

# Shining Stars Preschool Application

Check All That Apply:  
 Head Start Application \_\_\_\_\_  
 Early Head Start Application \_\_\_\_\_

Primary Adult Name \_\_\_\_\_ SSN \_\_\_\_\_ Birthday \_\_\_\_\_  
 Applicant 1 Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age as of 07/31/18 \_\_\_\_ Years \_\_\_\_ Months  
 Applicant 2 Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age as of 07/31/18 \_\_\_\_ Years \_\_\_\_ Months

General Information				
Living Address	City	State	Zip	County
Mailing Address (if different)	City	State	Zip	
Phone Number (and Relationship to Applicant)	Home, Work, Cell, etc.	Primary	Opt in for Text Messages	
		<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Number in Household _____	Num. in Family _____ / _____ EHS/HS	Total Num. of Children _____ / _____ EHS/HS	Num. Age P-3 _____	Num. Age 4-5 _____
Parental Status <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parents	Primary Language at Home	Homeless Family <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Receiving SNAP <input type="checkbox"/> Yes <input type="checkbox"/> No	Military Family <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Referred by Child Welfare <input type="checkbox"/> Yes <input type="checkbox"/> No		

Family Information										
TANF	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Formerly	Check all that apply:				<input type="checkbox"/> SSI	<input type="checkbox"/> WIC	<input type="checkbox"/> Public Assistance
Family Member		Income Source	Amount	Per	Annual Amount	Verif.	Notes			
<b>Verification Codes</b> CS--Check Stub   W2--W-2   EL--Employer Letter   TAN--TANF   UNE--Unemployment FCR- Foster Care Reimbursement   Tax-Income Tax Form										
If the wage is received:   Monthly, multiply by 12   Twice a Month, multiply by 24   Bi-Weekly, multiply by 26   Weekly, multiply by 52										

PRE-NATAL INFORMATION FOR CURRENT PREGNANCY	
Mothers Legal Name: Last _____ First _____ Birthday ____/____/____	
Race B W N A P Nationality: _____ Ethnicity: _____	
Primary Language: _____ Secondary Language: _____	
Expected Delivery Date ____/____/____	
When did you first receive prenatal care ____/____/____ When was your last visit ____/____/____	
When was your last dental visit ____/____/____	
Is this pregnancy considered high risk?   Yes   No	
Have you received Mental Health Intervention including substance abuse prevention and treatment?   Yes   No	
Have you received Prenatal Education on fetal development?   Yes   No	
Have you received information on the benefits of breast-feeding?   Yes   No	

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs 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 and is accessible to me during normal business hours.

**IMMEDIATE EMERGENCY:**  
 In case of an immediate emergency, I give my permission to use the nearest Doctor, Dentist, and/or facility available.

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

Verifying Staff Member \_\_\_\_\_

Date \_\_\_\_\_

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Primary Adult							
Last		First		Middle		Preferred	Suffix
Birthday		Gender		SSN		Alternate ID	
Highest Grade Completed		Employment Status <sup>1</sup>		<input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent <input type="checkbox"/> Subsidized		Email Address	
Race (check all that apply)		Ethnicity		English Proficiency		<input type="checkbox"/> Primary	
<input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____				<input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			
		Nationality		Other Language Spoken _____		<input type="checkbox"/> Primary	
				<input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			

Secondary Adult							
Last		First		Middle		Preferred	Suffix
Birthday		Gender		SSN		Alternate ID	
Highest Grade Completed		Employment Status		<input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent <input type="checkbox"/> Subsidized		Email Address	
Race (check all that apply)		Ethnicity		English Proficiency		<input type="checkbox"/> Primary	
<input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____				<input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			
		Nationality		Other Language Spoken _____		<input type="checkbox"/> Primary	
				<input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			

Applicant 1							
Last		First		Middle		Preferred	Suffix
Birthday		Gender		SSN		Alternate ID	
Race (check all that apply)		Ethnicity		English Proficiency		<input type="checkbox"/> Primary	
<input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____				<input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			
		Nationality		Other Language Spoken _____		<input type="checkbox"/> Primary	
				<input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			
Primary Adult Relationship				Secondary Adult Relationship		<input type="checkbox"/> Custody	
		<input type="checkbox"/> Custody					
Medicaid Eligibility Insurance Number		Medicaid Number		Primary Health Coverage		Other Health Coverage	

Applicant 2							
Last		First		Middle		Preferred	Suffix
Birthday		Gender		SSN		Alternate ID	
Race (check all that apply)		Ethnicity		English Proficiency		<input type="checkbox"/> Primary	
<input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____				<input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			
		Nationality		Other Language Spoken _____		<input type="checkbox"/> Primary	
				<input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient			
Primary Adult Relationship				Secondary Adult Relationship		<input type="checkbox"/> Custody	
		<input type="checkbox"/> Custody					
Medicaid Eligibility Insurance Number		Medicaid Number		Primary Health Coverage		Other Health Coverage	

Other Family Members					
Adult/Child	Last	First	Birthday	Gender	SSN

Highest Grade Completed: Grade 9 or less, Grade 10, Grade 11, Grade 12, HS Grad, GED, College or Advanced Training, College Degree/Training Certificate, Associates, Bachelors, Masters

