SEVCA Windsor County Head Start

107 Park Street Suite 1
Springfield, VT 05156
Phone: 885-6669 or Toll Free: 1-877-535-3497
Email: headstart@sevca.org

APPLICATION FOR ENROLLMENT

Child's Name:_____ Birth Date:_____ __M __F

Child is living with: ___Mother ___Father ___Grandparents ___ Foster Care ___Other:_____

Street Address:_____ Mailing Address:_____
□ Own □ Rent □ Living with Family Member/Friends
Town:_____ Zip Code:_____

Phone:_____ Emergency Contact:_____
Email Address:

Has your family been in Head Start before:_____ Program Name:_____

Springfield Applicants ONLY: Are you interested in enrolling your child into our Child Care program? ___yes ____no
Primary language spoken in the home?_____ Ethnic Origin:__ Hispanic __ Non-Hispanic

Race: ___ American Indian or Alaska Native ___ Asian ___ Black/African American ___ Native Hawaiian ___ White ___Biracial/Multi-racial ___ Other: Please Specify:_____

Please list all people living in your household:

Name:	Relationship:	DOB:	Social Security #:	Parent's Education: Highest grade completed:	Received Diploma/GED? Yes/No

Is this family expecting a new sibling? __Yes __No Arrival Date:_____

Mother's Name:_____ Phone:_____
Address:_____
SAME as above OR Street, Town, State, Zip Code
Employer:_____
Name, Address, and Phone Number

Father's Name:_____ Phone:_____

Address: _____
SAME as above OR Street, Town, State, Zip Code

Employer:_____
Name, Address and Phone Number

Does your family partner with other programs? Check all that apply:
___PATH ___Food Stamps ___ Dr. Dynosaur ___WIC ___HCRS ___ Reach-up ___Child Care Subsidy
___Job training program ___Adult Education (College, GED) ___TANF ___SSI ___None of the Above

Health Information
Type of Insurance:_____ Policy Number:_____

Doctor's Name:_____ Phone Number:_____

Date of last physical exam:_____

Dentist's Name:_____ Phone Number:_____

Date of last visit:_____

Daily Medications:_____ Allergies:_____

Is there any other information you would like to share with us about your child/family? (Speech/Developmental delays, family changes (divorce, death), etc.)
_____
_____

I certify that all of the information stated above is correct. I understand that the information provided will remain strictly confidential. By signing this application, I give permission for Head Start staff to access my child's immunization information on the VT State Registry.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Staff Member's Signature Date

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OFFICE USE ONLY

Income Verification: _____Income Tax Return _____Pay Stub _____ TANF ____SSI ____ Other
STAFF: Please attach copy of income verification

Eligible for program: ____Yes ____ No Placement:_____

Enrollment Date:_____ Waiting List:_____

Letter Sent to Parent/Guardian:_____
Date

Over Income:_____ Special Needs:_____

Manager Sign-off: ____Director ____Family Services Manager ____Ed. Manager ____Ad. Asst. ____ Health Manager