

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

**St. John the Baptist Parish School Board**  
118 West 10<sup>th</sup> Street \* P. O. Drawer AL \* Reserve, Louisiana 70084

**FOUR-YEAR-OLD PRESCHOOL PROGRAMS APPLICATION 2020-2021**

Your child must be four (4) years old by September 30, 2020 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:

<b>Garyville/Mt. Airy Math &amp; Science Magnet School</b>	<b>West St. John Elementary</b>
<b>240 Hwy 54</b>	<b>2555 Hwy 18</b>
<b>Garyville, LA 70051</b>	<b>Edgard, LA 70049</b>

**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 (2019)**
  - 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.

<b>FOR OFFICE USE ONLY</b>	
_____	1. <b><u>Head Start</u></b>
_____	2. <b><u>LA 4</u></b>
_____	3. <b><u>Model Early (8) g</u></b>
_____	4. <b><u>Universal PreK</u></b>
_____	5. <b><u>Child Care Provider</u></b>
_____	6. <b><u>NSECD</u></b>

**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: \_\_\_\_\_

Language(s) spoken: Primary: \_\_\_\_\_ Other: specify: \_\_\_\_\_

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 health 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):

- |  |   |
|--|---|
| <input type="checkbox"/> None  | <input type="checkbox"/> Sensory Impairment (i.e. hearing or vision impairment) |
| <input type="checkbox"/> Chromosomal abnormality (i.e. down syndrome)      | <input type="checkbox"/> congenital birth defect (i.e. myelomeningocele)        |
| <input type="checkbox"/> Congenital syndrome (i.e. fetal alcohol syndrome) | <input type="checkbox"/> HIV positive/AIDS                                      |
| <input type="checkbox"/> Medically fragile                                 |   |

**Environmental Risks** (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> None  | <input type="checkbox"/> Documented child abuse or neglect                        |
| <input type="checkbox"/> Biological mother younger than 17 years old | <input type="checkbox"/> maternal education less than 8 <sup>th</sup> grade level |
| <input type="checkbox"/> Family social disorganization               | <input type="checkbox"/> Parental substance abuse                                 |
| <input type="checkbox"/> Parental developmental disability           | <input type="checkbox"/> Family member smokes in household                        |
| <input type="checkbox"/> Suspected child abuse or neglect            | <input type="checkbox"/> 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 \_\_\_\_\_

**OTHER Household/Family Members (DO NOT LIST HEAD OF HOUSEHOLD OR CHILD LISTED ABOVE): (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

**ONLY** 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 \_\_\_\_\_