SEVCA Head Start

97 Park Street Suite 1
Springfield, VT 05156
Phone: 802-460-1552
E-mail: headstart@sevca.org
www.sevcaheadstart.org

Meeting Needs | Changing Lives
SEVCA
SOUTHEASTERN VERMONT COMMUNITY ACTION

Application for Enrollment

Child's Name _____ Date of Birth _____ ☐ Male ☐ Female

Best way to contact you during enrollment ○ Phone ○ E-mail

Child is Living With (Check All That Apply)
☐ Mother ☐ Father
☐ Foster Care ☐ Grandparent
☐ Other _____

Housing Situation
☐ Own
☐ Rent
☐ Living w/ Family/Friends

Emergency Contact/Phone #

Physical Address _____ Mailing Address _____ Phone _____

Town & Zip Code _____ Town & Zip Code _____

How did you hear about our program?

Has your family been in a preschool or Head Start Program before? ☐ Yes ☐ No

If yes, what is the name of the program? _____

Does your Child have an IEP? (Individual Education Plan) ☐ Yes ☐ No

Springfield/Chester Applicants: Do you need child care? ☐ Yes ☐ No

What is the Primary Language Spoken in the Home? _____

Ethnic Origin
☐ Hispanic
☐ Non-Hispanic

Race:
☐ American Indian
☐ Asian
☐ Native Hawaiian
☐ Biracial/Multi-Racial
☐ Alaskan Native
☐ Black/African American
☐ White
☐ Other _____

Is this Family Expecting any new siblings? Yes ○ No ○

Does your family partner with other program?
☐ PATH ☐ WIC ☐ Food Stamps ☐ HCRS ☐ Medicaid/Dr. Dyno ☐ Reach-Up
☐ Child Care Subsidy ☐ TANF ☐ Job Training Program ☐ SSI/SSDI ☐ Adult Education ☐ None of the Above

Parent/Guardian 1 Name _____ Phone Number _____ E-mail Address _____

Address _____ Employer (Name, Address, Phone) _____

Parent/Guardian 2 Name _____ Phone Number _____ E-mail Address _____

Address _____ Employer (Name, Address, Phone) _____

Household Members & Information

Name	Relationship	Date of Birth	Social Security #	Parent/Guardian Highest Level of Education	High School Diploma/GED
	Preschool Applicant				
	Parent/Guardian 1				
	Parent/Guardian 2				

Health Information

Type of Health Insurance

Policy Number

Allergies

Daily Medications

Primary Care Physician

Phone

Date of last exam

Dentist

Phone

Date of last exam

Is there any other information you would like to share with about your child/family such as: speech/developmental delays or concerns, family dynamics/changes, custody agreements, court orders involving the child, etc?

I certify that all of the information stated above is correct. I understand that the information provided will remain strictly confidential. By signing this application, I give permission for Head Start staff to access my child's immunization information on the VT State Registry.

Parent/Guardian Signature

Staff Signature

Date

Date

OFFICE USE ONLY

Income Verification:
Staff Please Attach

- Income Tax Return ☐
- TANF ☐
- SSI ☐
- Pay Stub ☐
- Other ☐
- Over Income

Eligible for program

☐ Yes ☐ No

- Waiting List
- Enrollment Date
- Placement
- Days and hours of attendance
- Date Letter sent to Family

Manager's Sign Off

- Director
- Family Service Manager
- Education Manager
- Health Manager
- Child Care Manager
- Admin Assistant

Special Needs

Notes