Child's Name _____

St. John the Baptist Parish School Board

118 West 10th Street * P. O. Drawer AL * Reserve, Louisiana 70084

FOUR-YEAR-OLD PRESCHOOL PROGRAMS APPLICATION 2019-2020

Your child must be four (4) years old by September 30, 2019 to be eligible. Your child will qualify for one of the preschool programs regardless of income. Applying early is recommended.

Applications should be submitted in person at one of the following addresses:

Garyville/Mt. Airy Math & Science Magnet School
240 Hwy 54
Garyville, LA 70051

West St. John Elementary
2555 Hwy 18
Edgard, LA 70049

INFORMATION NEEDED WITH APPLICATION:

1. **Income Verification-Your family income must be verified for program eligibility determination. ATTACH ONE PROOF OF INCOME LISTED BELOW IN A-K:**
   a. **Income Tax Form 1040 for the previous calendar year (2018)**
   b. **W-2 Statements for all working family members for the previous calendar year**
   c. **Pay Stubs-***(last 2 current) for all working family members**
   d. **Documentation showing current status/amount received from FITAP**
   e. **Letter showing current status/amount received from SSI/Social Security**
   f. **Foster Care documentation letter for Foster Child**
   g. **Documentation of Child Support/Alimony**
   h. **Documentation of Unemployment Compensation**
   i. **Written statement from current employer(s)**
   j. **Written statement of Family Support from person supporting the child**
   k. **Income Declaration Form**
2. **Child's Birth Certificate-to verify age of child**
3. **Child's Social Security Card**
4. **Child's Medical Insurance or Medicaid Card**
5. **Documentation of Child's Disability-IEP or IFSP (if applicable)**
6. **Child's Immunization Record-to show that child is up-to-date on all shots**
7. **Proof of residency-any two of the following: Utility bills (light, water, gas, phone or cable), Voter registration card, License/ID, Lease/Mortgage**
8. **Identification (State issued ID or Driver's License**
9. **Budget sheet if receiving SNAP benefits**

If you need assistance in obtaining any of the above information, the St. John Parish Head Start staff can assist you with contact phone numbers, applications (for birth certificate or social security card), physical exam form, or other assistance you might need in obtaining the above needed information. For more information, call St. John Head Start/PreK at (985) 535-3917.

FOR OFFICE USE ONLY

_____ **1. Head Start_____**
_____ **2. LA 4_____**
_____ **3. Model Early (8) g___**
_____ **4. Universal PreK____**
_____ **5. Child Care Provider_**
_____ **6. NSECD_____**
_____ **7. PreK Expansion____**

St. John Parish School Board Preschool

ENROLLMENT APPLICATION

Date of Application_____

Child's name: _____
First Name Middle Initial Last Name

Date of birth: _____/_____/_____ SSN: _____ - _____- _____ Gender: ____M ____F

Head of Household Name: _____ Birth date: _____

Home Address: _____City_____Zip_____

Mailing Address: _____City _____Zip _____

Telephone: _____ Cell Number: _____

Subdivision/Area: _____

Child's Race: _____ If bi-racial, specify races: _____

Is child Latino/Hispanic: ____Yes ____No If yes, ____Black Hispanic ____White Hispanic

Language(s) spoken: Primary: _____ Other: specify: _____
English fluency: ___Not At All ___ Not Well ___ Well ___ Very Well

Child previously enrolled in Early Head Start, Head Start, or other Childhood Development program: __Yes __ No

Are there Concerns about this child's overall heath and development: ___Yes ___No
If YES, WHAT concerns: _____

Child Health Insurance: ___LACHIP ___Medicaid ___Private Insurance ___No Insurance
___Other-Specify _____

Child's Medical Providers-Doctor/Clinic: _____
Dentist: _____

Child's General Health: ___Glasses ___Braces ___Wheel Chair ___Crutches ___Hearing Aid
___Other-Specify: _____

Child's Allergies: _____ Child's Medication(s): _____

Do you suspect a disability: __Yes __No

Does Child have an IEP or IFSP: __Yes __NO
If yes, what is your child's DIAGNOSED disability: _____

Established Risks (check all that apply):

