Head Start Child Application

Received in Office:	Enrolled:	Withdrawn:
Re-enrolled:	2nd School Year:	Withdrawn:

Child's Legal Name: First	**Middle**	**Last**
Preferred Name:	**Date of Birth:**	Social Security Number
Race: White Black Hispanic Bi-Racial Other_______	Sex: Male Female	Language:
Street Address:(P.O. Box First, if any)	**City:**	State: Zip Code:
Home Phone:	Child's Health Insurance:	Insurance Number:
Parental Status: One parent Two Parent Foster Not Parent	Number In Home_______ Number in Family______ Number of Children_____	Child will get to Head Start by: Bus Parent Other_________________________
Dual Custody: Yes No	Incarcerated Parent: Yes No	Receiving Public Assistance: TANF Food Stamps WIC
Does Child have a diagnosed disability?	Does Child have a suspected disability?	Child referred to program by?
Does family have a crisis?	If yes please describe	Does Child have any health problems?
Has your child been seen by a doctor or counselor for behavior?	Are there any other family health concerns or problems?	Who and what are the health concerns?
Primary Parent or Guardians First Name:	**Last Name:**	Social Security Number
Street Address:	City State Zip	**Home Phone** **Cell Phone** **Work Phone**
Marital Status: Married Single Divorced	Employment Status: Full Time Part Time Unemployed Self-employed	Student: Part time Full time Disabled: Yes No
Second Parent or Guardians First Name:	**Last Name:**	Social Security Number
Street Address:	City State Zip	**Home Phone** **Cell Phone** **Work Phone**
Marital Status: Married Single Divorced	Employment Status: Full Time Part Time Unemployed Self-employed	Student: Part time Full time Disabled: Yes No
Are you receiving rental assistance? Yes No	Does your family have a car? Yes No	Does your family have adequate housing? Yes No

Emergency Contact Name:	Home Phone: Work Phone: Cell Phone:	Address: City:
Emergency Contact Name:	Home Phone: Work Phone: Cell Phone	Address: City:

Release Child to: 1.	2.
3.	4.
Doctor's Name:	Doctor's Phone Number:

Adults

First and Last Name of Adults in home	Date of Birth	Social Security Number	Sex	Education Level	Employment Status	Occupation
			M F			
			M F			
			M F			
			M F			

Other Children in Home

First and last name of other children in home	Date of Birth	Sex	Relationship to Primary Parent
		M F	
		M F	
		M F	
		M F	

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent Guardian Signature:	**Date:**

Weekly X 52
Every 2 weeks X 26 = Annual Income
Twice Month X 24
Monthly X 12

For Center Use Only Do not write below this line
Income Verification

Family Member	Amount	Per	X	Annual Income	From Whom

Total yearly income of family	$
Signature of verifying Staff Member & Date	W2, Tax Return, Check Stub, Pay Envelope, Letter, Public Asst, etc.

Parents:	Disability	Income	Other	In District	Public Assistance	Special Needs	Age
Descr	Descr	Descr	Descr	Descr	Descr	Descr	Descr
Points:	Points	Points	Points	Points	Points	Points	Points
Total:							

Total Overall Amount of Points		
Accepted in Program: Yes No	Room Number: __________	Date: / /
Waitlist: Yes No	Date: / /	