



# DIVISION OF EARLY CHILDHOOD EDUCATION

## Section 1 : CHILD APPLICATION FORM

VERIFICATIONS RECEIVED:  Income  
 Birth Certificate  Social Security Card  CDIB  
 Current Health forms:  Physical  Dental  
 Immunizations Form 121  PPD  Nutrition Assessment

**\*\*Priority given to children with disabilities**

Parents, "to protect and promote the health and safety" of your child, please supply a **complete** response to every item on this form. This information is **required** by the Mississippi State Department of Health, Child Care Licensure Branch. If the item is not applicable, then please answer "N/A".

**Center Applying for:** \_\_\_\_\_ **Program:**  Child Care  Early Head Start  Head Start

**Child's Name:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_ **SSN:** \_\_\_-\_\_\_-\_\_\_ **GENDER:**  Boy  Girl

**Race/ethnicity: (Check all that apply if multi-racial)**  Choctaw  Black  White  Hispanic  Other: \_\_\_\_\_

**Home Language:**  English  Choctaw  Other \_\_\_\_\_

**Is Child enrolled in Early Intervention Program and has an IEP?**  Yes  No

**Special Needs information: Has your child been diagnosed with or tested for the following:**  Visual Impairment/Blindness  Developmental Delay  Hearing Impairment/Deafness  Orthopedic Impairment  Special Diet  Emotional Disorder  Learning Disability  Health Impairment  Autism  Traumatic Brain Injury  Speech/Language Impairment  Other \_\_\_\_\_

**List any special needs of the above child:** \_\_\_\_\_

**Has child previously been enrolled in :**  Child Care or Day Care  Early Head Start  Head Start  Other Where: \_\_\_\_\_

**Home Mailing Address:** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Home Physical Address (If Different from Mailing)** \_\_\_\_\_

**Hours of Care Needed** \_\_\_\_\_ **Days Needed: (Check all needed)**  Monday  Tuesday  Wednesday  Thursday  Friday

**Meals Needed: (Check As many as needed)**  Breakfast  AM Snack  Lunch  PM Snack  Supper

**\*\*\*Each question must be completed\*\*\***

**Mother/Guardian** \_\_\_\_\_ **Father/Guardian:** \_\_\_\_\_

**Date of Birth** \_\_\_/\_\_\_/\_\_\_ **Social Security #** \_\_\_-\_\_\_-\_\_\_ **Date of Birth** \_\_\_/\_\_\_/\_\_\_ **Social Security #** \_\_\_-\_\_\_-\_\_\_

**Relationship to child:**  Biological Parent  Other \_\_\_\_\_ **Relationship to child:**  Biological Parent  Other \_\_\_\_\_

**Person currently pregnant?**  Yes  No

**Race/ethnicity: (Check all that apply if multi-racial)**  Choctaw  Black  White  Hispanic  Other: \_\_\_\_\_ **Race/ethnicity: (Check all that apply if multi-racial)**  Choctaw  Black  White  Hispanic  Other: \_\_\_\_\_

**Place of Employment:** \_\_\_\_\_ **Place of Employment:** \_\_\_\_\_

**Work Address:** \_\_\_\_\_ **Work Address:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Cell Phone/Pager:** \_\_\_\_\_ **Cell Phone/ Pager:** \_\_\_\_\_

**Language** \_\_\_\_\_ **Language** \_\_\_\_\_

**Last Grade Completed** \_\_\_\_\_ **Year** \_\_\_\_\_ **Last Grade Completed** \_\_\_\_\_ **Year** \_\_\_\_\_

**Occupational Status:**  Working full time  Working part time  Working and going to school  School full time  Unemployed **Occupational Status:**  Working full time  Working part time  Working and going to school  School full time  Unemployed

**Head of Household**  Yes  No **Head of Household**  Yes  No

**Number of Adults in Household:** \_\_\_\_\_ **Number of Children in Household :** \_\_\_\_\_

Please fill out the following table for all **other** family members and persons living in this household:

Name	Date of Birth	Highest Grade or GED	Does this person have a job? Go to school? Stay at home?

