Date Application Completed_____ Date of Enrollment_____

CHILD'S APPLICATION FOR ENROLLMENT

I-CARE, Inc. Head Start

To be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually

CHILD INFORMATION:

Date of Birth: _____ Center Choice(s):_____

Full Name:_____
First Middle Last Nickname

Child's Physical Address:_____

Ethnicity: Black ☐ White ☐ Asian ☐ Hispanic ☐ Other ☐ _____

Insurance: Medicaid _____ Private _____ No Insurance _____

FAMILY INFORMATION:

Child lives with: _____

Father/Guardian's Name_____ Ethnicity:_____ DOB:_____

Address (if different from child's)_____ Zip Code _____

Work Phone_____ Cell Phone_____ Home Phone_____

Education: GED ☐ High Sch. ☐ Some College ☐ College ☐

Employment: Full Time ☐ Part Time ☐ Unemployed ☐ Enrolled in school ☐

Mother/Guardian's Name_____ Ethnicity:_____ DOB:_____

Address (if different from child's)_____ Zip Code _____

Work Phone_____ Cell Phone_____ Home Phone_____

Education: GED ☐ High Sch. ☐ Some College ☐ College ☐

Employment: Full Time ☐ Part Time ☐ Unemployed ☐ Enrolled in school ☐

Others in Home	Birthdate	Gender (M/F)

Family Email:_____

Does child have a diagnosed disability: Y ☐ N ☐ IEP: Y ☐ N ☐

Is child in child care: Y ☐ N ☐ If yes, Where_____ Daycare voucher: Y ☐ N ☐

CONTACTS:

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number

Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number

HEALTH CARE NEEDS:

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes ☐ No ☐ (office use only)

List any allergies and the symptoms and type of response required for allergic reactions. _____

_____

_____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns _____

_____

_____

List any particular fears or unique behavior characteristics the child has _____

_____

List any types of medication taken for health care needs _____

Share any other information that has a direct bearing on assuring safe medical treatment for your child _____

_____

Nutritional Needs:

Does child have special dietary needs: Y ☐ N ☐ if yes, please explain _____

Child needs special milk: Y ☐ N ☐ if yes, please list _____

EMERGENCY MEDICAL CARE INFORMATION:

Name of child's doctor _____ Office Phone _____

Name of child's dentist _____ Office Phone _____

Hospital preference _____ Phone _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian _____ Date _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator _____ Date _____