The Campagna Center

Early Childhood Programs

PRIMARY PARENT/GUARDIAN INFORMATION

Primary Parent/Guardian First Name: _____ MI: _____ Last Name: _____

Gender: ☐ Male ☐ Female **Birth Date:* _____

Contact Information:

Employer/School Name: _____Work Phone Number: _____

Work Address: _____City: _____ State: _____ Zip Code: _____

Home Address: _____City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Receiving TANF: ☐ Yes ☐ No ☐ Previously ***Receiving WIC:** ☐ Yes ☐ No ☐ Previously

***Receiving Food Stamps (SNAP)** ☐ Yes ☐ No

****Primary Language:*** _____ ****Secondary Language:*** _____

****Ethnicity:*** ☐ Latino ****Race:*** ☐ Asian ☐ Bi-Racial/Multiracial ☐ Black/African American ☐ White ☐ Native American/Alaskan ☐ Pacific Islander/Hawaiian ☐ Other ☐ Unspecified

***Education Level:** ☐ 9th Grade or less ☐ High School Graduate ☐ Associate's Degree ☐ 10th Grade ☐ GED ☐ Bachelor's Degree ☐ 11th Grade ☐ Training Certificate ☐ Master's Degree ☐ 12th Grade ☐ Some College ☐ Doctoral Degree

***Education Completion Date**: _____ ☐ ***Completed a job training program, professional certificate or license.**

***Program Completion Date:** _____

If in school/training, where? _____

***Veteran of the US military?** ☐ Yes ☐ No ***Member of US military on active duty?** ☐ Yes ☐ No

Employment Status: ☐ Employed full time ☐ Employed part time ☐ Self-employed ☐ Retired or Disabled ☐ Unemployed ☐ Training or in school FT ☐ Training or in school PT

****Family Structure:*** ☐ ***Single Parent*** ☐ ***Two Parent***

****# in Family***: _____ ****# in Household***: _____

***Does the Primary Parent have Health Insurance?** ☐ Yes ☐ No **Name of Insurance* _____

****Current Housing Status:*** ☐ Homeless ☐ Own ****Current Housing Date*** _____ ☐ Rent ☐ Other

****Previous Housing Status*** ☐ Homeless ☐ Own ☐ Rent ☐ Other

The Campagna Center

Early Childhood Programs

Secondary Parent/Guardian Information

___ NO SECONDARY PARENT/GUARDIAN (skip section if no secondary parent/guardian)

Secondary Parent/Guardian First Name: ___________________ MI:__________ Last Name: ___________________

Gender: ☐ Male ☐ Female *Birth Date:* ___________________

Primary Language: __________________________ **Secondary Language:** ______________________________

Ethnicity: ☐ Latino ***Race:***

☐ ! ǎƛl·ƴ ☐ Bi-Racial/Multiracial ☐ . ƒl·Ǒʅĸ ! ŦǋƛǑl·ƴ ! ƳŜǋƛǑl·ƴ
☐ Caucasian ☐ Native American ☐ Pacific Islander
☐ Other ☐ Unspecified

Education Level:

☐ 9th Grade or less ☐ High School Graduate ☐ Associate's Degree
☐ 10th Grade ☐ GED ☐ Bachelor's Degree
☐ 11th Grade ☐ Training Certificate ☐ Master's Degree
☐ 12th Grade ☐ Some College ☐ Doctoral Degree

If in school/training, where? ____

Employment Status:

☐ Employed full time ☐ Employed part time ☐ Self-employed
☐ Retired or Disabled ☐ Unemployed ☐ Training or in school

Contact Information:

Employer/School Name: ____________________Work Phone Number: ____

Work Address: _____________________________City: __________________ State: ______ Zip Code: ______________

☐ Home Address same as Primary Parent/Guardian

Home Address (if different than Primary Parent): ___________________________________City: ___________________

State: ______ Zip Code: _____________

Home Phone: ___________________________ Cell Phone: ________________________

Email Address: ____

Does the Secondary Parent have Health Insurance? ☐ Yes ☐ No

Name of Insurance: ____

*Certification:

I certify that this information is true. If any part is false, my participation in the program may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the program.
I further understand that this is an application for services that are paid for with federal funds and that intentionally providing misleading, inaccurate or untruthful information of a material nature could result in un-enrolling my child from Head Start/Early Head Start or VPI and could have serious legal consequences.