Employment Status Codes: F- Full Time, P- Part Time Training, R- Retired or Disabled, T- Training or School, B- Full Time & Training, I- Part

Time & Training, S- Seasonally Employed, U- Unemployed  
 Nationality Codes: Belize, Bosnia, china, Costa Rica, Cuba, Elsalvador, Guatemala, Honduras, India, Jamaica, Mexico, Nigeria, Philippines, Puerto Rico, United States  
 Ethnicity Codes: American Indian, Asian/Pacific Islander, Black, Cuban, Chinese, Hispanic, Mexican, Puerto Rican, Other, Vietnamese, White

Eligibility Criteria Other: \_\_\_\_\_

Eligibility				
Applicant 1	Number in Family	Participation Year	<input type="checkbox"/> Sibling Elig Next Year	Class Age
Child's Name:				Points
Parental Status				
Age as of 7-31-18				
Disability				
€ Homeless				
€ Foster Child				
€ Education				
€ Referral				
€ Medical or Mental Hardship				
€ High Social Needs				
€ Language Barriers				
€ Returning EHS/HS Family				
€ Re-Unification of Family				
€ Insurance Hardship				
€ State Funded Pre-K				
Eligibility Notes			Total	

Eligibility Criteria Other: \_\_\_\_\_

Eligibility				
Applicant 2	Number in Family	Participation Year	<input type="checkbox"/> Sibling Elig Next Year	Class Age
Child's Name:				Points
Parental Status				
Age as of 7-31-18				
Disability				
€ Homeless				
€ Foster Child				
€ Education				
€ Referral				
€ Medical or Mental Hardship				
€ High Social Needs				
€ Language Barriers				
€ Returning EHS/HS Family				

€	<b>Re-Unification of Family</b>		
€	<b>Insurance Hardship</b>		
€	<b>State Funded Pre-K</b>		
<b>Eligibility Notes</b>			<b>Total</b>

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Place child's photo here

### Emergency Information

Child's Name \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Child's Birth Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

Address \_\_\_\_\_ Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

Email Address \_\_\_\_\_

Work Phone-Mother \_\_\_\_\_ Employed By \_\_\_\_\_ Reg Hrs \_\_\_\_\_

Work Phone-Father \_\_\_\_\_ Employed By \_\_\_\_\_ Reg Hrs \_\_\_\_\_

#### DOCTOR/DENTIST

Doctor Name	Address/Clinic	City	State	Zip	Phone
_____	_____	_____	_____	_____	_____
Dentist Name	Address/Clinic	City	State	Zip	Phone
_____	_____	_____	_____	_____	_____

#### ALLERGIES

List: \_\_\_\_\_

#### OTHER MEDICAL INFORMATION

List: \_\_\_\_\_

I give Head Start 0-5 permission to post my child's allergy and picture in the classroom.  Yes  No

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

#### DO NOT RELEASE TO

**\*\*COPY OF LEGAL DOCUMENTATION OF CUSTODY OR COURT ORDER\*\***

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Transportation Notes: \_\_\_\_\_

If someone other than who is on the list above is to pick-up your child or is to get them off the bus a signed note by the parent/guardian is required. If they are not on the list or there is no note the child **will not** be released to that person. Picture identification is required for adults that staff are unfamiliar with. This is to be filled out at the time of application. Keep a copy on the bus, in an emergency binder to be taken to the classroom, and a copy in the child's file pocket two. **UPDATE MONTHLY.** Staff making the changes, be sure to change all three copies.

Contact 1	Name	Relationship to Child	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child To
	Phone 1                      Type	Phone 2                      Type	Address                      City                      State                      Zip
Contact 2	Name	Relationship to Child	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child To
	Phone 1                      Type	Phone 2                      Type	Address                      City                      State                      Zip
Co nta	Name	Relationship to Child	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child To

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

	Phone 1	Type	Phone 2	Type	Address	City	State	Zip
Contact 4	Name		Relationship to Child		<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child To			
	Phone 1	Type	Phone 2	Type	Address	City	State	Zip
Contact 5	Name		Relationship to Child		<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child To			
	Phone 1	Type	Phone 2	Type	Address	City	State	Zip
Contact 6	Name		Relationship to Child		<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child To			
	Phone 1	Type	Phone 2	Type	Address	City	State	Zip
Contact 7	Name		Relationship to Child		<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child To			
	Phone 1	Type	Phone 2	Type	Address	City	State	Zip
Contact 8	Name		Relationship to Child		<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child To			
	Phone 1	Type	Phone 2	Type	Address	City	State	Zip

**EMERGENCY CONTACTS**

**CHILD'S NAME** \_\_\_\_\_

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To remain in Child's File throughout the year.

Upload to ChildPlus: Enrollment at the end of the program year.

Contact 9	Name		Relationship to Child		<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child To			
	Phone 1	Type	Phone 2	Type	Address	City	State	Zip
Contact 10	Name		Relationship to Child		<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Release Child To			
	Phone 1	Type	Phone 2	Type	Address	City	State	Zip