-Emotional Development

Directions: Place an X in the box that tells how frequently your child shows each feeling or behavior. Again, think of your child on an average day, at home or with friends. Mark each item by putting an X in one of the boxes.

	Feeling or Behavior	Always or almost always	Sometimes or Partially	Rarely or Never
1	Smiles or laughs when something is funny	*		
2	Argues when denied own way			*
3	Breaks toys or other objects on purpose			*
4	Plays well with other children	*		
5	Has tantrums (stomps feet, screams, etc)			*
6	Solves problems by talking rather than by hitting, pushing or biting	*		
7	Acts without thinking (runs into street without looking both ways, etc.)			*
8	Admits when he or she makes a mistake	*		
9	Stays calm when things do not go as planned	*		
10	Blames others when bad things happen			*
11	Knows when people are happy or sad	*		
12	Interrupts (talks when others are speaking)			*
13	Goes to bed easily	*		
14	Asks before using other people's things	*		
15	Works well with others	*		
16	Shows pride in doing something well	*		
17	Bangs head on the floor, wall, or bed			*
18	Clings or hangs on to you			*
19	Whines or pouts			*
20	Seems afraid of many things			*
21	Shows concern for someone who is crying	*		
22	Hurts others (hits, bites, kicks, punches, etc.)			*
23	Gives up easily			*
24	Makes transitions easily (moves easily from one activity to the next, etc	*		
25	Falls and hurts self			*
26	Is restless and can't sit still			*
27	Wanders away from you in public places			*
28	Acts very sad or withdrawn			*

Little Badger Pre-K is dedicated to identifying and providing services for any of our students who might have developmental delays. If your child receives any services now (OT, PT, speech/language, social etc.) please indicate which facility and provide a copy of current paperwork that was provided to you by the facility that provides services. If your child will continue to receive these therapies once the 2024-2025 school year starts in August, the facility is welcome to come during your child's Pre-K school day to continue those therapies. You, as the parent will need to contact the Pre-K office and the therapy clinic to put this into motion for your child.

Child's Name:_____

_____Wilbur D. Mills Co-Op

_____Destination Education

_____Clearly Speaking

_____Reaper

_____Milestones

_____Allied

_____Kids Unlimited

_____Building Bridges

_____Kids First

_____Life Within

_____other