Family Member Information

The following information is requested from the child's legal caregiver(s): (ex: parent, guardian, or foster parent)

How did you hear about Head Start? ____

Primary Caregiver:

First Name: ______________________ Last Name:___________________ Birth Date: __________

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Preferred Contact Phone Number (circle one) Home Work Cell

Race: (check all that apply)

□ Black □ White □ Multi-racial/Bi-racial □ Asian □ Native American

□ Pacific Islander □ Other ___________________

Ethnicity:

□ Hispanic □ Non-Hispanic □ Other

Highest Grade Completed: _______ Graduated/GED? Yes No

Are you currently a student? □ Yes □ No

Employment Status: □ Full time □ Part time □ Seasonal □ Unemployed □ Retired

Place of employment (if applicable): _______________________________________

Relationship to child: ____________________________ Custody of child □ yes □ no

Age of parent at first child's birth ____________________________

Primary language of this adult family member: □ English □ Spanish □ Other ______________

Primary Caregiver: □ Lives with family □ Provides Financial Support □ Teen Parent

Email Address: ____

Does your family have health insurance? Yes No If yes, with whom ______________________

Secondary Caregiver:

First Name: ____________________ Last Name:_________________ Birth Date:__________

Home Phone: ______________ Work Phone: _____________ Cell Phone: _____________

Preferred Contact Phone Number (circle one) Home Work Cell

Race: (check all that apply)

□ Black □ White □ Multi-racial/Bi-racial □ Asian □ Native American

□ Pacific Islander □ Other ______________

Ethnicity:

□ Hispanic □ Non-Hispanic □ Other ______________

Highest Grade Completed: _______ Graduated/GED? yes no

Are you currently a student? □ yes □ no

Employment Status: □ Full time □□ Part time □ Seasonal □□ Unemployed □ Retired

Place of employment (if applicable): _____________________________________

Relationship to child: ___________________________ Custody of child □□ yes □□ no

Age of parent at first child's birth ___________________________

Primary language of this adult family member: □□ English□ □ Spanish □ Other ___________

Secondary Caregiver: □□ Lives with family □ Provides Financial Support □ Teen Parent

Email Address: ____

Office Use Only:

Child Information: (Head Start age eligible child)

First Name: ___________________ Last Name: ________________ Nickname: ____________

Birth Date: _______________ Gender: □ Male □ Female

Child lives with: Mother Only Both Parents Guardian Other _____________________

Race: (check all that apply)

□ □ Black □ □ White □□ Multi-racial/Bi-racial □ □ Asian

□ □ Native American □ □ Pacific Islander □ □ Other _____________

Ethnicity:

□ □ Hispanic □ □ Non-Hispanic □ Other ______________

Primary Language:

□ □ English □ □ Spanish □ □ Other ______________________

Insurance Type

□□ Private □ □ Medicaid □□ KidCare □□ Military □ Other ______ ___________□

Medicaid / Insurance ID # ____________________________________

Has your child had a recent physical exam? Yes No If so, Month/Year ______________

Child's Doctor: ________________________________ Phone: ___________________________

Child's Dentist: ________________________________ Phone: __________ _________________

Dental Plan: □ Medicaid □ Private __________ _________ □ Other ______________________

St. Johns County School District does not provide transportation for Head Start Students.

How will this child get to/from school? □ parent □ childcare □ other _________________

Office Use Only:

Other Family Members

In order to determine if your family income is at or below the Federal Poverty Guidelines, we must know how many people are in your family as well as your total family income. For our purposes, a family is "…all persons living in the same household who are (1) supported by the income of the parent(s) or guardian(s) of the child enrolling in the program, and (2) related to the parent(s) or guardian(s) by blood, marriage, or adoption".

Please list all people in the household who are supported by the parent(s) or guardian(s) applying for Head Start.

