Fayette County Early Learning Center Enrollment Form

For Office Use Only
Date Accepted ___________
Date Of Entry ___________
Early Head Start _________
H.S.-Jeff. __________
H.S.-W.C.H. __________
W.C.-Preschool __________
Income Verified:
Under __________
Over __________
Points __________
Age __________
Referral __________
Federal __________
Other __________
SSI/TANF __________

____
Child's Last Name First Name Middle Preferred Name

____
Date of Birth Age Social Security Number Sex

____
Child's Home Address –Street City State Zip Code County

____
Name of Parent(s)/Guardian Parent/Guardian Social Security Number

____
Home Phone # Cell Phone# E-mail Address

Child's Race_____________________ Language Spoken________________

Child's year in program ________

Parent(s) Race Mom _____________ Dad_______________ Is parent pregnant? ____________ Mom's doctor?__________

Current living arrangement: Own______ Rent ______ **(Specify if you pay rent to the person you are living with)**

Motel_______ Shelter________ Friends_________ Relative-Who? __________ Other (specify) __________ Homeless_______

What is the name of child's doctor? __________________________ Child's dentist? ______________________________

Do you receive WIC? _____ Is parent/legal guardian currently working? Mom _______ Dad_______ Guardian_______

Is there shared parenting? _______ Do you have custody papers? ___________ (WE MUST HAVE A COPY)

Names of **Siblings** in the home	Birth date	Age	Relationship to child **(brother or sister)**	Last grade completed
1.________________________	________	______	________________	____________________________________
2.________________________	________	______	________________	____________________________________
3.________________________	________	______	________________	____________________________________
4.________________________	________	______	________________	____________________________________
Names of **Parents** in the home				
1._________________________	________	______	________________	____________________________________
2._________________________	________	______	________________	____________________________________

Do you currently have health insurance? Y______ N______ Insurance name and number ________________________________

Do you now receive cash benefits (TANF/OWF) from ODJFS? _______ In the past? _______ Do you receive food stamps? _____

How did you find out about the Head Start program? (Flyer/parent/friend/former H.S. child or sibling/referral) ________________

I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and may be subject to legal action. I understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Date Received___________
By ______________________

____
Parent/Guardian Signature Date

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PLEASE BE SURE TO ANSWER EACH QUESTION. NOT COMPLETELY FILLING OUT THE APPLICATION MAY DELAY THE ENROLLMENT PROCESS.

Have you ever worked with any of the following programs or agencies?

	YES	NO	
1.	_____	_____	Hopewell SERCC (Special Educational Regional Resource Center)
2.	_____	_____	Fayette Progressive School/Industries
3.	_____	_____	Summer Speech Program
4.	_____	_____	Children's Hospital ______________________________
5.	_____	_____	Early Intervention/ Help Me Grow
6.	_____	_____	Early Head Start
7.	_____	_____	Other Program: ______________________________
8.	_____	_____	Does your child have a disability or delay? ____________________
9.	_____	_____	Has the disability been professionally diagnosed? If so, by who? ____________
10.	_____	_____	Is your child receiving special services for the disability? If so, what? __________
11.	_____	_____	In your opinion, does your child have any special needs? ______________

Check all that apply:

Family Issues

__ Parent with developmental issues as a child
__ Parent that was a victim of child abuse/neglect
__ Severe family crisis
__ Unusual or recurring accidents involving children
__ Environment poses risk
__ Family often in turmoil
__ Current or history of domestic violence
__ Current or history of drug or alcohol abuse
__ Inadequate healthcare/ no health insurance
__ Lack of stable residence/ homeless
__ Single parent household
__ Single parent household with 4 or more preschool age children
__ One or more incarcerated parent
__ Current or previous case with Children's Services
__ Involved with mental health clinic or private practice
__ Parent/guardian w/disability or medical diagnosis
____

Biological Factors– Child

__ Asphyxia (not breathing)
__ Chronic ear infections
__ Small for gestational age
__ Very low birth weight
__ Genetic disorder ____________________

Biological Factors– Parent

__ Chronic or acute mental illness
__ Drug or alcohol dependence
__ Limited prenatal care
__ Maternal prenatal substance abuse
__ Mental retardation
__ Severe chronic illness ________________
__ Genetic disorder ____________________

Parent Issues

__ Inadequate parenting skills or inability to interact w/child
__ Parent and child separation
__ Physical/social isolation or no adequate social support

______________________ ______________________________

Child's Name Parent/Guardian Signature Date