



ENROLLMENT APPLICATION

Thank You for your interest in Enfield Head Start! Enfield Head Start serves Enfield children ages 3 to 5. There is **NO COST** to attend. Enfield Head Start enrolls a minimum of 90% of the families who are within the Federal Income Guidelines; a maximum of 10% of the families may be over-income.

Enfield Head Start offers:

- Six preschool classrooms of varying hours to accommodate families' schedules
- Breakfast, lunch, morning & afternoon snack
- Health and developmental screenings
- Enfield Board of Education approved preschool curriculum program, *Creative Curriculum*, based upon the Connecticut Early Learning Development Standards
- Opportunities for parent involvement with a variety of family activities.
- Teachers and parents develop individual child goals together
- Resources for families
- **Enfield Head Start also PROVIDES BUS TRANSPORTATION for those in need.**
- **THERE IS NO COST TO ATTEND ENFIELD HEAD START.**

Attached is the ENROLLMENT APPLICATION. Please fill out both sides completely and sign. After completing the application please send it to Enfield Head Start along with the following items:

1. A copy of your child's BIRTH CERTIFICATE
2. A copy of PROOF OF RESIDENCY (examples include a utility bill with your Enfield address shown, a copy of your lease, or a notarized Enfield Public Schools residency form.)
3. A copy of your driver's license or State PHOTO ID
4. Proof of income. (Examples include a copy of 1 paystub per working parent, or TAX forms)
5. A Copy of your child's most current physical INCLUDING immunization and lead test.

If you need further information or have any questions regarding enrollment, please contact Enfield Head Start at one of the numbers below. We look forward to speaking with you soon!

Enfield Head Start Main Office: 860-253-6470

Kelly Bowles, Family Support Manager: 860-253-4717

Maria Burrows, Family Advocate: 860-253-6469

Casey DeHorta, Family Advocate: 860-253-6471

Cindy Eugenio, Family Advocate: 860-253-6596

Enfield Head Start is located at 1270 Enfield St.

FAX- 860-253-6472

ENFIELD HEAD START
1270 Enfield Street, Enfield, CT 06082 860 253 6470
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Date _____
Child's legal name (must match name on birth certificate)
Last _____ First _____ Nickname (if any) _____ Date of Birth ____ / ____ / ____
Mother and/or Father/ Guardian _____
Who does child live with? ____ Mother ____ Father ____ Both ____ Guardian ____ Marital Status: M S D W
Address _____ Phone # () _____
EMAIL ADDRESS _____
How long have you lived in Enfield? _____ Where did you reside prior? _____
Country of Origin _____ Race _____ Sex F / M
Languages spoken in home _____ If foster child, name of state worker _____
Is there a surrogate parent assigned? _____ Name _____

Household Information

Number of persons in the home _____

Adult(s) name	Relationship to child	Date of Birth	Sex	Last year of school	Occupation
_____	_____	____ / ____ / ____	M/F	_____	_____
_____	_____	____ / ____ / ____	M/F	_____	_____
_____	_____	____ / ____ / ____	M/F	_____	_____
_____	_____	____ / ____ / ____	M/F	_____	_____

Children in Home

_____	_____	____ / ____ / ____	M/F	_____	_____
_____	_____	____ / ____ / ____	M/F	_____	_____
_____	_____	____ / ____ / ____	M/F	_____	_____
_____	_____	____ / ____ / ____	M/F	_____	_____
_____	_____	____ / ____ / ____	M/F	_____	_____

Has your child been diagnosed with a disability or received services from Birth to Three? If yes, what was the diagnosis, and when we're services received? _____

Does any person listed above have any health problems? _____ Describe _____

Referred to program? ____ By Whom? _____ Has your child had any pre-school or childcare experience? Yes/No

If yes, where & what year. _____ Have you had any children the Head Start program in the past? Yes/No

If yes, who and what year? _____ Are you receiving any state benefits? If Yes, What benefits are you receiving? _____

Are there any specific family needs or crisis? _____

If yes, please describe. _____

Income: List by family member:

Family Member	Amount received	weekly, monthly, yearly	Source
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Total yearly income by family \$ _____ Verified by (staff member) _____

Type of verification _____

Certification: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency.

Signature of parent or guardian _____ Date _____

Signature of staff member _____ Date _____

March 14, 2018

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Emergency Information

Child's Name _____ Date of Birth _____

Emergency contacts

Parent/Guardian to be contacted in case of emergency

Name _____ Home phone _____ Work phone _____ Cell phone _____

Address _____

We must have at least two other **current** and **local** numbers on file at all times. We must be able to call if we are unable to reach you in an emergency or if your child is sick. (If the child's father will be picking him up from school, please add him to the list)

Name _____
Address _____
Home phone _____
Work _____ phone _____
Cell phone _____
Relationship to child _____

Name _____
Address _____
Home phone _____
Work phone _____
Cell phone _____
Relationship to child _____

Release Child To

I understand that I and/or the below person(s) (children thirteen years of age or older) **MUST** meet my child at the bus stop. The child **WILL NOT** be allowed off the bus if I am not there to meet him/her. All unsupervised children will be returned to Head Start. (Please notify us when changes are made to these names.)

Name _____
Name _____

Name _____
Name _____

*** RESTRICTIONS ***

Please list here the names of any individuals who are not allowed to have contact with your child while he/she is enroute to/from school or at school. We must have legal documentation on file. i.e.: Divorce decree, restraining order, protective order, etc.

Photograph / Videotape/ Data release

I authorize Head Start to photograph and videotape my child, this may also include press photos.

Yes _____ No _____

I authorize Head Start to document information on the State Data system (ECIS-ECE)

Yes _____ No _____

Medical Information

Name, address and phone number of doctor _____

Name, address and phone number of dentist _____

Insurance _____ Medical ID number _____

Are immunizations up to date? Yes _____ No _____

Any medications taken regularly, or often? Yes _____ No _____ If yes please list. _____

Conditions to be noted in an emergency

Severe Asthma _____ Diabetes _____ Seizures/ Convulsions _____ Insect Allergies _____ Medication Allergies _____
Food Allergies _____ Other _____

Does child have any disabilities? Yes _____ No _____ If yes, please describe. _____

(Including speech, OT, PT needs)

Diagnosed by _____ Name and Date of diagnosis _____

I understand that I will be notified as soon as possible in the event of an emergency. I give my permission for emergency treatment to be administered. I give permission, in the event of a serious illness or accident, for my child to be transported to the nearest medical facility.

Signature of Parent/Guardian _____ Date _____