Student Application

Please do not leave anything blank, if it does not apply to you please write "N/A"

Site: _____ Today's Date: _____

Applicant's info:

Name: _____ Nickname: _____

Date of Birth: _____/_____/_____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: (___) ____-_____Mother Cell: (___) ____-_____Father Cell: (___) ____-_____

Language spoken at Home: Primary _____ Secondary _____

Email Address: _____

Race (for Head Start reporting purposes only):

O Asian

O Black or African American

O White

O Native Hawaiian

O American Indian or Alaska Native

O Biracial/Multiracial

O Other: _____

Ethnicity: **O** Hispanic or Latino **O** Non-Hispanic or Non-Latino

Family Housing

Where Is your child currently living?

O With another family or other person because of loss of housing/economic hardship

O In a shelter

O In a hotel or motel

O In a car, park, but or train station or campsite

O Other temporary living situation:

_____

O In permanent housing

List all applicants' family members:

Name	D.O.B.
Father:	
Mother:	

Family Resources

Father:
Employed at: _____
Annual Income: _____
Education Level: GED HS BA MA
Attending School? **O** Yes **O** No

Mother:
Employed at: _____
Annual Income: _____
Education Level: GED HS BA MA
Attending School? **O** Yes **O** No

Circle the programs you are receiving:
Food Stamps, TANF, WIC, SSI, HRA Voucher

Parent Marital Status: _____

Total # of family members: _____

Child in foster care? **O** Yes **O** No

Child's Health Information:

Does your child have Health Insurance? **O** Yes **O** No

Health Insurance Company: _____Policy # _____

MEDICAID # _____

Does your child have a Primary Care Physician? **O** Yes **O** No

Primary Care Physician: _____Date of child's last exam: _____

Address: _____ Phone # _____

Is your child up-to-date on all age-appropriate preventive and primary health care and well child care? **O** Yes **O** No

Is your child up-to-date on all age-appropriate immunizations: **O** Yes **O** Valid Exemption

Is your child diagnosed by a doctor with any chronic condition? **O** Yes **O** No

If Yes, what is the condition? _____

Is your child receiving medical care for the condition? **O** Yes **O** No (Reason):_____

Does your child have any allergies? _____

Does your child have a dentist? **O** Yes **O** No

Dentist: _____ Date of child's last exam _____

Address: _____ Phone # _____

Did your child receive all age-appropriate dental care? **O** Yes **O** No

In case of Emergency please provide us with a relative that we can contact:

Name of relative: _____ Relationship to child: _____

Home Phone# (_____) _____-_____ Cell Phone # (_____) _____-_____

Services:

Does your child have a diagnosed disability or developmental delay: _____?

Does your child have an **O** IFSP **O** IEP

Is your child receiving services, such as Speech Therapy, ABA, PT, OT etc.?

If yes, please explain_____

Please Note: Once your child is enrolled in Head Start, he/she is eligible to stay in the program until the child ages out of the program.

I certify that the information provided is correct to the best of my knowledge and is subject to verification.

Signature: _____ Date: _____