

**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: Black___ White___ Hispanic___ American Indian___ Asian___ Pacific Islander___ Multi___ | | Ethnicity: Hispanic/Latino___ Non Hispanic/Latino___ | |
| Language Spoken in Home: English___ Spanish___ Other___ Interpreter Needed: Yes___ No___ | | | |
| Physical Address: | | City: | State: |
| Mailing Address: | | City: | State: |
| Zip Code: | | Zip Code: | 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: |
| Mother's Name: | | DOB: | Family is Homeless: |
| 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: _____ | | | |

**People Incorporated of Virginia
Child and Family Development
Enrollment Application**

| 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: | | Documentation Provided: | |
| Diagnosed ___ Suspected/Concern ___ None ___ | | 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

| | |
|---|-------------|
| <p>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.</p> | |
| Parent/Guardian Signature: _____ | Date: _____ |
| Email Address: _____ | |