# EMERGENCY CONTACT LISTING

I authorize the DOECE staff to contact and/or release my child to the following adults when:

1. I am unable to pick him/her up at the agreed upon, specified time.
2. I cannot be reached at the phone number or location I have specified, on any given day.
3. I am on travel, out of town, and cannot be reached immediately.
4. I cannot be contacted and my child develops a fever, communicable disease or condition.
5. A life threatening emergency situation occurs and I cannot be contacted immediately.
6. A natural disaster occurs which prevents me from accessing my child.
7. Emergency medical treatment is necessary to prevent death or permanent injury to my child.

<b>Name of Adult</b>	_____	_____	_____	_____
<b>Address</b>	_____	_____	_____	_____
<b>Relationship to the child</b>	_____	_____	_____	_____
<b>Home phone number</b>	( ) _____ - _____	( ) _____ - _____	( ) _____ - _____	( ) _____ - _____
<b>Work phone number</b>	( ) _____ - _____	( ) _____ - _____	( ) _____ - _____	( ) _____ - _____
<b>Message number or Cell number</b>	( ) _____ - _____	( ) _____ - _____	( ) _____ - _____	( ) _____ - _____

**AUTHORIZED ADULTS TO BE CONTACTED** \*Adult refers to individuals who are 18 years of age or older.

(Please list adults with day time phone numbers and phone numbers that can be reached after 4:30 p.m.)

The following people are authorized to pick up and drop off my child/children (Must be 18 years or older):

Name	Phone Number	Name	Phone Number

**Complete each of the following sections :**

My child may **be photographed** or video taped at the child care center \_\_\_ Yes \_\_\_ No  
 My child may take approved **field trips** sponsored by the Early Childhood Center \_\_\_ Yes \_\_\_ No  
 The child care center may give my child **emergency medical treatment** if needed: \_\_\_ Yes \_\_\_ No

My child is **toilet trained**  Yes  No. If no, a consultation between the parent and caregiver is required to be documented prior to toilet training.  
 Date of consultation: \_\_\_\_/\_\_\_\_/\_\_\_\_.

My child will **eat breakfast** at the center  Yes  No. If no, my child will eat BEFORE coming into the center.

**Read and initial the appropriate answer to the following items:**

I have been given a copy and have read a copy of the **MSDH Regulation Summary for Parents**: \_\_\_ Yes \_\_\_ No  
 A **121 Immunization compliance Form** is on file in the facility before the child attends : \_\_\_ Yes \_\_\_ No  
 I have been informed that **DOECE does/does not** provide **liability insurance** for my child: \_\_\_ Yes \_\_\_ No

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Childcare Director Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Record updated & signed by parent (as necessary):

Signature: _____	Date: _____	Child Care Initials: _____
Signature: _____	Date: _____	Child Care Initials: _____
Signature: _____	Date: _____	Child Care Initials: _____

**OFFICE USE ONLY:** Acceptance Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Enrollment date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Withdrawal: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Income Verification Received**

<input type="checkbox"/> 1040 Tax Statement	<input type="checkbox"/> Income Declaration	<input type="checkbox"/> Unemployment	<b>Status</b> Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No verified by: _____
<input type="checkbox"/> W2 Statement	<input type="checkbox"/> IC Supplement	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Pay Stubs	<input type="checkbox"/> Public Assistance Form (SSI or TANF only)		

