WCCA Early Head Start/EHS-CCP/Head Start
Enrollment Application

Phone: 828-693-1711 Fax: 828-697-4277

Child's Name:____ **Name child is to be called**:________________
First Middle Last

Date of Birth:_______________________ Primary Language of the child**:** ____________________________________
Gender: ☐ Male ☐ Female
Race: ☐ American Indian ☐ Asian ☐ Biracial ☐ Black/African American ☐ Hispanic ☐ White ☐ Hawaiian or Pacific Islander

Email:_______________________________________ Phone Number (s):__________________________________

Can we text you? ☐ Yes ☐ No Can we email you? ☐ Yes ☐ No **Data/Message rates may apply**

Mailing Address:____

Living Address (if different):____

Primary Supporting Adult(s):____ **Date of Birth**:__________________

Relationship to Child:____
Employed? ☐ Yes ☐ No If yes, ☐ Full Time ☐ Part Time
Employer:____ Work Phone:______________________
Parent in school? ☐ Yes ☐ No If yes, ☐ Full Time ☐ Part Time Where?____________________________________
Highest education level: ☐ Less than high school graduate ☐ High school graduate or GED
☐ Some college, vocational school, or Associates Degree ☐ Bachelor's or Advanced Degree

Primary Supporting Adult(s):____ **Date of Birth**:__________________

Relationship to Child:____
Employed? ☐ Yes ☐ No If yes, ☐ Full Time ☐ Part Time
Employer:____ Work Phone:______________________
Parent in school? ☐ Yes ☐ No If yes, ☐ Full Time ☐ Part Time Where?____________________________________
Highest education level: ☐ Less than high school graduate ☐ High school graduate or GED
☐ Some college, vocational school, or Associates Degree ☐ Bachelor's or Advanced Degree

Household yearly gross income: $_____________________________

Other Adult (s) in the child's home:____________________________________ Relationship:___________________

Number of other children in the home:________________ Please list name, age, and relationship to applicant:

1.____ 3.___________________________________

2.____ 4.___________________________________

Family Type:
☐ Foster family ☐ Single parent ☐ Single parent living with partner ☐ Stepfamily (natural mother) ☐ Stepfamily (natural father)
☐ Two parent family ☐ Multigenerational family ☐ Other relative:____

Has the child been in any other preschool program? ☐ Yes ☐ No When/Where:_________________________________

Persons who the child may be released to: ____

Is the child exempt from immunizations? ☐ Yes ☐ No

Name of child's doctor:____ Date of most recent physical exam:___________________

Name of child's dentist:____ Date of most recent dental exam:_____________________

Choice of hospital in case of emergency:____

Concerns about the child's overall health and development: ☐ Yes ☐ No ☐ Don't know

If yes, describe concerns: ☐ Asthma ☐ Feeding issues or allergic reactions ☐ Other (Describe below):

List any allergies and the symptoms and type of response required for allergic reactions: ____

____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns: _____________________

____

List any type of medication to be taken for health care needs:____

Child suspected to be experiencing developmental delays: ☐ Don't know ☐ No ☐ Yes

If yes, who expressed concerns:____

Child received evaluation due to concerns about overall development/suspected developmental delay: ☐ Don't know ☐ No ☐ Yes

If yes, who did the evaluation and when:____

Has the child been suspected or identified with the following: ☐ No ☐ Yes (check all that apply)

☐ Emotional/behavior disorder ☐ Hearing Impairment ☐ Learning disability ☐ Orthopedic impairment

☐ Speech or language impairment ☐ Traumatic brain injury ☐ Visual impairment ☐ Autism

☐ Health impairment (including asthma, allergies, diabetes) ☐ Other:____

Does your child currently have a: ☐ IFSP ☐ IEP

Types of services or financial assistance received (check all that apply):

☐ Medicaid ☐ Health Choice ☐ Private Insurance ☐ Unemployment insurance ☐ Public Housing Assistance

☐ Food Stamps ☐ WIC ☐ SSI ☐ Child support/Alimony ☐ Energy Program Assitance

☐ Foster Care/Adoption Subsidy ☐ No services received

Child Service Coordination through:

☐ Children's Development Services ☐ CC4C through local health department

☐ Work First/Public Assistance (include WFFA): Date began receiving services:______/______/______

Program options provided include center base and home-based. Please check first choice and second choice.

☐ Center ☐ Home-Based (Home Visitor visits once a week in your home)

Additional (confidential) information needed for point (selection) system:

☐ Either parent is a teenager ☐ Current domestic abuse of a family member(s) in home ☐ Substance abuse in home

☐ Open case with DSS ☐ Currently receives child care subsidy (voucher) ☐ Current incarceration of a parent

☐ Severe health, mental health, emotional, or behavioral problems of immediate family

List any particular fears or unique behavior characteristics the child has: ____

____

How did you hear about our program?____

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

Signature:____ **Date**:______________________________

***I agree this information is accurate. I give permission for WCCA to contact necessary parties for income verification.*

KB 4/2018 *The information on this application is confidential and is only used in providing the services of the Head Start program.*