Marshfield Clinic
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Office Use Only	
Student ID:	
Date Sent:	
Date Received:	
Start Date:	
Inactivate Date:	

Afterschool Demographics Form

Afterschool Program Start Date: ___/___/____
mm/dd/ yyyy

ABOUT THE CHILD

Child's name: First _____
Middle initial _____
Last _____

Gender: ☐ Male ☐ Female

Child's date of birth: ___/___/____
mm/dd/ yyyy

Child resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian ☐ Parent Dual Guardianship

PRIMARY PARENT/GUARDIAN

Parent and/or Guardian name: First _____
Middle initial _____
Last _____

Phone (home): (__ __ __) __ __ __-__ __ __ __
Phone (cell): (__ __ __) __ __ __-__ __ __ __
Phone (work): (__ __ __) __ __ __-__ __ __ __

E-mail: _____

Street Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____

PRIMARY HOUSEHOLD MEMBERS

How many individuals live in your household? #_____

Name 1:		Age 1:		Name 5:		Age 5:	
Name 2:		Age 2:		Name 6:		Age 6:	
Name 3:		Age 3:		Name 7:		Age 7:	
Name 4:		Age 4:		Name 8:		Age 8:	

Employment status of primary parent/guardian:

- ☐ Employed: name of employer _____
- ☐ Unemployed
- ☐ Other: specify: _____

PARENT/GUARDIAN 2

Parent and/or Guardian 2 name: First _____
Middle initial _____
Last _____

Phone (home): (__ __ __) __ __ __-__ __ __ __
Phone (cell): (__ __ __) __ __ __-__ __ __ __
Phone (work): (__ __ __) __ __ __-__ __ __ __

E-mail: _____

Address same as primary parent/guardian ☐

Street Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____

Employment status of parent/guardian 2:

- ☐ Employed: name of employer _____
- ☐ Unemployed
- ☐ Other: specify: _____

EMERGENCY CONTACTS/AUTHORIZED PICKUPS

Name: _____ Relationship: _____
Phone: (__ __ __) __ __ __-__ __ __ __ Phone: (__ __ __) __ __ __-__ __ __ __

Name: _____ Relationship: _____
Phone: (__ __ __) __ __ __-__ __ __ __ Phone: (__ __ __) __ __ __-__ __ __ __

Name: _____ Relationship: _____
Phone: (__ __ __) __ __ __-__ __ __ __ Phone: (__ __ __) __ __ __-__ __ __ __

ACADEMIC SUCCESS

Name of school your child is attending: _____ Grade: _____

Is your child eligible for free and reduced lunch? ☐ No ☐ Yes

Name of your child's teacher(s): 1. _____ 2. _____

Is your child receiving any special services at school? ☐ No ☐ Yes (check all that apply)

☐ Learning disability ☐ Emotional/behavioral disability ☐ Cognitive disability
☐ English Language Learner ☐ Speech ☐ Reading intervention (including Title 1)
☐ Math intervention ☐ Other interventions (specify) _____

Has your child ever been retained (held back)? ☐ No ☐ Yes

Has your child ever had any truancy issues? ☐ No ☐ Yes

Does your child get along with teachers and other school staff? ☐ No ☐ Yes

Does your child get along with classmates? ☐ No ☐ Yes

What academic skills would you like to see your child work on during the afterschool program (check all that apply)?

☐ Reading ☐ Spelling ☐ Handwriting
☐ Writing ☐ Mathematics ☐ Study Skills

Identify the top **two** academic goals you would like the afterschool program to work on with your child.

☐ Increase homework completion ☐ Improve organizational skills
☐ Decrease late work ☐ Maintain grades
☐ Improve study skills ☐ Increase reading level or lexile score
☐ Improve math skills ☐ Other (specify)_____

SOCIAL/EMOTIONAL DEVELOPMENT

Please use 2 words that best describe your child:

1. _____ 2. _____

What were your child's previous afterschool arrangements?

☐ Home (supervised) ☐ Home (unsupervised) ☐ Day Care
☐ Family member's house ☐ Other (specify) _____

Is there tobacco use or exposure to secondhand smoke in the household? ☐ No ☐ Yes

Do you feel like your child is being bullied? ☐ No ☐ Yes

If so, what type of bulling has your child experienced? ☐ Verbal ☐ Physical ☐ Electronic/Cyber bullying

Do you feel like your child has ever bullied someone? ☐ No ☐ Yes

Identify the top **two** personal/social goals you would like the afterschool program to work on with your child.

- ☐ Improve peer relationships
- ☐ Take responsibility for actions
- ☐ Make new friends
- ☐ Improve attitude
- ☐ Show respect
- ☐ Be more trustworthy
- ☐ Be more confident
- ☐ Be more assertive
- ☐ Other (specify)_____

HEALTHY ACTIVE LIVING

Does your child have health insurance? ☐ No ☐ Yes ☐ Unknown

Is your child on Medicaid (Badger Care, Badger Care Plus, Forward Card, etc.)? ☐ No ☐ Yes

Name of your child's insurance provider or HMO: _____ ☐ Unknown

Name of your child's healthcare facility:_____ ☐ None ☐ Unknown

Name of your child's primary healthcare provider (i.e. doctor, nurse practitioner): _____
☐ None ☐ Unknown

Does your child have any type of allergic reactions? ☐ No ☐ Yes (check all that apply)

Food Allergies:
☐ Eggs ☐ Fish/Shellfish ☐ Fruit ☐ Garlic ☐ Gluten ☐ Meat ☐ Milk ☐ Oats ☐ Peanuts
☐ Tree Nuts ☐ Soy ☐ Wheat ☐ Other Foods (specify) _____

