E.I. C., Inc Head Start
PO Box 549/712 Virginia Rd
Edenton, NC 27932
Central Office: (252) 482-4495 Fax: (252) 482-7564

Local Center Contact:
_____

_____

This Application is not complete without proper proof of income, proof of the child's birthdate, child's immunization record, and Copy of Health Insurance (if child has insurance)

Child's Information

Child'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

Insurance Coverage (Copy of Ins. Card Required): ☐ Medicaid ☐ NC Health Choice ☐ TriCare ☐ Private ☐ Other:_____

Insurance #: Date Issued:

Current Medical Doctor: Phone:

Current Dentist: Phone:

Primary Adult Caring for Child

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

Living Address:

Mailing Address (if different):

Primary Phone: Alternate Phone: Email:

Parental Status: ☐ One Parent Figure ☐ Two Parent Figure

Is either parent in the household a Military Veteran? Yes ☐ No ☐

Housing Status: ☐ Own Home ☐ Rent Home/Apt/MobileHome ☐ Living with Relative/Friend **(Long Term)** ☐ Shelter ☐ Hotel/Motel ☐ Other (Explain): ☐ Living with Relative/Friend **(Temporarily)**

Were you referred to Head Start by the Health Department or Social Services? ☐ Yes ☐ No

Do you receive any of the following? (check all that apply) ☐ Food Stamps ☐ TANF/WorkFirst ☐ SSI ☐ WIC ☐ Child Support

AGENCY USE ONLY

Center	**Status**	**Eligible Age**
Disability Status	**Acceptance Date**	**Data Entry Notes**
Primary-		

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

Head Start Staff Will Complete This Section

	Annual Amount		Annual Amount
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

☐	Seizures	☐	Asthma	☐	Diabetes
☐	Allergies	☐	Vision	☐	Hearing
☐	Anemia	☐	High Lead Level	☐	Developmental Delay
☐	Autism	☐	Hyperactivity	☐	Behavior/Emotional
☐	Weight	☐	Orthopedic Impairment	☐	Speech/Language Impairment
☐	Traumatic Brain Injury	☐	Downs Syndrome	☐	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: _____

3/2017