

Enrollment Application	Program Year: <u>2021-2022</u>
Early Head Start – Home Based prenatal to age 3 <input type="checkbox"/>	Rugby Early Learning Center ages 3 to 5 <input type="checkbox"/>

Applicant Information

Child's Name	Date of Birth	Sex

First Middle Initial Last

Race/Ethnicity: <i>(check all that apply)</i>			
African American	<input type="checkbox"/>	Native American	<input type="checkbox"/>
Asian	<input type="checkbox"/>	Native Hawaiian or Pacific Islander	<input type="checkbox"/>
Caucasian	<input type="checkbox"/>	I prefer not to specify	<input type="checkbox"/>
Other	<input type="checkbox"/> <i>please specify</i>		
Bi-racial	<input type="checkbox"/> <i>please specify</i>		

Hispanic/Latino:			
<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes, check all that apply)</i>			
Central American	<input type="checkbox"/>	Cuban	<input type="checkbox"/>
Mexican/Chicano	<input type="checkbox"/>	Puerto Rican	<input type="checkbox"/>
I prefer not to specify	<input type="checkbox"/>		
Other	<input type="checkbox"/> <i>please specify</i>		

Primary Language:		Secondary Language:	
Is your family learning a language other than English:		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Has this applicant ever been enrolled in Early Head Start/Head Start? Yes No

If yes, when and where: _____

Does your child currently have medical coverage? Yes No

If yes, please give your type: _____

Are there concerns about the child's overall health & development? Yes No

If yes, please describe those concerns below

	Suspected	Diagnosed		Suspected	Diagnosed
Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Traumatic Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>
Speech or Language Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Non-categorical Delay	<input type="checkbox"/>	<input type="checkbox"/>
Health Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Mentally Impaired	<input type="checkbox"/>	<input type="checkbox"/>			
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>			

Family Information

Physical Address: *(Where applicant is living)*

Street

City

State

Zip

Mailing Address: *(If different)*

Street/PO Box

City

State

Zip

Telephone Numbers:

Home:

Work (Mom):

Work (Dad):

Cell:

Message:

Other:

Email Address:

Which of the following best describes the applicant's family?

Two parent family

Single parent

Single parent living with partner

Foster family

Teen parent living with parents

Other *(please explain)*

Head of Household *please print*

Name	Date of Birth	Relation to Child
Education – Highest Completed		
<input type="checkbox"/> Less than High School	<input type="checkbox"/> High School Diploma/GED	<input type="checkbox"/> Some College (no degree)
		<input type="checkbox"/> Associates Degree
		<input type="checkbox"/> Bachelors Degree or higher
Current Employment Status		
<input type="checkbox"/> Full Time (32 hours/week or more)	<input type="checkbox"/> Part Time	<input type="checkbox"/> Unemployed
		<input type="checkbox"/> Retired
		<input type="checkbox"/> Disabled
Are you currently attending school?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a member of the United States military on active duty?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a veteran of the United States military?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Other parent/guardian living in the home *please print*

Name	Date of Birth	Relation to Child
Education – Highest Completed		
<input type="checkbox"/> Less than High School	<input type="checkbox"/> High School Diploma/GED	<input type="checkbox"/> Some College (no degree)
		<input type="checkbox"/> Associates Degree
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Current Employment Status		
<input type="checkbox"/> Full Time (32 hours/week or more)	<input type="checkbox"/> Part Time	<input type="checkbox"/> Unemployed
		<input type="checkbox"/> Retired
		<input type="checkbox"/> Disabled
Are you currently attending school?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a member of the United States military on active duty?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a veteran of the United States military?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list all the applicant's siblings:

Name	Gender	Date of birth	Does the child live in the home?	Has this child ever been enrolled in EHS or HS? If yes, when & where

Number of adults (18 years or older) in the household:	
Number of children (under 18 years) in the household:	
Do you use or need child care? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time

Many families receive service or financial assistance from one or more programs or agencies. Does your family receive services from any of the following services:

- Medical Assistance
- Unemployment Insurance
- WIC
- Child Care Assistance
- Public Assistance/TANF/TEAM
- Public Housing Assistance
- Health Tracks
- Foster Care/Adoption Subsidy
- Food Stamps
- Energy Assistance
- Supplemental Security Income (SSI)
- Other: _____

Is your family experiencing crisis or unmet family needs at this time? Yes No

If yes, please explain: _____

Were you referred to the Head Start/Early Head Start/Pre-K Program? Yes No

If yes, by whom: _____

I give my permission that:

_____ Any photographs or news film may be used in newspapers, television, displays, bulletin boards or other publications.

_____ I give my permission for Early Explorers to release my child's name, my name, address, & telephone number to the county social services office & county public health services office, Early Head Start, Infant Development and Even Start. My child's name & information is being released for sole purposes to schedule & complete my child's health screening as required by Head Start Federal Regulations.

_____ **Head Start & Early Head Start applicants: A copy of your child's birth certificate and proof of income are required for enrollment. Your application is not complete and cannot be processed without them.**

_____ *Parent Signature*

_____ *Date*

_____ *Parent Signature*

_____ *Date*

In granting consent, I understand that all information will remain confidential and will be used solely for the benefit of our child and family. I release Head Start/Early Head Start and all staff from any legal liability for disclosing and acquiring information which I have permitted by signing this form. I also release the above named person from any legal liability for giving information to the Head Start/Early Head Start Program.