

**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:
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:		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

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: _____