

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

<b>County of Residence:</b>	<b>Head Start</b> ___ <b>Early Head Start</b> ___ <b>Home Based</b> ___ <b>Daycare</b> ___	<b>Application Date:</b>	
<b>Child' Legal Name (First, Middle, Last):</b>		<b>DOB:</b>	<b>Gender:</b>
		<b>Last 4 SSN:</b>	
<b>Race:</b> Black___ White___ Hispanic___ American Indian___ Asian___ Pacific Islander___ Multi___		<b>Ethnicity:</b> Hispanic/Latino___ Non Hispanic/ Latino___	
		<b>Language Spoken in Home:</b> English___ Spanish___ Other___	
		<b>Interpreter Needed:</b> Yes___ No___	
<b>Legal Residence Address:</b>		<b>City:</b>	<b>State:</b>
			<b>Zip Code:</b>
<b>Mailing Address:</b>		<b>City:</b>	<b>State:</b>
			<b>Zip Code:</b>
<b>Pick Up:</b>		<b>Drop Off:</b>	
<b>Please List Previous Childcare Centers Attended:</b>			
<b>Previously Applied for Program:</b>		<b>Previously Enrolled in Program:</b>	<b>Sibling in EHS/HS:</b>
<b>How did you hear about program?</b>			

<b>Medical Information</b>			
<b>Disability Status:</b> Diagnosed___ Suspected/Concern___ None___		<b>Documentation Provided:</b> IEP___ IFSP___ Evaluation/Doctor's Note___	
<b>Area of Concern:</b> Vision___ Developmental___ Hearing___ Speech___ Other___			
<b>Medical Concerns:</b>	<b>Medical Diagnosis:</b>	<b>Prescribed Medication or Medical Equipment</b>	
<b>Nutrition Concerns:</b>		<b>Special Diet:</b>	
<b>Diagnosed Allergies:</b> Steps to Take if Allergic Reaction or Contact with Allergen Occurs:		<b>Diagnosed Asthma:</b>	
<b>Medical Doctor Name:</b>		<b>Dentist Name:</b>	
<b>Insurance Name &amp; Number:</b>		<b>Dental Insurance Name &amp; Number:</b>	

<b>Emergency Contact Information-Required</b>			
<b>Name</b>	<b>911 Address:</b>	<b>Telephone #</b>	<b>Relationship to Child</b>
	<b>City, State, Zip:</b>		
<b>Name</b>	<b>911 Address:</b>	<b>Telephone #</b>	<b>Relationship to Child</b>
	<b>City, State, Zip:</b>		

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**Family Information**

<b>Child Lives With:</b> One Parent__ Two Parents__ Legal Guardian__ Foster__ Other_____		<b>Family in Military:</b>	<b>U.S. Veteran:</b>	<b>Family is Homeless:</b>	
<b>Mother's Name</b>		<b>DOB:</b>	<b>Marital Status:</b>	<b>Gender:</b>	<b>Last 4 SSN:</b>
<b>Highest Grade Completed:</b>	<b>Occupation:</b>	<b>Race:</b>		<b>Language Spoken:</b>	
<b>Mother's Telephone Numbers:</b>					
<b>Home:</b> _____		<b>Cell:</b> _____		<b>Work:</b> _____	
<b>Father's Name</b>		<b>DOB:</b>	<b>Marital Status:</b>	<b>Gender:</b>	<b>Last 4 SSN:</b>
<b>Highest Grade Completed:</b>	<b>Occupation:</b>	<b>Race:</b>		<b>Language Spoken:</b>	
<b>Father's Telephone Numbers:</b>					
<b>Home:</b> _____		<b>Cell:</b> _____		<b>Work:</b> _____	
<b>Guardian's Name</b>		<b>DOB:</b>	<b>Marital Status:</b>	<b>Gender:</b>	<b>Last 4 SSN:</b>
<b>Highest Grade Completed:</b>	<b>Occupation:</b>	<b>Race:</b>		<b>Language Spoken:</b>	
<b>Guardian's Telephone Numbers:</b>					
<b>Home:</b> _____		<b>Cell:</b> _____		<b>Work:</b> _____	

**Other Members in Household Supported by Head of Household**

Name:	DOB:	Gender:	Race:	Relationship to Child:	Last 4 SSN:

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: \_\_\_\_\_ I do not want to be contacted by email

I do not want to be contacted by text message  "People Incorporated nor its staff are responsible for charges incurred"