

The Improvement Association

Applicant & Family Member Information

This Section for Agency Use Only:

Applicant Name: _____

BC# _____

Previous Child Care: _____

Applicant

First	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None			<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			
Primary Health Coverage	Other Health Coverage	Insurance #	Medicaid	Medicaid #	Doctor	Dentist
			<input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially Eligible			

Adult 1

First	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None			<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Natural/Adopted/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Niece/Nephew		<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster		If teen parent, subsidized?
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Master's					
Phone # _____		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other / Email Address: _____				

Adult 2

First	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None			<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient			
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Natural/Adopted/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Niece/Nephew		<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster		If teen parent, subsidized?
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Master's					
Phone # _____		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other / Email Address: _____				

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
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This Section for Agency Use Only:

Applicant Name: _____

Family Information, Income & Contacts

Family Information							
Living Address		Address Line 2	Zip	City	State	County	
Mailing Address (if different)		Address Line 2	Zip	City	State	County	
Employer Name (Adult 1)		Address Line 2	Zip	City	State	Phone #	
Employer Name (Adult 2)		Address Line 2	Zip	City	State	Phone #	
Parental Status (check one)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (if applicable)
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/> Yes <input type="checkbox"/> No					

Family Income			
TANF		Supplemental Security Income	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Emergency Contacts								
Contact 1	Name		Relationship		Emergency Contact		Release To	
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address		Zip		City		State	
	Phone # 1		Phone # 2		Phone # 3			
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		
Contact 2	Name		Relationship		Emergency Contact		Release To	
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address		Zip		City		State	
	Phone # 1		Phone # 2		Phone # 3			
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		

I understand that my child cannot begin classes until his/her immunization record is given to the school nurse, secretary or TIA staff. If the record is incomplete I understand that I must present an appointment card for completion of the immunizations to the nurse, secretary or TIA staff before my child can begin classes.

Parent Signature

I understand that if my child is selected to attend a 3 or 4-year-old program, I must present a completed physical examination form to the school nurse or secretary before my child can attend classes.

Parent Signature

Applicant Name: _____

Health Information

Does your child show signs of (Check all that apply)

- Speech Impairment
- Physical Impairment
- Hearing Impairment
- Mental Health Impairment
- Visual Impairment
- No Impairment
- Other (please explain) _____

Has he/she been professionally diagnosed? _____ No _____ Yes (Attach Documentation)

Service Provider for Impairment _____ Phone _____

Does your child have any of the following conditions (Check all that apply)

- Asthma
- Diabetes
- Seizures / Convulsions
- Food Allergies (please explain) _____
- Other Allergies (please explain) _____

Has he/she been professionally diagnosed? _____ No _____ Yes (Attach Documentation)

Service Provider for allergy/ condition: _____ Phone _____

Permits & Agreements

Please Initial questions 1 through 16

My child _____ will receive the following health screenings.

- 1 _____ Physical Exam
- 2 _____ Vision
- 3 _____ Mental Health
- 4 _____ Dental Screening and Exam
- 5 _____ Hemoglobin or Hematocrit
- 6 _____ Hearing
- 7 _____ Lead

I, _____ give The Improvement Association the following permissions:

- 8 _____ For Head Start to secure emergency treatment in my absence _____ Yes _____ No
- 9 _____ To allow The Improvement Association staff to make home visits _____ Yes _____ No
- 10 _____ That my child may go on all field trips with the program _____ Yes _____ No
- 11 _____ That my child will attend each day he/she is able _____ Yes _____ No
- 12 _____ I will make effort to attend the bi-monthly Parent Center Committee Meetings _____ Yes _____ No
- 13 _____ Myself or a Representative of my household will volunteer in the center _____ Yes _____ No
- 14 _____ I give permission for my child to be assessed through Head Start _____ Yes _____ No
- 15 _____ I will inform The Improvement Association within 24 hours of the next business day if my child or any member of the household has developed any reportable communicable disease as described in the Head Start Parent Handbook Exclusion Policy _____ Yes _____ No
- 16 _____ The Improvement Association Head Start has the absolute right and permission to copyright and/or publish photographs or videos of the above named child and I agree that any such photographs and/or videos become the exclusive right of the Improvement Association, and I waive all rights thereto _____ Yes _____ No

AGREEMENT: The Improvement Association Head Start agrees to notify parents/guardians when a child becomes ill and the parent/guardian agrees to pick child up within one hour. Parent/Guardian agrees to permit The Improvement Association Head Start to secure emergency treatment in my absence. 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. I understand that the information provided above will remain strictly confidential.

Parent / Guardian Signature Date

