



## Other Parent/Guardian Living in the Home

Adult's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  M  F Race:  American Indian/Alaska Native  Asian  Black/African American  Hispanic  
 White  Pacific Islander/Hawaiian (Multi-Racial please check multiple boxes)

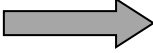
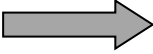
Primary Language at Home: \_\_\_\_\_ Speaks English:  Very Well  Well  None

Highest Level of Education:  High School Grad  GED  Associates  Bachelors  Masters  Other: \_\_\_\_\_

Relationship to Child:  Biological Parent  Grandparent  Foster  Aunt/Uncle  Other: \_\_\_\_\_

Current Employment Status:  Current Active Military  Full Time  Part Time  Retired  Disabled  
 Seasonal  Unemployed – When? \_\_\_\_\_

## Family Information

 <b>Head Start Staff Will Complete This Section</b> 		<u>Annual Amount</u>		<u>Annual Amount</u>	
	Wages (Working Income)			Unemployment Insurance	
	Public Assistance			Contribution	
	Social Security/Pension			Supplemental Security Income	
	Child Support/Alimony				
	Foster Care/Adoption Subsidy				
Annual Household Total:					

How many family members live on the income indicated above? Adults: \_\_\_\_\_ Children: \_\_\_\_\_

## Emergency Contact Information

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

## Concerns

Do you have any Medical or Behavioral concerns?  Yes (please indicate with check below)  No

<input type="checkbox"/> Seizures	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Allergies	<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing
<input type="checkbox"/> Anemia	<input type="checkbox"/> High Lead Level	<input type="checkbox"/> Developmental Delay
<input type="checkbox"/> Autism	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Behavior/Emotional
<input type="checkbox"/> Weight	<input type="checkbox"/> Orthopedic Impairment	<input type="checkbox"/> Speech/Language Impairment
<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Downs Syndrome	<input type="checkbox"/> Health Impairment

Other Concern (Please Explain): \_\_\_\_\_

Has the child been diagnosed with a disability?  Yes  No  Suspected

If Yes, does the child have an IEP?  Yes  No

If Suspected, who has the child seen regarding your concern? \_\_\_\_\_

Is your family in need or experiencing a crisis?  Yes  No

If Yes, Please explain: \_\_\_\_\_

Is either biological parent incarcerated at this time?  Yes  No

**Male Involvement**

Is there a significant male role model in the child's life that we may contact regarding center activities? (father, uncle, grandfather, cousin, etc.)       Yes       No

If Yes, Please provide :      Name      Relationship to Child:

Mailing Address:

Phone #:

Please read the following carefully:

Purpose of Enrollment: The purpose of enrollment is to offer children and families the opportunity to receive a comprehensive selection of services and educational experiences that support school readiness in preparing children for kindergarten and future life learning. Our attendance goal for children is that they will attend class regularly and on a daily basis with the exception of excused illness. It is important for children to attend class to achieve a successful outcome of their planned school readiness goals.

\_\_\_\_\_ (parent initials)      I understand that according to NC General Statute 110-91(1) that each child must have a health assessment before being admitted, or within 30 days following admission to a child care center and yearly, thereafter. Failure to comply with this statute may interrupt services for my child.

I certify that the information given on this application is true and accurate and all income has been reported and is subject to verification by the program. I understand that this information is being given for services provided by federal and/or state funds and that deliberate misrepresentation of any information will disqualify me from services.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Printed Name: \_\_\_\_\_

Intake Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_