**SECTION 2 : FAMILY COMPOSITION AND RESOURCES**

<b>Family Type (Please Check one)</b>	<input type="checkbox"/> Two parent family <input type="checkbox"/> Single parent family (mother figure only) <input type="checkbox"/> Single parent family (father figure only) <input type="checkbox"/> Single parent family (mother figure only) living with partner <input type="checkbox"/> Single parent family (father figure only) living with partner <input type="checkbox"/> Other relative(s) <input type="checkbox"/> Foster family <input type="checkbox"/> Other family type
<b>Family's Income source (Please check all that apply)</b>	<input type="checkbox"/> Non-Agricultural Earned income (i.e. wages, tips) <input type="checkbox"/> Agricultural Earned Income (i.e. wages, tips) <input type="checkbox"/> Public Assistance, Welfare (i.e. TANF, AFDC) <input type="checkbox"/> Social Security / Pension <input type="checkbox"/> supplemental Security Insurance (SSI) <input type="checkbox"/> Foster Care / Adoption Subsidy <input type="checkbox"/> Unemployment Insurance <input type="checkbox"/> Child Support / Alimony <input type="checkbox"/> Other: Specify _____
<b>Family applied to receive supplemental security income (SSI)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Length of time at current address:</b>	<input type="checkbox"/> Less than 6 months <input type="checkbox"/> 6 – 12 months <input type="checkbox"/> 1 – 2 years <input type="checkbox"/> More than 2 years
<b>Number of times family moved in the past 12 months.</b>	<input type="checkbox"/> Family has not moved <input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times
<b>Has family been homeless in Past 12 months (including currently homeless)</b>	<input type="checkbox"/> Yes (Length of time homeless _____ ) <input type="checkbox"/> No
<b>Is Family or Child is signed up for (Check for yes)</b>	<input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP

**SECTION 3 : DISPENSING OF GENERIC MEDICATION**

The following medical treatment may be given to my child while attending a DOECE program. I understand that I have the right to review all medical records maintained on my family, dispute and correct any information I feel to be incorrect, and to be contacted when the following medications will be administered. I understand that I must provide written authorization to the staff to dispense prescription medications to my child. The Division of Early Childhood Education will not be liable for medications which have been opened prior to being dispensed at the center.

CONDITION	TREATMENT	DIVISION POLICY
Illness requiring a prescription drug.	Medication will be dispensed by staff, according to directions on the label.	Parent signature required.
Minor cuts or Abrasions.	Area will be cleansed and an antibiotic ointment applied.	Accident report will be provided to the parent or guardian.
Insect bite or stings.	Calamine lotion will be applied and basic first aid provided.	Parent will be contacted. Emergency procedures will be initiated for severe allergic reactions.
Diaper rash	Area cleansed and Vitamin A&D ointment applied.	Incident report will be given to the parent or guardian.
Dental Care	Emergency care will be initiated by the staff. Routine dental care will be coordinated between staff and parents.	Parents will be contacted in emergency situations. Appointments for routine care are the responsibility of the parents.

I understand that I have the right to review records maintained on my family and to dispute or correct any information I feel to be incorrect. In understand that any information provided will be strictly confidential.

\_\_\_\_\_  
Signature of Parent/Guardian Date

I do hereby give the Program permission to seek emergency medical attention, including transportation to the nearest hospital, as deemed necessary. In understand that I will be contacted as soon as possible and a written accident form will be given to me.

\_\_\_\_\_  
Signature of Parent/Guardian Date

**SECTION 4 : CONSENTS, AUTHORIZATIONS, AND RELEASES**

<p style="text-align: center;">Consents for Initial Screenings</p> <p style="text-align: center;">Vision _____</p> <p style="text-align: center;">Hearing _____</p> <p style="text-align: center;">Height and Weight _____</p> <p style="text-align: center;">Dental _____</p> <p style="text-align: center;">Speech _____</p> <p style="text-align: center;">Developmental Screening _____</p>	<p>Please initial on the lines if you give DOECE permission for the screenings:</p>
---	---

**PERMISSION FOR CHOCTAW LANGUAGE PROGRAM**

The Choctaw Language Program will have Language Aides working in the classrooms to help teach and promote our Choctaw Language.

