

FAMILY UNIT INFORMATION

PARENT / LEGAL GUARDIAN

Name: _____ D.O.B: _____
(First) (Middle) (Last)

Relationship to Child: _____ Home Telephone: _____

Address (if different from child): _____

Marital Status: Single Married Divorced Separated Widow Widower

Ethnicity: Hispanic or Latino Non-Hispanic/Non-Latino Primary Language: _____

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Biracial/Multi-racial Other: _____

Parent/Legal Guardian Education (please circle the number of years completed):

Elementary/Secondary: K 1 2 3 4 5 6 7 8 9 10 11 12 GED College: 1 2 3 4 5+ In a job training program? Yes No

Employment Information

Employer Name & Address: _____

Position: _____ Work Hours: _____

Work #: () _____ Ext: _____ Cell #: () _____

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PARENT / LEGAL GUARDIAN'S SPOUSE

Name: _____ D.O.B: _____
(First) (Middle) (Last)

Relationship to Child: _____ Home Telephone: _____

Address (if different from child): _____

Marital Status: Single Married Divorced Separated Widow Widower

Ethnicity: Hispanic or Latino Non-Hispanic/Non-Latino Primary Language: _____

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Biracial/Multi-racial Other: _____

Parent/Legal Guardian Education (please circle the number of years completed):

Elementary/Secondary: K 1 2 3 4 5 6 7 8 9 10 11 12 GED College: 1 2 3 4 5+ In a job training program? Yes No

Employment Information

Employer Name&Address: _____

Position: _____ Work Hours: _____

Work #: () _____ Ext: _____ Cell #: () _____

PLEASE LIST ALL OTHER HOUSEHOLD MEMBERS

NAME (First, Last) RELATIONSHIP DOB

MEDICAL INFORMATION

Child's Dentist: _____ Phone #: _____

Child's Physician: _____ Phone #: _____

Do you have health insurance coverage: Yes No

If yes, Health Insurance Carrier: Husky A Husky B Private Other _____

Policy #: _____

OTHER REMARKS

Please indicate any limitations, restrictions, or concerns you have for your child (i.e., allergies, health problems, diet restrictions, fear of dogs, etc.).

Custody Alert/Special Family Circumstances: _____



Please check off if your family receives any of the following services:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Husky A Health Insurance | <input type="checkbox"/> Domestic Violence Program | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Husky B Health Insurance | <input type="checkbox"/> Care 4 Kids | <input type="checkbox"/> Migratory |
| <input type="checkbox"/> Private Insurance | <input type="checkbox"/> Court custody pending | <input type="checkbox"/> DCF |
| <input type="checkbox"/> WIC | <input type="checkbox"/> Energy Assistance | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Cash Assistance/TANF | <input type="checkbox"/> SNAP (Food Stamps) | <input type="checkbox"/> SSI/SSDI |
| | <input type="checkbox"/> Jobs First | |
| <input type="checkbox"/> Other _____ | | |

Were you referred by a community agency? Yes No Contact person _____

The Vernon Preschool Collaborative includes Head Start spaces for income eligible families. Head Start provides services to families including health screenings and parent support. Are you interested in learning more about Head Start? If you check YES, a Family Advocate will be in contact with you to discuss Head Start services and eligibility for Head Start. Yes No

In the event my child is placed on the wait list, please share my application with other center based early education programs in Vernon. Yes No

Parent/Legal Guardian's Signature _____ Date _____



*** For Office Use Only ***

Empty rectangular box for office use.