



SEVCA Head Start

4 Dunham Avenue
 Windsor, VT 05089
 Phone: 802-674-8419
 E-mail: headstart@sevca.org
 www.sevcaheadstart.org



Application for Enrollment

Child's Name _____ Date of Birth _____ Best way to contact you during enrollment
 _____ Male _____ Female _____ Phone _____ E-mail _____

Child is Living With (Check All That Apply) _____ Housing Situation _____ Emergency Contact/Phone # _____
 Mother _____ Father _____ Own _____
 Foster Care _____ Grandparent _____ Rent _____
 Other _____ Living w/ Family/Friends _____

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? _____ If yes, what is the name of the program? _____ Does your Child have an IEP? (Individual Education Plan) _____ Do you need child care? _____ What is the Primary Language Spoken in the Home? _____
 Yes _____ No _____ Yes _____ No _____ Yes _____ No _____

Ethnic Origin _____ Race: _____ Is this Family Expecting any new siblings? _____
 Hispanic _____ American Indian _____ Alaskan Native _____ Yes _____ No _____
 Non-Hispanic _____ Asian _____ Black/African American _____
 _____ Native Hawaiian _____ White _____
 _____ Biracial/Multi-Racial _____ Other _____

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

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) _____

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				

Household Members & Information

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

Staff Signature

Date

Date

OFFICE USE ONLY

Income Verification:
Staff Please Attach

Eligible for program

Manager's Sign Off

Yes No

Income Tax Return

Waiting List

Director

TANF

Enrollment Date

Family Service Manager

SSI

Placement

Education Manager

Pay Stub

Days and hours
of attendance

ERSEA Coordinator

Other

Date Letter

Child Care Manager

Over Income

sent to Family

Health Support Coordinator

Special Needs

Notes