Name (First, Last)	Birth Date	Gender	Relationship to Child
1.___________________________	_____________	_______	_____________________
2.____________________________	_____________	_______	_____________________
3.____________________________	_____________	_______	_____________________
4.____________________________	_____________	_______	_____________________
5._____________________________	_____________	_______	_____________________
6.____________________________	_____________	_______	_____________________
7.____________________________	_____________	_______	_____________________

Family Information

General Household Information:

Living Address: ______________________________ ____________________ __________
street city zip

Mailing Address: _____________________________ _____________________ _________
street city zip

Home Phone: _____________ Work Phone: _____________ Cell Phone: _______________

Number in Household _____ Number in Family ______ Total number of children _______

Number of children age 0-3 ______ Number of children age 4-5 _____

Child lives with:

_____ Two parents

_____ Single mother

_____ Single mother living with partner

_____ Single father

_____ Single father living with partner

_____ Single parent living with relatives

_____ Guardian – documentation required

_____ Foster family – legal documentation required

_____ Other (specify) ____

Primary Language at Home: ☐ English ☐ Spanish ☐ Other _____________________

Family Information

TANF ☐ yes ☐ no ☐ formerly **SSI** ☐ yes ☐ no

Food Stamps ☐ yes ☐ no **WIC** ☐ yes ☐ no

Episcopal Children's Services ☐ yes ☐ no

Other agencies involved with your child/family: ____

Do you receive Child Support? ☐ yes ☐ no

If yes, amount received: ______________ How often? _______________

Emergency Contacts (other than parent/guardian)

Name:			Relationship to child:
Address:			Home phone number:
City:	State:	Zip:	Cell phone number:
			Work phone number:
☐ ☐ **Emergency Contact**			☐ ☐ **Child may be released to this person**

Name:			Relationship to child:
Address:			Home phone number:
City:	State:	Zip:	Cell phone number:
			Work phone number:
☐ ☐ **Emergency Contact**			☐ ☐ **Child may be released to this person**

Name:			Relationship to child:
Address:			Home phone number:
City:	State:	Zip:	Cell phone number:
			Work phone number:
☐ ☐ **Emergency Contact**			☐ ☐ **Child may be released to this person**

Name:			Relationship to child:
Address:			Home phone number:
City:	State:	Zip:	Cell phone number:
			Work phone number:
☐ ☐ **Emergency Contact**			☐ ☐ **Child may be released to this person**

Priority

The following information will determine your child's eligibility priority. This information is maintained in your child's confidential application file. Please check all that apply.

Diagnosed issues currently affecting your child:

☐ ADHD / ADD
☐ Hearing Impairment
☐ Asthma (requiring medication)
☐ Heart Condition
☐ Visual Impairment
☐ Diabetes
☐ Severe Tooth Decay
☐ Speech / Language Delay
☐ Emotional / Behavioral Disorder
☐ Developmental Delay
☐ Autism
☐ Seizure Disorder (requiring medication)
☐ Other ___________________________________
☐ None

Do you **suspect** any of the above issues to be affecting your child: ☐ Yes ☐ No

Please explain: ____

Do you suspect any **other issues** to be affecting your child: ☐ Yes ☐ No

Please explain: ____

Environmental issues currently affecting your child:

☐ Child Abuse & Neglect
☐ Domestic Violence
☐ Drug or Alcohol Abuse
☐ Divorce (within past 24 months)
☐ Incarceration of a parent
☐ Disabled Parent/Guardian (receiving benefits)
☐ Parent Active Duty Military (out of home)
☐ Teen Parent

☐ Death of immediate family member (within 24 months)

☐ Receiving services through DCF (foster care, protective services, Family Integrity Program, etc.)

☐ Homelessness (includes families living temporarily in shelters, hotels, or vehicles or moving frequently between the homes of relatives and friends)

☐ Other issues (pregnancy, previous homelessness, family health concerns, etc.)

Please explain: ____

Truth Statement

I certify that the information I have provided is true. I also understand that the information provided in this application will be held in strict confidence within the St. Johns County School District and is accessible to me by appointment during normal business hours.

I authorize Head Start to verify my family income and circumstances with my employer or other agency, if necessary. I understand that if I deliberately misrepresent my family income or circumstances, my family may not be eligible for further services.

____ _____________________________

Parent/Guardian Signature Date

Office Use Only / Notes:

School Zone: ____

Head Start Site:

____ Crookshank ____ Osceola ____ South Woods ____ Webster

Date Application Received: ______________ Received by: __________________________