Child's Name ____

St. John the Baptist Parish School Board

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

HEAD START PROGRAM 2018-2019

HEAD START is a federal program for low-income families who are eligible within the income guidelines. It provides services for all children; a sound educational program, nutritional program, social services, parental involvement, and medical/dental health services.

Your child must be three (3) years old by September 30, 2018 to be eligible for this program.

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

ADDITIONAL INFORMATION NEEDED WITH APPLICATION:

1. **Income Verification-Your family income must be verified before your child's eligibility for Head Start can be determined. PLEASE ATTACH ONE OF THE FOLLOWING TO THIS APPLICATION:**
   a. **Income Tax Form 1040 for the previous calendar year (2017)**
   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 (2)**
8. **Identification**
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 Child Development Center at (985) 535-3917 or 535-2713.

FOR OFFICE USE ONLY
_____ 1. Head Start
_____ 2. Child Care Provider

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): (add sheet if necessary)</u>

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
☐ Foster Family
☐Other family type
☐Other relative(s)
☐Single Parent (father figure only)
☐Single Parent (father figure only) living w/ partner
☐Single Parent (mother figure only)
☐Single Parent (mother figure only) living w/partner
☐Two Parent Family
☐Single parent, Not working or Student
☐Single Working Parent or Student
☐Two Parents, Both Working or Students
☐Two Parents, Neither Working or Students
☐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)
___Public assistance/Welfare (i.e. FITAP/TANF)
___Social Security
___Supplemental Security Income (SSI)
___Child Support/Alimony
____Food Stamps (SNAP)
____WIC
____Foster Care Subsidy
____Housing
____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: _____________________

Staff Member: ______________________________________ Date: _____________________

Position ____