FIRST BAPTIST HEAD START
Registration Form

Needs Full Day _________
Needs Part Time ________

School Year _________________
Child ID # ___________________
Family ID # __________________

Child's Legal Name – LAST ________________	FIRST ________________	Date of Birth: ________________ Month/Day/Year

Address: ________________ City: ________________ Zip Code ________________

Child's Race: B H N W A O National Origin: _____________	Sex: M F	Primary Language: _____________ Secondary Language: ___________	Child's Social Security #: ________________

Child's Medical # and Health Insurance Company:

Medical Insurance: ______________________ Medical Number: _____________________ Physician: ______________________ Phone #: _____________________

Dental Insurance: ______________________ Dental Number: _____________________ Dentist: ________________________ Phone #: _____________________

Does child have a disability or special need? Y N Suspected? Y N (Describe: if disability has been diagnosed, give) Source: ____ Date: ________________

Mother / Guardian	Father / Guardian
Mother or Guardian Full Name: ________________	Father or Guardian Full Name: ________________
Street Address (if different from Child) City Zip Code	Street Address (if different from child) City Zip Code
Home Phone Number: ( ) ________________	Phone: Other / Message: ( ) ________________
Mother's Cell # : ________________	Father's Cell #: ________________
Mother's work #: ________________	Father's Work # ________________
Mother's Social Security #: ________________	Father's Social Security: ________________
Mother's Medical Ins. ____________________ #__________________	Father's Medical Ins. _____________________ # __________________
Mother's primary language: ________________	Father's primary language: ________________
Does Mom live in the home? Yes No	Does Dad live in the Home? Yes No
Have you moved in the past 24 months? Yes No	Have you moved in the past 24 months? Yes No
Previous address ________________	Previous address ________________

Parental Status: O = One Parent T = Two Parents F = Foster Parent N = Not Parent Other: ____________________________
Number of Persons: [ ] In Family [ ] In Home **Number of Children:** [ ] In Family [ ] Birth to 4 Years Old [ ] 5 Years & Older

Child will get to program by: B = Public Bus W = Walking P = Parent O = Other _________________

Has child attended other child development program? Y N	If Yes, Name:	Address:
Has a child in this family been enrolled in this program before this year? Y N		If yes, what year?
Are you on TANF? (Public Assistance) Y N	Do you receive food stamps? Y N	Do you receive WIC? Y N
Are you receiving child care subsidy? Y N	Is child receiving child care at: Family Child Care Home ___ Child Care Center ___ Your home with relative ___ Another home not relative ___	

Any specific family need or crisis? (optional) Y N If yes, describe: ____

(Agency Use Only) Income (list by family member)	Weekly X 52 Bi-weekly X 26 Semi-month X 24 Monthly X 12			Federal Income Guideline $ _____________ Number in Family ______________	
Family Member	Amount	Per	X	Annual Income	Source
	$			$	
	$			$	
			Total Yearly Income of Family	$	

FAMILY MEMBER INFORMATION

ADULTS (List significant family members, beginning with head of family)

First and Last Name of adult(s) in home	Date of Birth	Social Security #	Sex	How relate to child	Education Level	Employment Status	Occupation
A-1			M F				
A-2			M F				
A-3			M F				
A-4			M F				
A-5			M F				

CHILDREN (list program applicant first, then other children)

First and Last Name of children in home	Date of Birth	Social Security #	Sex	Related To Child How?
C-1			M F	
C-2			M F	
C-3			M F	
C-4			M F	
C-5			M F	
C-6			M F	
C-7			M F	
C-8			M F	

Certification: *I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subjected to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Guardian's Signature ____ Date ______________________

****FOR AGENCY USE ONLY, DO NOT WRITE BELOW THIS LINE****

Income Verified? Y N By: [ ] Check Stub [ ] TANF [ ] W-2 [ ] Tax Return [ ] Letter [ ] Other _____________

Birth Verified? Y N By: [ ] Birth Certificate [ ] Hospital Certificate [ ] Health Dept. Certificate [ ] Other ____________

Signature of verifying staff member: _____________________________ Date: _____________

First Year Center Name:	Class	Income Status: E O
Second Year Center Name	Class	

Comments: ____

Start Date:	Director's Signature:	Date:
Return Date:	Director's Signature:	Date: