

**ENROLLMENT APPLICATION**

(If you have questions or need assistance when filling out this application, please contact the center nearest you.  
This application is also available in Spanish and can be made available in any other language.)

CHILD'S INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Child goes by: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  FEMALE  MALE Primary Language: \_\_\_\_\_

Nationality/Country of Origin: \_\_\_\_\_ Secondary Language: \_\_\_\_\_

Race/Ethnicity: (Check all that apply)

- White (Non Hispanic)  Black (Non Hispanic)  Mexican/Chicano  Hispanic/Latino  Hawaiian  Puerto Rican  American Indian  Pacific Islander  
 Central American  Asian  Other: \_\_\_\_\_

Health Insurance: (Check all that apply)  Medicaid  CHP+  Private  Other  Pending  None NUMBER: \_\_\_\_\_

Child's Primary Doctor: \_\_\_\_\_ Child's Primary Dentist: \_\_\_\_\_

Address & Phone Number: \_\_\_\_\_ Address & Phone Number: \_\_\_\_\_

To your knowledge does your child have any of the following? (Check all that apply)

- IEP (Individualized Education Plan)  IFSP (Individualized Family Service Plan)  Doctor's diagnosis: \_\_\_\_\_  NA

If YES, please name the agency providing services to your child? \_\_\_\_\_

Is your child receiving services for, or would you like for your child to receive services for any of the following? (Check all that apply)

- Visual Impairment/Glasses  Developmental Delay  Special Diet  Autism  Speech/Language Impairment  Hearing Impairment  
 Emotional/Behavioral Disorder  Learning Disability  Other: \_\_\_\_\_  None

Current Jefferson County Home Address: (For Lakewood please contact Lakewood Head Start)

\_\_\_\_\_

Mailing Address if different than Home address:

\_\_\_\_\_

Please Provide ALL CURRENT Telephone Numbers:

Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Other: \_\_\_\_\_ Other: \_\_\_\_\_

Parental Status: (check all that apply)  One Parent  Two Parent  Foster  Grandparent/Relative

Housing: (check all that apply)  Own  Rent  Public Housing (Section 8, subsidized, etc)  Make no payment  Live with Relative  Homeless (Car, shelter, motel/hotel)

Referred to Head Start by: \_\_\_\_\_

Please check all services your family currently receives:  TANF  CCCAP  Food Stamps  SSI  WIC (ID #: \_\_\_\_\_)

- Child Support  Involved with Children Youth & Families (Open case with Child Welfare or Child Protection)  Other: \_\_\_\_\_  NONE

Please turn over to fill out back side!

**MOTHER/LEGAL GUARDIAN INFORMATION**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

Nationality/ Country of Origin: \_\_\_\_\_

**Race/Ethnicity:** (Check all that apply)

- White (Non Hispanic)    Black (Non Hispanic)    Mexican/Chicano    Asian  
 Hispanic/Latino    Hawaiian    Puerto Rican    American Indian  
 Central American    Pacific Islander    Other: \_\_\_\_\_

**Highest grade completed in school:** (check all that apply)

- Grade 9 or less    Grade 10    Grade 11    Grade 12    GED  
 High School Graduate    College Degree/Training Cert.  
 College or Advanced Training    Associate's Degree  
 Bachelor's Degree    Master's Degree (or above)

**Employment Status:** (check all that apply)

- Full time Work & Training    Full time Work (35hrs/week or more)  
 Part time Work & Training    Part Time Work (Under 35hrs/week)  
 Retired or Disabled    Seasonally Employed    Training or School  
 Unemployed (looking for employment)    Not Employed (stay at home)

**Child's Relationship to this individual:** (check all that apply)

- Birth mother    Adoptive    Step Child    Foster Child    Grandchild  
 Niece/Nephew    Other: \_\_\_\_\_

1) Does the child live with you?    Yes    No    Part Time

2) Do you have the same home & mailing address as the Child?    Yes    No  
 If No, please provide current address:

**FATHER/LEGAL GUARDIAN INFORMATION**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

Nationality/ Country of Origin: \_\_\_\_\_

**Race/Ethnicity:** (Check all that apply)

- White (Non Hispanic)    Black (Non Hispanic)    Mexican/Chicano    Asian  
 Hispanic/Latino    Hawaiian    Puerto Rican    American Indian  
 Central American    Pacific Islander    Other: \_\_\_\_\_

**Highest grade completed in school:** (check all that apply)

- Grade 9 or less    Grade 10    Grade 11    Grade 12    GED  
 High School Graduate    College Degree/Training Cert.  
 College or Advanced Training    Associate's Degree  
 Bachelor's Degree    Master's Degree (or above)

**Employment Status:** (check all that apply)

- Full time Work & Training    Full time Work (35hrs/week or more)  
 Part time Work & Training    Part Time Work (Under 35hrs/week)  
 Retired or Disabled    Seasonally Employed    Training or School  
 Unemployed (looking for employment)    Not Employed (stay at home)

**Child's Relationship to this individual:** (check all that apply)

- Birth Father    Adoptive    Step Child    Foster Child    Grandchild  
 Niece/Nephew    Other: \_\_\_\_\_

1) Does the child live with you?    Yes    No    Part Time

2) Do you have the same home & mailing address as the Child?    Yes    No  
 If No, please provide current address:

# ADULTS in the Family/Household: \_\_\_\_\_ # CHILDREN in the Family/Household: \_\_\_\_\_ TOTAL in the Family/Household: \_\_\_\_\_

**Children**

DO NOT INCLUDE HEAD START CHILD!  
 Only include other children living in household.

First & Last Name of Child	Relationship to HEAD START Child	Date of Birth	Gender M/F

**Priority Score** (This is OPTIONAL, but will help us in giving your child priority into the program.)

*Please check all that applies to your family:*

- |   |  |
|---|--|
| <input type="checkbox"/> Returning or Transferring Head Start Child                       | <input type="checkbox"/> History of Drug or Alcohol Abuse in Family  |
| <input type="checkbox"/> Sibling in Head Start-Current or Former                          | <input type="checkbox"/> Domestic Violence-Current or Former   |
| <input type="checkbox"/> Other Relative in Head Start (Cousin)                            | <input type="checkbox"/> Teen Parent (When child was born)   |
| <input type="checkbox"/> Military Deployment/Veteran                                      | <input type="checkbox"/> Involved with Children Youth & Families<br>(Open case with Child Welfare or Child Protection) |
| <input type="checkbox"/> Chronic/Severe Medical Condition<br>(ex: Cancer, MS, Depression) | <input type="checkbox"/> Currently Unemployed Due to Lay Off in past 12 Months   |
| <input type="checkbox"/> Incarcerated Parent-Current or Former                            | <input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Transportation Services Needed                    |

*I certify that the information provided in this form is accurate and truthful to the best of my knowledge.*

Jefferson County does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in the provision of services.

Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_