- YES, I want my child to participate in Choctaw Language Program activities**
- NO, I do not want my child to participate in Choctaw Language Program activities**

**PERMISSION FOR OTHER FAMILY MEMBERS**

Only the custodial parent/legal guardian listed on the enrollment form is allowed to sign permission slips and other forms for this child. If the unmarried parents listed wishes for another family member to be allowed to sign permission slips, referrals, and other forms, please fill out the following section.

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, do hereby give permission to \_\_\_\_\_ to sign permission slips, referrals, and other forms as necessary.

\_\_\_\_\_  
Signature of Parent/Guardian Date

**SECTION 5 : DEVELOPMENTAL HEALTH HISTORY**

<b>BEHAVIOR/MENTAL HEALTH</b>		<i>Mark all that apply</i>
How does your child act with adults he/she doesn't know?	<input type="checkbox"/> shy <input type="checkbox"/> scared <input type="checkbox"/> no reaction <input type="checkbox"/> other _____	
Does your child worry a lot, or is he/she very afraid of anything?	<input type="checkbox"/> No <input type="checkbox"/> Yes explain _____	
Have there been any big changes in your child's life in the last six months?	<input type="checkbox"/> No <input type="checkbox"/> Yes explain _____	
Are you or your family having any problems now that might affect your child?	<input type="checkbox"/> No <input type="checkbox"/> Yes explain _____	
Does your child display any excessive behavior problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes explain _____	
What method of discipline do you use at home?	<input type="checkbox"/> time out <input type="checkbox"/> spanking <input type="checkbox"/> talking to <input type="checkbox"/> none <input type="checkbox"/> other _____	

**DEVELOPMENTAL HISTORY**

Please indicate by placing a checkmark as to whether your child has met the following developmental tasks based on the age ranges provided: *(please remember that all children are different and accomplish tasks at varying ages)*

	Not Yet	Earlier	When Expected	Later	Age Range
Sit up without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6-9 Months
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6-9 Months
Play with toys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6-9 Months
Feed Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9-12 months
Hold bottle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9-12 months
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12-18 months
Talk (2 word sentences)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18-24 months
Respond to directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18-24 months
Use crayons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18-24 months
Understand names of familiar objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18-24 months
Dress self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2-2 ½ years
Learn to use the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2-3 years

**NUTRITION INFORMATION**

Is your child currently on WIC?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, would you like more information?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**HEALTH PROBLEMS**

How frequently does your child have:

	Never	Seldom	Often		Never	Seldom	Often
Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toothaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Has your child ever had: *(Mark if yes)*

- |  |  |
|--|--|
| Asthma <input type="checkbox"/> Yes              | Bleeding Tendencies <input type="checkbox"/> Yes |
| Diabetes <input type="checkbox"/> Yes            | Epilepsy <input type="checkbox"/> Yes            |
| Rheumatic Fever <input type="checkbox"/> Yes     | Physical Impairment <input type="checkbox"/> Yes |
| Sickle Cell Disease <input type="checkbox"/> Yes | Hives <input type="checkbox"/> Yes               |
| Polio <input type="checkbox"/> Yes               | Chickenpox <input type="checkbox"/> Yes          |
| German Measles <input type="checkbox"/> Yes      | Measles <input type="checkbox"/> Yes             |
| Mumps <input type="checkbox"/> Yes               | Scarlet Fever <input type="checkbox"/> Yes       |
| Whooping Cough <input type="checkbox"/> Yes      |  |

Name and phone number of your primary care physician:

Phone Number \_\_\_\_\_

**ALLERGY PROBLEMS** *(Mark if yes)*

Does your child have any allergy problems with the following?

- Eating Foods or Drinking Liquids (milk)*     Yes
- Animals, Furs, Insects*     Yes
- Latex*     Yes
- Taking Medication*     Yes

Explain and identify any reactions if yes to any of the above:

---



---

**OTHER INFORMATION**

Is there anything else concerning your child's health that you would like us to know?

