SEVCA Head Start

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Springfield, VT 05156
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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

How was this application completed?

☐ In-Person ☐ Phone ☐ Zoom/Video Call ☐ Mail ☐ Other: _____

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

Date

Staff Signature

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