Enrolled Date:	
Wait Listed Date:	
Entry Date:	

Early Head Start Enrollment Form

Date Enrollment Form Completed: _____

Parent/Guardian 1 Name	**Address**	**Phone**	**Date of** Birth:

Relationship to the child(ren)	**Lives with the child?**	**Email**
	❑ **Yes, Full time** ❑ **Yes, Part Time** ❑ **No**	
Employer ❒ **full time** ❒ **part time**	**If you are currently a student, where are you enrolled?** ❒ **full time** ❒ **part time**	**Education level:** ☐ Less than High School Diploma ☐ High School Diploma or GED ☐ Some College ☐ Associates Degree ☐ Bachelors Degree ☐ Post Bachelorette Degree

Parent/Guardian 2 Name	**Address**	**Phone**	**Date of Birth:**

Relationship to the child(ren)	**Lives with the child**	**Email**
	❑ **Yes, Full time** ❑ **Yes, Part Time** ❑ **No**	
Employer ❒ **full time** ❒ **part time**	**If you are currently a student, where are you enrolled?** ❒ **full time** ❒ **part time**	**Education level:** ☐ Less than High School Diploma ☐ High School Diploma or GED ☐ Some College ☐ Associates Degree ☐ Bachelors Degree ☐ Post Bachelorette Degree

People Living in Your Home								
Name	**DOB**	**Relationship to Child**	**Dependent**	**Race**	**Income toward Household**	**Foster Care Placement**	**Insurance Provider**	**Insurance Number**
			❒ Yes ❒ No					
			❒ Yes ❒ No					
			❒ Yes ❒ No					
			❒ Yes ❒ No					
			❒ Yes ❒ No					
			❒ Yes ❒ No					

CHILD'S MEDICAL/ INFORMATION

Child's Physician/Practice	**Date of last medical exam**	**Do you have any concerns about your child's development?** ☐ yes ☐ no If yes, please explain:
	Is your child up-to-date on immunizations? ☐ yes ☐ no	
Child's Dentist/Practice	**Date of last dental exam**	

Childcare Applicant's Only: Information to Help Us Care for Your Child

Please list fears your child has:	**Please describe your child's routines:**	**What behaviors does your child have that you would like us to know about**

Who do you currently use for child care?	**What is your primary reason for wanting to change?** ☐ Child was asked to leave ☐ Quality of care ☐ Need a different schedule ☐ Convenience ☐ Other:

FOR EXPECTANT FAMILIES

When is your due date?	**OB/GYN Name/Phone**	**Which is your preferred hospital?** ☐ Grace Hospital ☐ Caldwell Memorial ☐ Catawba Valley Medical Center ☐ Frye Regional Hospital ☐ Iredell Memorial Hospital ☐ Other _____ ☐ I am not sure
Has this pregnancy been diagnosed high risk? ☐ Yes ☐ No		
Who are your support partners?	**How do you plan to feed your newborn?** ☐ I plan to breastfeed ☐ I plan to bottle feed ☐ I plan to breast and bottle feed ☐ I haven't decided	**Date of first prenatal appointment** **Number of pregnancies _____** **Number of live births _____**

FAMILY RESOURCE SCALE					
To what extent are the following resources adequate for this family:	**Does not apply**	**Not at all Adequate**	**Seldom Adequate**	**Sometimes Adequate**	**Usually Adequate**
Food for 2 meals a day (CCR 10)	N/A	1	2	3	4
House or apartment (CCR 15)	N/A	1	2	3	4
Money to buy necessities (CCR 13)	N/A	1	2	3	4
Enough clothes for your family	N/A	1	2	3	4
Heat for your house or apartment	N/A	1	2	3	4
Indoor plumbing/water	N/A	1	2	3	4
Money to pay monthly bills (CCR 13)	N/A	1	2	3	4
Stable job for yourself or spouse// partner (CCR 6)	N/A	1	2	3	4
Medical care for your family (CCR 16, 19)	N/A	1	2	3	4
Public assistance (SSI, TANF, Medicaid) (CCR 14)	N/A	1	2	3	4
Dependable transportation (CCR 5)	N/A	1	2	3	4
Time to get enough sleep/rest	N/A	1	2	3	4
Furniture for your home or apartment	N/A	1	2	3	4
Time to be by yourself	N/A	1	2	3	4
Time for family to be together	N/A	1	2	3	4
Telephone or access to a phone	N/A	1	2	3	4
Child care/respite for your child(ren)	N/A	1	2	3	4
Money to buy special equipment/supplies for child(ren)	N/A	1	2	3	4
Dental care for your family	N/A	1	2	3	4
Someone to talk to	N/A	1	2	3	4
Toys for your child(ren)	N/A	1	2	3	4
Money to buy things for self	N/A	1	2	3	4
Money to save	N/A	1	2	3	4
Travel/vacation	N/A	1	2	3	4

HEALTHY LIFESTYLES					
To what degree do you feel you are in need of professional support in the following areas:	**Does not apply**	**Not at all Adequate**	**Seldom Adequate**	**Sometimes Adequate**	**Usually Adequate**
Support for healthy lifestyles (e.g., tobacco use, alcohol or substance abuse)	N/A	1	2	3	4
Emotional/psychological support	N/A	1	2	3	4
Prenatal support	N/A	1	2	3	4
Nutrition	N/A	1	2	3	4

CHILD STRENGTHS/NEEDS ASSESSMENT					
Routine health care	N/A	1	2	3	4
Immunizations	N/A	1	2	3	4
Specialized health care	N/A	1	2	3	4
Equipment	N/A	1	2	3	4
Special formula/diet	N/A	1	2	3	4
Understanding of child's condition	N/A	1	2	3	4
Understanding of child development	N/A	1	2	3	4
Therapies	N/A	1	2	3	4
Preschool/early intervention	N/A	1	2	3	4
Parent/child interactions	N/A	1	2	3	4

CHILD SAFETY					
Does your child use a car seat?	N/A	1	2	3	4
Do you have covers for your electrical outlets?	N/A	1	2	3	4
Do you have safety gates to protect your child from stairs or other hazards in your home?	N/A	1	2	3	4
Do you have a place to keep cleaning supplies away from your child?	N/A	1	2	3	4
Do you have a plan for what to do if your child eats or drinks something poisonous?	N/A	1	2	3	4
Do you keep small toys and objects that your child could choke on out of your child's reach?	N/A	1	2	3	4
Do you have a working smoke detector in your home?	N/A	1	2	3	4
Do you have a working carbon monoxide detector in your home?	N/A	1	2	3	4

❒ I have provided complete and accurate information to the best of my knowledge.

_____ _____

Parent Signature Date

FOR OFFICIAL USE ONLY

Child is Eligible for the Following Programs	Other Services Child/Family Receives
❒ Early Head Start Center-Based	❒ Infant Toddler Program (Part C)
❒ Early Head Start Home-Based	❒ Special Care Nursery
❒ Prenatal Supports	❒ Catawba Valley Healthy Families
	❒ Child Care program
	❒ Pregnancy Care Center
	❒ Other _____