



Jackson-Vinton Community Action
Head Start Enrollment Application
 320 W. South St. Jackson, OH 45640
 Phone: 740-286-8441 Fax: 740-286-0803

It is the responsibility of Head Start personnel to maintain confidentiality and protect the privacy of Head Start children and families. Head Start parents also have the right to review child and family records and to request an explanation for information in those records as well as how it is used.

Child's full name _____ Sex: M F Age: _____
 Birth Date _____ Race _____ Social Security # _____

Child's Address: _____
 City Zip County

Primary Adult name _____ Relationship to Child: _____

Phone # _____ DOB _____ Race _____ Email Address: _____

Address _____
 (If different from child) City Zip County

Highest level of education completed: Some high school GED High School Diploma Some college
Bachelor degree Associates Degree Other: _____

Are you currently employed? Y N Are you currently in school? Y N

Active Military or Military Veteran? Y N

Other Adult name _____ Relationship to Child: _____

Phone # _____ DOB _____ Race _____ Email Address: _____

Address _____
 (If different from child) City Zip County

Highest level of education completed: Some high school GED High School Diploma Some college
Bachelor degree Associates Degree Other: _____

Are you currently employed? Y N Are you currently in school? Y N

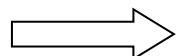
Active Military or Military Veteran? Y N

List other children (under age 21) in the home:

Name	DOB	Name	DOB
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please answer all of the following questions:

What language does your child speak? _____



What language does your family speak? _____

Is your family receiving SNAP or TANF benefits? Y N

Do you receive WIC? Y N

Is this a foster child? Y N

Is your family receiving cash assistance? Y N

Is your family homeless? Y N

Do you need assistance with housing? Y N

Who does the child live with? ____ Mom ____ Dad ____ Other please explain: _____

How did you hear about Head Start? _____

Child Information - Provide information relating to your child

Was your child referred to Head Start from an outside agency (Help Me Grow, Doctor, Board of DD): Y N
If yes, who? _____

Please list any disability or special need of your child _____

Is this special need or disability documented by a physician or therapist? Y N

If yes, please give us the name of the physician or therapist _____

Does your child have an IEP through a school system? Y N

If yes, please name the school system _____

Does your child receive services through a mental health agency? Y N

Is your child potty trained? Y N

Additional information you would like for us to know _____

I hereby submit the application for my child _____, to be enrolled in the Head Start program and agree to accept the Center Based option according to availability. I also confirm that the information contained on this form is true and correct.

Signature _____
(Parent/Guardian)

Date _____

***Please Note: This application will not be considered complete until we have your proof of income, which may include: Most recent check stub, W-2, Income tax form, proof of cash assistance and/or SNAP benefits from ODJFS, proof of child support, unemployment check stub, written statement from employer, foster care reimbursement, SSI documentation or Zero Income form. Please also provide your child's birth certificate, health insurance card, any legal documents, and shot record.**