**SECTION 6 : CHILD PRENATAL AND BIRTH HISTORY**

**PRENATAL HISTORY**

- Time mother first received prenatal care:**  First 3 months of pregnancy  Middle 3 months of pregnancy  
 Last 3 months of pregnancy  No prenatal care received  
 Don't remember/Don't know

- Complications mother experienced during pregnancy (check all that apply)**
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Don't know           | <input type="checkbox"/> Stress             | <input type="checkbox"/> Diabetes (insulin dependent)    |
| <input type="checkbox"/> Abdominal pain       | <input type="checkbox"/> Swelling           | <input type="checkbox"/> Pregnancy-induced hypertension  |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Chronic Fatigue    | <input type="checkbox"/> Low Birth Weight                |
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Pre-term labor     | <input type="checkbox"/> Vaginal Bleeding (after 12 wks) |
| <input type="checkbox"/> Uterine irritability | <input type="checkbox"/> C-Section          | <input type="checkbox"/> Anemia (Hgb<10 or Hct <30)      |
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Other _____                     |

- Prenatal Exposure to Drugs:**
- |   |   |
|---|---|
| <input type="checkbox"/> Don't know                   | <input type="checkbox"/> Prescription Drugs _____ |
| <input type="checkbox"/> Caffeine _____               | <input type="checkbox"/> Alcohol _____            |
| <input type="checkbox"/> Cigarettes/Tobacco _____     | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Non prescription drugs _____ |   |

**BIRTH HISTORY**

- Delivery Location**  Hospital/Clinic  Birthing Center  At Home  
 Don't Know  Other \_\_\_\_\_

- Type of delivery**  Vaginal  C-Section  Don't know

- Length of infant hospital stay**  Routine Stay (1 or 2 days)  One week to one month  
 Non-routine (less than 1 week)  Over 1 month  Don't know

**Reason for non-routine hospital stay:** \_\_\_\_\_

**Observable birth defects:** \_\_\_\_\_

**Comments if unable to complete Sections 6 (e.g. child is under Social Service program, or guardianship, etc.)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION 7: BUS RULES (HEAD START ONLY)**

**Skip to next section if applying for Early Head Start or Child Care**

1. Head Start children will be returned to the place they were picked up. If there is to be a change in pick-up or deliver, WRITTEN NOTICE must be given to the driver in advance or notification must be given to the center by 1:30 p.m. There are no transportation services after 2:00 p.m.
2. Parents should notify the center when their child will not be attending class or riding the bus.
3. Should a child not ride the bus for 3 consecutive days, the parent will need to contact the Center Director in order to make transportation arrangements.
4. Parents should notify Head Start a week in advance when changing residences.
5. Children should be dressed and ready when the bus arrives.
6. The bus will beep twice and then will continue on route. If the child misses the bus, it is the parent's responsibility to take the child to school.
7. When a child is delivered home, the parent or an adult should let the driver know there is someone to receive the child.
8. If no one is home, the child will be returned to the center, and it will be the parent's responsibility to see that his or her child is picked up.
9. If a child has to cross the street to get on or off the bus, he or she must be accompanied by an adult (parent or monitor). The child must cross in front of the bus.
10. Only Head Start children and volunteers will ride the bus to and from the center.
11. There is no food, drink, or smoking allowed on the bus. (exception will be on fieldtrip for food and drink)
12. Toys should not be sent with the child.
13. There will be two adults on the bus at all times.
14. All bus passengers must wear seat belts.
15. The bus monitor may determine if a child is ill at the time he or she boards the bus. A sick child will be returned to the parent(s).
16. Parents who transport their child to Head Start must accompany the child into the building.
17. There is a daily sign in/out sheet that must be signed by those that drop-off/pick up their child at the center.
18. For safety's sake, buses will only be allowed to stop at designated drop-offs.
19. At no time will a child be left on the bus/van unattended by an adult.
20. Head Start buses are not permitted to turn or pull into driveways per the Federal Regulation Code 1310.20 (b)(3).
21. The Head Start buses begin services at 7:00 p.m. (morning route) and 2:00 p.m. (afternoon route)