- ☐ None
- ☐ Chromosomal abnormality (i.e. down syndrome
- ☐ Congenital syndrome (i.e. fetal alcohol syndrome)
- ☐ Medically fragile
- ☐ Sensory Impairment (i.e. hearing or vision impairment)
- ☐ congenital birth defect (i.e. myelomeningocele)
- ☐ HIV positive/AIDS

Environmental Risks (check all that apply):

- ☐ None
- ☐ Biological mother younger than 17 years old
- ☐ Family social disorganization
- ☐ Parental developmental disability
- ☐ Suspected child abuse or neglect
- ☐ Documented child abuse or neglect
- ☐ maternal education less than 8th grade level
- ☐ Parental substance abuse
- ☐ Family member smokes in household
- ☐ Poverty

Mother's Name _____
Date of Birth _____/____/_____ Living with child:_____

____ Employed If Employed, work phone number _____-_____ Ext. _____
Name of Employer: _____
Full Time: _____Part Time: _____ Hours: _____

____In School Last grade completed: _____
____Neither Employed or In School Are you interested in Adult Education classes? _____

Father's Name _____
Date of Birth _____/____/_____ Living with child: _____

____ Employed If Employed, work phone number _____-_____ Ext. _____
Name of Employer: _____
Full Time: _____Part Time: _____ Hours: _____

____In School Last grade completed: _____
____Neither Employed or In School _____ Are you interested in Adult Education classes _____

<u>OTHER</u> Household/Family Members (<u>DO NOT LIST HEAD OF HOUSEHOLD OR CHILD LISTED ABOVE</u>): (add sheet if necessary)

Name	Gender	Race	Date of Birth	Relation to Child	Occupation-Adults	Education Level-Adults	Income-Adults
1.							
2.							
3.							
4.							

Family Data:
Family in Military: ☐ Yes ☐ No Substance Abuse: ☐ Yes ☐ No
Family Member with Disability: ☐ Yes ☐ No Teen Mother: ☐ Yes ☐ No
Family Member Currently in Early Head Start, Head Start or other Child Development Program: ☐ Yes ☐ No

Family Type:
☐ Biological Family ☐Single Parent (father figure only) ☐Single parent, Not working or Student
☐ Foster Family ☐Single Parent (father figure only) living w/ partner ☐Single Working Parent or Student
☐Other family type ☐Single Parent (mother figure only) ☐Two Parents, Both Working or Students
☐Other relative(s) ☐Single Parent (mother figure only) living w/partner ☐Two Parents, Neither Working or Students
☐Two Parent Family ☐Two Parents, One Working or Student

Income verified by: ____W-2 ____Check Stub ____Tax Return ____Letter ____Other_____

Receive pay from job: ____Weekly _____Every 2 weeks _____ Monthly

Yearly gross income: $ _____ Number of adults contributing to income: _____

Number of children in family: _____ Number of adults in family: _____

Types of services or financial assistance received (Mark all that apply):
___Medical assistance (i.e. Medicaid) ____Food Stamps (SNAP)
___Public assistance/Welfare (i.e. FITAP/TANF) ____WIC
___Social Security ____Foster Care Subsidy
___Supplemental Security Income (SSI) ____Housing
___Child Support/Alimony ____Child Care Assistance Program
____Other: Specify _____

Has your family been Homeless during the last year? __YES __NO If yes, for how long? ___months

Emergency Information

In Case of an Emergency Notify:

Name	Relationship	Address	Phone Number

<u>ONLY</u> the above persons have my permission to receive my child off the bus or pick my child up at the Head Start center.

Transportation Information: _____Parent will bring _____ Ride Bus

Pick-up location: _____

Drop-off location: _____

Publicity Release

I give my permission for _____to be identified with St. John Parish School Board in print (newspaper), photographs, videos, and social media.

Parent's/Guardian's Signature: _____ Date: _____

Certification: I certify that this information is true. If any part is false, my participation in this program may be terminated. I also understand that the information in this application will be held in strict confidence with the agency and is accessible to me during business hours. I have been afforded an interview giving assistance in filling out this application and obtaining information about the Head Start program.

Parent's/Guardian's Signature: _____ Date: _____

Email address: _____

Staff Member: _____ Date: _____

Position _____