# BOSSIER PARISH HEAD START/EARLY HEAD START
# CHILD APPLICATION

**(Please Print)**

***Child's Name:***

_____ _____ _____
Last Name First Name Middle Name

Date of Birth _____/_____/_____ Social Security Number _____/_____/_____ [] Male [] Female

Race: Arabic__ Asian __ Black __ Hispanic ___ White ___ Other/Specify: _____
Preferred Language: English ___ Spanish ____ Other/Specify: _____

Head Start Returnee: [] Yes [] No Have child been in Early Head Start: [] Yes [] No

***Mother/Female Guardian***

_____ _____ _____ Age ____
Last Name First Name Initial

Home Address: _____ Phone: _____
City State
DOB: ____/____/____ Highest Grade Completed _____ Email: _____

Employer: _____ Phone: _____

Relationship to child: [] Mother []Grandmother []Foster Parent []Other_____

***Father/Male Guardian***

_____ _____ _____ Age ____
Last Name First Name Initial

Home Address: _____ Phone: _____
City State
DOB: ____/____/____ Highest Grade Completed _____ Email: _____

Employer: _____ Phone: _____

Relationship to child: []Father []Grandfather [] Foster Parent [] Other_____

***Marital Status of Parents***: [] Single [] Married [] Divorced []Widow [] