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