



RETURN TO:

2496 145th St. W., Rosemount, MN 55068
 Telephone: 651-322-3500/Fax: 651-322-3555

Please **print** all information clearly and complete information for all family members.

- Program** (check one): Head Start Ages 3-5 yrs. (Must be 3 by Sept 1st)
 Early Head Start – Ages prenatal to 3 years old (Home Visit Program)

*****Parent/guardian must provide transportation*****

- Preferred Location/s:** Rosemount Apple Valley Savage
 S.St.Paul Eagan Chaska
 Inver Grove Heights Shakopee

Number of individuals in the household _____

Parent/Guardian Information for Family Member 01: Head of Household (HOH)

Parent/Legal Guardian First Name	Middle Name	Last Name	
Street Address	City	County	Zip Code
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Text	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Text	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Text	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Text
Email Address: _____			

Date of Birth:	Gender: MALE FEMALE	Disabled: YES NO
Hispanic: YES NO	Education Level:	Employed: YES NO - Full or Part Time?
Do you speak English? YES NO	1 st Language Spoken:	Parent In School or Training: YES NO
Interpreter needed? YES NO		Full or Part Time? (circle applicable answers)
Are you the legal guardian of the Head Start Child: YES NO		U S Military Member: YES NO
Race (Choose as many as apply)		Veteran: YES NO
<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Am Indian/Alaska Native <input type="checkbox"/> Black or African-American <input type="checkbox"/> Other		

Housing Situation - Please check all that apply:

A. Home that I rent, own or **share by choice**

B. Temporarily living with a family member or friend due to loss of housing, economic hardship or similar reason

C. Subsidized (Section 8, HUD, CDA, Rent Assistance)

D. At Risk of Homelessness

E. Homeless

F. Staying in emergency or transitional shelter/housing

G. Living in a motel/campground/vehicle because I cannot afford or find affordable housing

H. Other: _____

Family Information: One Parent Household Two Parent Household Foster Parent(s)*

(** If a Foster Parent, a copy of the court/legal doc must be included for eligibility verification)

LIST ALL FAMILY MEMBERS LIVING IN THE HEAD START CHILD'S HOUSE. INCLUDE THE HEAD START CHILD.**2nd Parent/Guardian Member 02**

First Name:	Last Name:	U S Military Member:	Yes / No
		Veteran:	Yes / No
Relationship to HOH:	Gender (circle one): Male Female	Date of Birth:	Disability (circle one): Yes No
Education Level:	Employed: Yes / No Full or Part Time?	Parent In School or Training: Yes / No Full or Part Time? (circle applicable answers)	

Family Member 03

First Name:	Middle:	Last:	
Relationship to HOH:	Gender (circle one): Male Female	Date of Birth:	Disability (circle one): Yes No
Education Level:		Race:	

Family Member 04

First Name:	Middle:	Last:	
Relationship to HOH:	Gender (circle one): Male Female	Date of Birth:	Disability (circle one): Yes No
Education Level:		Race:	

Family Member 05

First Name:	Middle:	Last:	
Relationship to HOH:	Gender (circle one): Male Female	Date of Birth:	Disability (circle one): Yes No
Education Level:		Race:	

Family Member 06

First Name:	Middle:	Last:	
Relationship to HOH:	Gender (circle one): Male Female	Date of Birth:	Disability (circle one): Yes No
Education Level:		Race:	

*Attach another sheet for additional family members.

You must complete a copy of this page for **each** child that you wish to enroll

Legal name of child or prenatal mom you wish to enroll:

First	Middle	Last
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Does your child go by any other name? Yes /No Please List: _____

Child's Birth/Due Date: _____ / _____ / _____
Month Day Year

Male / Female (circle one)

Has your child ever been diagnosed by a doctor for any of the following conditions?

- Allergic Reaction
- Food Allergy
- Asthma or other upper respiratory breathing issues

Specify Allergies/Medical Conditions: _____

Specify medications child is currently taking: _____

*Does your child have a special need (IFSP or IEP)? Yes / No Explain _____

*Head Start accepts children with special needs and/or medical conditions

Do you have concerns about your child's development or behavior? Yes / No Explain _____

Has your family been in Head Start before? Yes / No If yes, when? _____ If yes, which county? _____

Has your child had an Early Childhood Screening in MN? Yes / No Which school district? _____

I have read and fully understand the above. I agree that all answers given are true and complete to the best of my knowledge. **I also agree to contact Head Start if any of the information changes or is not current, as failure to do so could delay my child's enrollment.** All information will remain confidential.

Parent/Guardian Signature: _____ **Date:** _____
(Signature and Date Required)

****Head Start staff will conduct an in-person or phone interview with each family****

****Please provide a copy of your child's birth certificate****

Return application, birth certificate, and all income documents to:
CAP Agency, 2496 145th St. W., Rosemount, MN 55068

If you need help completing this application:

Please call 651-322-3500.

Hearing impaired use MN Relay Service 1-800-627-3529.