Parent Signature: ____ **Date:** _________________________

Parent Printed Name: ______________________________________

The Campagna Center

Early Childhood Programs

Child Information

Child's First Name: _____ MI:_____ Last Name:_____

Preferred Site 1: _____ Preferred Site 2: _____ Preferred Site 3: _____

****If no bus transportation is available, are you willing to transport?** ☐ Yes ☐ No

****Will you be requiring extended care services**? ☐ Yes ☐ No

☐ Before School (7:30-8:30) ☐ After School (3:00-6:00) ☐ Both

☐ Child is receiving a childcare subsidy (Voucher or Contracted Slot)

Gender: ☐ Male ☐ Female **Birth Date:* _____

****Primary Language:*** _____ **Other Language:* _____

Speaks English?: ☐ Yes ☐ No English Skills: ☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

****Ethnicity:*** ☐ Latino ****Race:*** ☐ Asian ☐ Bi-Racial/Multiracial ☐ . lackĸ ! ŦNJĂŎI·y ! Y ŜNJĂŎI·y

☐ Caucasian ☐ Native American ☐ Pacific Islander

☐ Other ☐ Unspecified

US Citizen?: ☐ Yes ☐ No

Eligibility Information

***Parental Status (check all that apply)**

☐ Two Parents ☐ Single Parent

☐ Teen Parent ☐ Disabled Parent ☐ Foster Parent ☐ Active Male ☐ Homeless

☐ Guardian ☐ Dual Custody ☐ Student Parent welation to Primary Caregiver _____

Additional Eligibility Information

Does your child have a disability? ☐ Yes ☐ No Does your child have an IEP/IFSP? ☐ Yes ☐ No

Type of Disability: _____

(Check all that apply)

☐ CPS Referral ☐ Domestic Violence Referral ☐ Sibling of another child in HS/EHS

☐ TANF ☐ SSI

☐ Pregnant Teen ☐ Pregnant Woman (EHS only) ☐ Rising Kindergartner

Other Information

☐ Father/father figure will participate in regularly scheduled activities designed for involvement in HS or EHS.

Child has a medical card? ☐ Yes ☐ No Name of Insurance: _____

Medicaid #: _____

If applicable:

2nd year application review – No changes needed (Parent Initials _____)

3rd year application review – No changes needed (Parent Initials _____)

The Campagna Center

Early Childhood Programs

Alexandria Head Start/Early Head Start
Important Medical Information

Child's Name: _____ Date: _____

To ensure the health and safety of all students, please provide the following information about your child.

- My child takes prescription medication on a regular schedule. ☐ Yes ☐ No
- My child has an Epi-Pen (epinephrine injection). ☐ Yes ☐ No
- My child has an Inhaler. ☐ Yes ☐ No
- My child has **medically diagnosed** asthma. ☐ Yes ☐ No
- My child has **medically diagnosed** diabetes. ☐ Yes ☐ No
- My child has **medically diagnosed** seizures. ☐ Yes ☐ No
- My child has **medically diagnosed** allergies. ☐ Yes ☐ No

  Type of allergies: _____
- My child has medically diagnosed dietary restrictions. ☐ Yes ☐ No

  Type of dietary restrictions: _____
- My child has religious dietary restrictions. ☐ Yes ☐ No

  Type of religious dietary restrictions: _____
- My child has a chronic medical condition not listed above: ☐ Yes ☐ No

  Please explain: _____

  _____
- My child is under the care of a physician for the following conditions: _____

  _____

  _____

Parent/Guardian Signature: _____ Date: _____

Verifying Staff Signature: _____
Printed Name: _____

**If the answer is "Yes" to any of these questions, please have the parent submit the appropriate forms. (Chronic Health Conditions and Health Plan, Permission to Administer Medication, Statement for Special Diet Prescription)