

Center Name: _____ Eligibility Status: _____

CHILD'S INFORMATION			
Child's Last Name	Child's First Name	Child's Middle/Preferred Name	
DOB (mm/dd/yyyy):	SSN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race (check all that apply): <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____			
Primary Language:	Secondary Language:	National Origin:	Ethnicity:

FAMILY INFORMATION			
Living Address (No PO Box)			
City	State	Zip	County
Mailing Address (If different from above)			
City	State	Zip	County

PHONE NUMBERS				****(If more space is needed use back of form)****
Type	√ If Primary (Check One)	Phone Number	Note	
Home	<input type="checkbox"/>	() () ()		
Cell	<input type="checkbox"/>	() () ()		
Work	<input type="checkbox"/>	() () ()		

MEMBERS IN HOUSEHOLD					
***If guardians are not child's natural parents please complete BOTTOM OF PAGE 2 of Application.					
* Employment Codes			** Education Codes		
F - Full Time	U - Unemployed	T - Training/School	G9 - Grade 9 or Less	G10 - Grade 10	G11 - Grade 11
P - Part Time	S - Seasonally Employed	R - Retired/Disabled	COL - College/Tech Training	CTG - College Graduate/Certificate	A - Associates Degree
			HSG - High School Graduate	GED - General Education Diploma	B - Bachelor's Degree
			M - Masters Degree		
Primary Guardian		If not Mother, Relationship to child: <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster <input type="checkbox"/> Other _____			
Last		First		SSN	
DOB		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Provides Financial Support: Yes No	
Employment Status*:		Education Level**:		Teen Parent: Yes No	
Place of Employment:		Work Address:		Work Phone #:	
Secondary Guardian (Only Applicable if Living in Household)		If not Father, Relationship to child: <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster <input type="checkbox"/> Other _____			
Last		First		SSN	
DOB		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Provides Financial Support: Yes No	
Employment Status*:		Education Level**:		Teen Parent: Yes No	
Place of Employment:		Work Address:		Work Phone #:	

Other Children Living in Home					****(If more space is needed use back of form)****
First and Last Name	Please enter ONE of the following:			Gender	Relationship
	DOB	Social Security Number			
		-	-	M F	
		-	-	M F	
		-	-	M F	
		-	-	M F	

Child's Name: _____ Center: _____

EMERGENCY CONTACTS & CHILD RELEASE INFORMATION

(If more space is needed use back of form)

Contact 1	Name		Phone Number		
	Address (No PO Box)		Home	()	Relationship to Child
	City		Cell	()	Emergency Contact? Yes No
	State	Zip	Other	()	Release Child To? Yes No
Contact 2	Name		Phone Number		
	Address (No PO Box)		Home	()	Relationship to Child
	City		Cell	()	Emergency Contact? Yes No
	State	Zip	Other	()	Release Child To? Yes No
Contact 3	Name		Phone Number		
	Address (No PO Box)		Home	()	Relationship to Child
	City		Cell	()	Emergency Contact? Yes No
	State	Zip	Other	()	Release Child To? Yes No

GENERAL INFORMATION

# in Household _____	# in Family _____	# of Children _____	By age: 0-3 _____	4-5 _____	Child Eligible Next Year: Yes No
TANF: Yes No	SSI: Yes No	WIC: Yes No	Food Stamps: Yes No		Sibling Eligible Next Yr.: Yes No
Medicaid/WellCare Eligibility Status (circle one): On Medicaid Not Eligible Potentially Eligible			Medicaid/WellCare #:		
Other Health Coverage:			Insurance #:		
Doctor's Name	Address	City	State	Zip	Phone()
Dentist's Name	Address	City	State	Zip	Phone()
Does Child have Diagnosed Food Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does Child Have: <input type="checkbox"/> Suspected Disability <input type="checkbox"/> Diagnosed Disability <input type="checkbox"/> Child Has No Disability/Developmental Concerns			
If YES, Please include Doctor's Excuse listing Food Allergies.		If Child has been DIAGNOSED, Please Include Paperwork Specifying Disability			
Mother			*****Complete only if not listed as Primary Guardian*****		
Last			First		
Living Address(No PO Box)		City	State	Zip	Home/Cell Phone () -
Place of Employment:		Work Address: (No PO Box)		Work Phone #:	
Father			*****Complete only if not listed as Primary Guardian*****		
Last			First		
Living Address(No PO Box)		City	State	Zip	Home/Cell Phone () -
Place of Employment:		Work Address: (No PO Box)		Work Phone #:	

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also 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.

Parent/Guardian Signature _____ Date _____

Verifying Staff Member _____ Date _____