

If available I would like classes in a.m. p.m. full day

BRAZORIA COUNTY HEAD START PROGRAM
PRE-ENROLLMENT APPLICATION

1ST TERM
 2ND TERM
 3RD TERM

Child's Age By Sept. 1st. _____

DATE: _____ CENTER: _____

NAME OF CHILD: _____ CHILD'S DATE OF BIRTH: _____

HOME ADDRESS: _____ PARENT OR GUARDIAN: _____

OTHER #: _____ EMAIL: _____

RACE:	<input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> BIRACIAL / MULTI-RACIAL <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> OTHER (EXPLAIN)
ETHNICITY:	<input type="checkbox"/> HISPANIC OR LATINO ORIGIN <input type="checkbox"/> NON HISPANIC OR NON LATINO ORIGIN

PRIMARY LANGUAGE(S) SPOKEN IN THE HOME: _____ LANGUAGE CHILD SPEAKS MOST OF THE TIME: _____

FAMILY TYPE: (Mark all that apply)

- SINGLE PARENT FAMILY(MOTHER FIGURE ONLY) SINGLE PARENT FAMILY (FATHER FIGURE ONLY)
 SINGLE PARENT FAMILY (MOTHER FIGURE ONLY) LIVING WITH PARTNER SINGLE PARENT FAMILY(FATHER FIGURE ONLY)LIVING WITH PARTNER TWO PARENT FAMILY FOSTER FAMILY GRANDPARENTS AS PARENTS

MARITAL STATUS: MARRIED SINGLE SEPARATED DIVORCED WIDOW Other _____

EMPLOYMENT/FATHER: _____ CITY: _____ PHONE #: _____

EMPLOYMENT/MOTHER: _____ CITY: _____ PHONE #: _____

Family Members Supported by Parent Income: (use back if needed)

Name (First Name, Last Name)	Age	Sex	Date of Birth

Total number in family _____

Are you currently pregnant? Yes No

Has your child ever attended a pre-school program Yes No

Has your child ever attended Early Head Start Yes No

Has your child ever attended Head Start Yes No

Identification of Homeless Family:
Is your current address a temporary living arrangement? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please check current temporary housing arrangement
<input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Shelter <input type="checkbox"/> With more than one family in a house or apartment <input type="checkbox"/> Moving from place to place <input type="checkbox"/> In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite <input type="checkbox"/> Other: _____

Special Needs:
Has the ISD,ECI or another agency diagnosed your child with a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, attach a copy of the IFSP or IEP paperwork and explain: _____
Do you suspect your child has some type of disability? Example: difficulty saying words; problems hearing; walking, or learning; slow development of skills? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please describe: _____

What else do we need to know to help you qualify for our program? _____

*Parents/guardians, the completion of this application does not mean that your child is being enrolled in the Head Start Program. You will be contacted by mail or by telephone for the next step in the pre-enrollment process. If information is found to be falsified you may be dropped from the program.

Certification: I certify that all information on this application is true and correct. _____

Parent/Guardian Signature