

*** PARTICIPANT INFORMATION: Fill out information about the child ***

Last:	First/Middle:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Birth Date:		Parental Status: One <input type="checkbox"/> Two <input type="checkbox"/>	
Living Address:			
City:	State:	Zip	

Program Options

Are you interested in: Part-time: 9:00-3:00 Full-time services Either

*** DEMOGRAPHIC information for the child***

Race (check all that apply): <input type="checkbox"/> American Indian/Alaskan N <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hawaiian/Pacific Is <input type="checkbox"/> White <input type="checkbox"/> Other: _____	Language	Primary Language?	Proficiency
	English	Yes <input type="checkbox"/> No <input type="checkbox"/>	None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient <input type="checkbox"/>
	Spanish	Yes <input type="checkbox"/> No <input type="checkbox"/>	None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient <input type="checkbox"/>
Ethnicity: Circle one Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient <input type="checkbox"/>
Nationality:			

FAMILY INFORMATION: Fill out information about adults and family who are part of child's life

PARENT/GUARDIAN	Name:	Primary Adult?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Relationship to Child:		Birth Date:	
Living Address:			
City		State	
E-mail Address:		Where parent was born?	
Phone Number		Primary Phone?	Phone Type (Work, Home, Cell)
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Name:
			Phone #:
Teen Parent (19 or younger): Yes <input type="checkbox"/> No <input type="checkbox"/>	Custody: Yes <input type="checkbox"/> No <input type="checkbox"/>	Lives with Child: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Child's Relationship to Adult:	English Level:	Education Level:	Employment Status:
Natural/Adopted/Step-Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Foster Child <input type="checkbox"/> Other <input type="checkbox"/>	None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient <input type="checkbox"/>	Some College <input type="checkbox"/> Certificate <input type="checkbox"/> High School Grad <input type="checkbox"/> GED <input type="checkbox"/> Master's Degree <input type="checkbox"/>	<Grade 9 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12 <input type="checkbox"/> Associate's <input type="checkbox"/> BA <input type="checkbox"/>
			Full Time (35+hours) <input type="checkbox"/> Part Time <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Training or School <input type="checkbox"/>
			Full Time & Training <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Unemployed <input type="checkbox"/>

PARENT/GUARDIAN	Name:	Primary Adult?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Relationship to Child:		Birth Date:	
Living Address:			
City		State	
E-mail Address:		Notes (when not to call, etc.)	
Phone Number		Primary Phone?	Phone Type (Work, Home, Cell)
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Teen Parent (19 or younger): Yes <input type="checkbox"/> No <input type="checkbox"/>	Custody: Yes <input type="checkbox"/> No <input type="checkbox"/>	Lives with Child: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Child's Relationship to Adult:	English Level:	Education Level:	Employment Status:
Natural/Adopted/Step-Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Foster Child <input type="checkbox"/> Other <input type="checkbox"/>	None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient <input type="checkbox"/>	Some College <input type="checkbox"/> Certificate <input type="checkbox"/> High School Grad <input type="checkbox"/> GED <input type="checkbox"/> Master's Degree <input type="checkbox"/>	<Grade 9 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12 <input type="checkbox"/> Associate's <input type="checkbox"/> BA <input type="checkbox"/>
			Full Time (35+hours) <input type="checkbox"/> Part Time Training <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Training or School <input type="checkbox"/>
			Full Time & Training <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Unemployed <input type="checkbox"/>



* ADDITIONAL MEMBERS of Family / Household *

Name:	Relationship to Child:	Date of Birth:
Name:	Relationship to Child:	Date of Birth:
Name:	Relationship to Child:	Date of Birth:
Name:	Relationship to Child:	Date of Birth:
Name:	Relationship to Child:	Date of Birth:
Name:	Relationship to Child:	Date of Birth:
Name:	Relationship to Child:	Date of Birth:

Total # of people (including the participant and adults listed on front, and all listed above) who live in child's household and are part of his/her family: ____

CHILD'S NEEDS ++

Does your child have a disability (diagnosed by a doctor or specialist)? Yes No Does s/he have an IEP or IFSP? Yes No

If yes, please list the specific disability: _____

Do you have any concerns about your child in any of the areas listed below? *If yes, please check appropriate item(s).*

Hearing Vision Obesity Allergies Asthma Dental problems

Other medical problems - *Please describe:* _____ Other development concerns - *Please describe:* _____

Speech or language development Physical development

please provide medical documentation of concerns if available

Behavior or emotional problems (e.g. tantrums) - *Please describe:* _____

* SERVICES: What services is your family receiving or have received in the past 12 months? *

Food Stamps Unemployment Utility/Energy Assistance

Foster Care/Adoption Subsidy Public Housing Child Support

Medicaid Section 8 Vouchers Private Health Insurance

State Health Insurance Social services from other agency

Emergency/Crisis Intervention *Which agency?:* _____

DO YOU HAVE: TANF? Yes No **SSI?** Yes No **WIC?** Yes No **Referred to:** _____

Child Care Subsidy/Voucher? Yes No Don't know about it

* LEGAL ISSUES: Is your family currently dealing with legal issues? * ++

Is your family currently dealing with legal issues such as divorce, probation, custody, restraining orders, etc.? Yes No

If yes, please clarify: _____

Additional Information

Has your child previously been enrolled in Head Start or another preschool program? Yes No

Has your child had a sibling previously enrolled in this Head Start program? Yes No

If yes, what program? _____

If yes, is he or she currently enrolled? Yes No
Specify dates of attendance? _____ to _____

How did you hear about our program?
 Word of mouth (friend, family)
 Saw/received a flyer
 Saw/passed the center
 Know someone who works here

Referred by agency (WIC, child support services, child care subsidy, etc.)
Please specify: _____
 Other
Please specify: _____

I—or another adult in my family—accesses the Internet: *Mark one of the following:* Every day Several times per week Once a week Several times per month Rarely or never

PLEASE SIGN HERE to verify that you have completed this application and provided true information.

** For pregnant women under 18, a parent/guardian should sign here **

Signature of Parent/Guardian: _____ Print Name _____ Date: _____

FSW Signature: _____ Print Name _____ Date: _____

