

Aleutian Pribilof Islands Association, Inc. Head Start Program

Enrollment Application

Child Name (Last, First)		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Parent/Legal Guardian Name (Last, First)		Secondary Parent/Legal Guardian Name (Last, First)	
Site <input type="checkbox"/> King Cove <input type="checkbox"/> Saint Paul <input type="checkbox"/> Sand Point AM <input type="checkbox"/> Sand Point PM <input type="checkbox"/> Unalaska			
Mailing Address		Physical Address	
City, State, Zip Code		City, State, Zip Code	
How would you like to receive information from the Anchorage Office? <input type="checkbox"/> Mail <input type="checkbox"/> E-mail <input type="checkbox"/> Both (mail and e-mail)			
Primary Phone <input type="checkbox"/> Home <input type="checkbox"/> Work		Secondary Phone <input type="checkbox"/> Home <input type="checkbox"/> Work	
		E-mail Address	
Race <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Other (Please list):		Language Primary _____ Secondary _____ Nationality: <input type="checkbox"/> United States Citizen <input type="checkbox"/> Other: _____	
Has your child ever been referred for any service? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:			
Does your child have a Disability/Special Need? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected or Maybe <input type="checkbox"/> Existing IEP			
Does your family have any specific family need? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:			
Do you have any existing plans with other agencies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:			
Does your child wear diapers or pull ups? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does your child need help using the toilet? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Child's Name: _____

Date of Birth: _____

Family Member Information

Parental Status <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Foster <input type="checkbox"/> Non-parent <input type="checkbox"/> Other		Total # in Family	Total # in Household
# of Children Ages 0-3 yrs.	# of Children Ages 4-5 yrs.	# of Children Ages 6-17 yrs.	Total # of Children

Adult # 1 (18 years or older)

Name (Last, First)	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Highest Grade Completed <input type="checkbox"/> High School Graduate or <input type="checkbox"/> Other:
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Employment Status

Full Time Part Time Seasonal Unemployed Retired School

Adult # 2 (18 years or older)

Name (Last, First)	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Highest Grade Completed <input type="checkbox"/> High School Graduate or <input type="checkbox"/> Other:
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Employment Status

Full Time Part Time Seasonal Unemployed Retired School

Adult # 3 (18 years or older)

Name (Last, First)	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Highest Grade Completed <input type="checkbox"/> High School Graduate or <input type="checkbox"/> Other:
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Employment Status

Full Time Part Time Seasonal Unemployed Retired School

Other Family Member Information

Other Children in Home Name (Last, First) Do not list Head Start applicant	Gender	Date of Birth	Related to Adult
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3

Child's Name: _____

Date of Birth: _____

Transportation Information

Pick up Address

Drop Off Address

Child Release Information: (DO NOT list Parents/Legal Guardians)

Name (Last, First)

Relationship to child

Name (Last, First)

Relationship to child

Emergency Contacts: (DO NOT list Parents/Legal Guardians)

Name (Last, First)

Address

Phone #

Eligibility Information

ATAP (TANF) Yes No

SSI Yes No

WIC Yes No

Medicaid Or Denali Kid Care Yes No

Other Insurance Yes No
Insurance # Type

Income (List all family members that receive income) Monthly x 12; Biweekly X 26; Weekly x 52; or seasonal total

Family Member Name

Amount

Weekly/Monthly/Yearly

Employer or Income Source

Total Yearly Income of Family

Pay Stub Employer Statement ATAP SSI Unemployment W2 or Tax Form

Certification

I certify that the above information is true to the best of my knowledge. If any part is proven false, your child's status may be changed.

I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Legal Guardian Signature

Date

Staff Verification Signature

Date

Child Health History and Health/Nutritional Assessment

Child Name (Last, First)

Date of Birth

These answers will help us understand your child's needs and provide information for menu planning. If you have any additional concerns please use the back of this form.

Were there any complications during pregnancy or newborn period?

Birth Weight:

Has child ever been hospitalized?

Reason:

Is child on any long-term medication?

If so, what kind?

Is child being treated by a physician, PA, or RN?

Who?

Condition?

Does child have frequent:

sore throat cough vomiting urinary tract infections diarrhea constipation

Please describe:

Has the child ever had (check all that apply):

Asthma Epilepsy Hepatitis B Eczema/dry skin RSV Anemia
 Rheumatic fever TB Diabetes Hepatitis A Impetigo Meningitis
 Scarlet fever Sickle cell anemia Seizures Food allergies Cavities/dental problems Any other allergies

Please describe:

Has your child ever had chicken pox?

Date:

If yes, please sign:

Does child have difficulty seeing or hearing?

Please describe:

Does child wear glasses or use hearing aides?

Please describe:

Does your child use any assistive devices?

Please describe:

Has your child ever received fluoride treatment?

When?

Is tobacco used in the home?

What kind?

Food Allergies and Food Related Problems

A child who is unable to eat or drink food required by the meal pattern may be served substitute foods. A substitution may be made only with the form "Medical Statement for Food Substitutions" signed by a doctor or village health aide. The statement should include recommended alternate foods. Please get your statement to the Head Start Center as soon as possible.

Is there any food your child should not eat for

medical religious personal reasons

Please describe:

Is your child under a medically prescribed diet?

Please provide diet:

Does your child have any food or non-food allergies?

Please list:

Has your child tried peanut butter? Yes No

Can your child drink milk? Yes No

Does your child take vitamins and mineral supplements? Was it prescribed?

With iron?

Name brand:

Does your child eat or chew things that are not food? (dirt, etc.) Describe:

How many times a day does your child like to eat?

How much?

Does your family use food from hunting, gardening, gathering, or fishing?

What foods does your child like?

What foods does your child dislike?

Do you have family style meals? (Where everyone sits together)

Any other information that you would like to share?