**WILL YOUR CHILD RIDE THE BUS EVERY DAY? (PLEASE CHECK ONE)**

**Yes, my child will ride the bus every day.**  
 Where will your child be picked up each day? \_\_\_\_\_  
 Where will your child be dropped off each day? \_\_\_\_\_

**No, my child will only ride the bus for field trips.**

\_\_\_\_\_  
 Signature parent/guardian Date

**SECTION 8 : PARENT VOLUNTEER INTEREST QUESTIONNAIRE**

Please select the activities you would be willing to assist with in our program. Some of these activities require a health card and/or criminal background check. These activities are noted by an \*.

I will be willing to donate my time and efforts to the following activities:

- |  |  |   |   |
|--|--|---|---|
| Classroom Substitute* <input type="checkbox"/> | Substitute Cook* <input type="checkbox"/>  | Office Aide <input type="checkbox"/>          | Parent Committee Officer <input type="checkbox"/> |
| Craft Displays <input type="checkbox"/>        | Disabilities Aide <input type="checkbox"/> | Janitor Assistant <input type="checkbox"/>    | Policy Council Officer <input type="checkbox"/>   |
| Center Repairs <input type="checkbox"/>        | Training Sessions <input type="checkbox"/> | Special Art Projects <input type="checkbox"/> | Field Trips* <input type="checkbox"/>             |
| Storytelling* <input type="checkbox"/>         |  |   |   |

**HOLIDAY/CELEBRATION VOLUNTEERS**

- |   |  |                                     |
|---|--|-------------------------------------|
| National Indian Day* <input type="checkbox"/> | Thanksgiving* <input type="checkbox"/>         | Easter* <input type="checkbox"/>    |
| Christmas* <input type="checkbox"/>           | Chata Ayopachi Nitak* <input type="checkbox"/> | Halloween* <input type="checkbox"/> |
| Valentine's Day* <input type="checkbox"/>     | Year End Celebration* <input type="checkbox"/> |                                     |

What are some special skills or talents that you would like to share with us?

What are some traditional skills you would like to share with us?

*\*Note: Anyone who volunteers on a regular basis must have a TB skin test and criminal background check on file at the center. Thank you.*

**SECTION 9: FAMILY CIRCUMSTANCES SURVEY**

**Ade  
quat  
e** **Inad  
equ  
ate** **Urg  
ent  
Nee  
d**

**CATEGORY**

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
| <b>Education:</b> (Example: Adult Ed, Basic Life Skills, Scholarship Program, Communication/Literacy Skills, Etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Child Care:</b> (Example: Head Start, Early Head Start, Day Care, other child care, etc.)                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Clothing Banks</b>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Early Intervention Services</b>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Employment</b> (Example: Employment/Training Program, Income, Income Support, Etc.)                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Family/Community Health</b> (Example: Women's Wellness, Diabetic Clinic, Nutrition, Etc.)                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Family Services / Legal Assistance (Adult or Child)</b>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Housing / Utilities</b>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Mental Health</b>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Parent Involvement in Head Start</b>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Parenting / Family Planning</b>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Social Support</b>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Transportation</b> (Example: CHC, H/S Bus for Appointment relating to health, etc.)                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Other: Specify</b> _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>No Needs:</b> Check this box if the listing above does not apply or services are not needed.                    | <input type="checkbox"/> |                          |                          |

**SECTION 10 : CERTIFICATION AND SIGNATURE**

I certify that the information provided in this enrollment application is accurate and truthful to the best of my knowledge.

\_\_\_\_\_  
Signature of Parent/Guardian Date