People Incorporated of Virginia
Child and Family Development
Enrollment Application

County of Residence:	**Head Start☐ Early Head Start☐ Home Based☐ Daycare☐ Prenatal☐**	**Application Date:**	
Child's Legal Name (First, Middle, Last):		**DOB:**	**Gender:**

Race:	**Ethnicity:**	**Language Spoken in Home:**
Black☐ White☐ Hispanic☐ American Indian☐ Asian☐ Pacific Islander☐ Multi☐	Hispanic/Latino☐ Non Hispanic/Latino☐	English☐ Spanish☐ Other☐ **Interpreter Needed:** Yes☐ No☐

Physical Address:	**City:**	**State:**	**Zip Code:**
Mailing Address:	**City:**	**State:**	**Zip Code:**

Pick up:	**Drop Off:**

Please list Previous Childcare Centers Attended:

Previously Applied for Program:	**Previously Enrolled in Program:**	**Sibling in EHS/HS:**

How did you hear about program?

Family Information

Child Lives With:_____ One Parent☐ Two Parents☐ Legal Guardian☐ Foster☐ Other☐	**Family in Military:**	**U.S. Veteran:**	**Family is Homeless:**

Mother's Name:	**DOB:**	**Marital Status:**	**Gender:**
Education Level:	**Occupation:**		

Mother's Telephone Numbers:

Home:_____ Cell:_____ Work:_____

Father's Name:	**DOB:**	**Marital Status:**	**Gender:**
Education Level:	**Occupation:**		

Father's Telephone Numbers:

Home:_____ Cell:_____ Work:_____

Guardian's Name:	**DOB:**	**Marital Status:**	**Gender:**
Education Level:	**Occupation:**		

Guardian's Telephone Numbers:

Home:_____ Cell:_____ Work:_____

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Other Members in Household Supported by Head of Household			
Name:	**DOB:**	**Gender:**	**Relationship to Child:**

Emergency Contact Information			
Name	**Complete 911 Address**	**Telephone #**	**Relationship to Child**

Medical Information		
Disability Status: Diagnosed☐ Suspected/Concern☐ None☐		**Documentation Provided:** IEP☐ IFSP☐ Evaluation/Doctor's Note☐
Area of Concern: Vision☐ Developmental☐ Hearing☐ Speech☐ Other_____		
Medical Concerns:	**Medical Diagnosis:**	**Prescribed Medication:**
Diagnosed Asthma:_____	**Nutrition Concerns:_____**	**Special Diet:_____**
Diagnosed Allergies:_____		
Steps to Take if Allergic Reaction or Contact with Allergen Occurs:		
Medical Doctor Name:	**Dentist Name:**	
Insurance Name & Number:	**Dental Insurance Name & Number:**	

Please Read Prior to Signing

I certify that all of the above information is true and correct and that all income is reported and the client resides in the specified county. I understand that this information is being given to determine eligibility for a Federal Program and will be verified for accuracy. I understand that deliberate misrepresentation of this information may subject me to corrective actions under applicable state and federal laws.

Parent/Guardian Signature: _____ Date: _____

Email Address: _____