Medication Allergies:
☐ Cephalosporins ☐ Dilantin ☐ I.V. Contrast Dye ☐ Local Anesthetics
☐ Non-steroidal anti-inflammatories ☐ Penicillin ☐ Sulfonamides ☐ Tegretol ☐ Tetracycline
☐ Other Antibiotics (specify) _____ ☐ Other Medicines (specify) _____

Environmental (allergy or other environmental factors):
☐ Cat ☐ Chromium ☐ Cobalt Chloride ☐ Cosmetics ☐ Dog ☐ Formaldehyde ☐ Gold
☐ House dust mite ☐ Mold ☐ Nickel ☐ Insect Bites/Stings (specify) _____
☐ Other (specify) _____

Does your child have any other dietary restrictions? ☐ No ☐ Yes (specify) _____

Does your child have asthma?
☐ No ☐ Yes→ If yes, what causes asthma to flare up? Cause: _____
↓
Do they have an inhaler? ☐ No ☐ Yes
↓
Do they have an asthma case management plan? ☐ No ☐ Yes

Does your child have any special condition(s) requiring accommodations? ☐ No ☐ Yes

Explain: _____

Has your child ever had a diagnosis of any of the following conditions? ☐ No ☐ Yes

If yes, check all that apply.

- ☐ Anxiety
- ☐ Attention-Deficit/ Hyperactivity Disorder (ADHD)
- ☐ Autism Spectrum Disorder (ASD)
- ☐ Bipolar Disorder
- ☐ Bleeding disorder
- ☐ Bone/joint condition
- ☐ Cancer
- ☐ Conduct Disorder
- ☐ Depression
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Ear infections
- ☐ Eating disorders
- ☐ Epilepsy/seizures/ blackouts
- ☐ Fetal Alcohol Spectrum Disorders (FASDs)
- ☐ Gastrointestinal/bowel disorder
- ☐ Headaches/migraines
- ☐ Hearing disabilities
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High/low blood pressure
- ☐ Kidney disease
- ☐ Menstrual difficulties
- ☐ Mononucleosis
- ☐ Muscular disorders
- ☐ Neck/back pain/injury
- ☐ Obesity
- ☐ Obsessive-Compulsive Disorder (OCD)
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Rheumatic fever
- ☐ Tuberculosis (TB)
- ☐ Ulcer
- ☐ Vision disabilities
- ☐ Other, explain: _____
- ☐ Past Surgeries, explain: _____

When was the date of your child's last **Well Child Visit**? (*Well-child visit* is a scheduled appointment with your healthcare provider when your child is NOT sick)

(month/year) __ __ / __ __ __ __ ☐ Unknown

Are your child's immunizations up to date? ☐ No ☐ Yes ☐ Unknown

Is your child prescribed any medications? ☐ No ☐ Yes (please list on last page of form)

Does your child have dental insurance? ☐ No ☐ Yes ☐ Unknown

Name of your child's dental insurance provider: _____ ☐ Unknown

Name of your child's dental care facility: _____ ☐ Unknown

Name of your child's dentist: _____ ☐ None ☐ Unknown

Date of your child's last routine dental examination? (month/year) __ __ / __ __ __ __ ☐ Unknown

If you sought dental care services for your child, have you experienced any barriers?

☐ No ☐ Yes If yes, please check all that apply.

☐ Did not know who to call ☐ Cost and/or insurance not covered
☐ Unable to get to dentist ☐ Unable to make an appointment
☐ Other: _____

Does your child have dental sealants? ☐ No ☐ Yes ☐ Unknown

Identify the top **two** healthy active living goals you would like the afterschool program to work on with your child.

- ☐ Increase physical activity
- ☐ Maintain current physical activity
- ☐ Decrease screen time
- ☐ Try new activities
- ☐ Try new foods
- ☐ Decrease sugar-sweetened beverages
- ☐ Improve healthy food choices
- ☐ Other (specify)_____

The following questions are optional:

Which best describes your child? (you may choose one or more of the following)

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black
- ☐ Native American or Other Pacific Islander
- ☐ White
- ☐ Prefer Not to Answer
- ☐ Do Not Know

Do you consider your child Hispanic or Latino? ☐ No ☐ Yes ☐ Prefer Not To Answer ☐ Do Not Know

To better serve you in the future, please indicate what language you prefer when writing and speaking.

Written: _____ Spoken: _____

Is your child receiving counseling? ☐ No ☐ Yes ☐ Not Specified If yes, who is providing counseling?

☐ School counselor ☐ Agency (Counselor Name and Location _____)
☐ Other (specify) _____

If you sought mental health services for your child, have you experienced any barriers?

☐ No ☐ Yes If yes, please check all that apply.

☐ Did not know who to call ☐ Cost and/or insurance not covered ☐ Stigma
☐ Unable to get to appointment ☐ Unable to make an appointment
☐ Other: _____

Are there any drug/alcohol concerns in the family? ☐ No ☐ Yes (specify below) ☐ Not Specified

_____

Are there any legal issues, past or present, with the child or other family members that we need to be aware of?

☐ No ☐ Yes (specify below) ☐ Not Specified

_____

My child will depart from afterschool by (check all that apply):

☐ Parent pick-up ☐ Walk (with parent permission)
☐ Bus ☐ Walk (without parent permission)

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Medications

Name of Medication	Prescribing Doctor	Amount to be taken	How it is taken	Time(s) of day to be taken	Reason for Taking/Special Instructions

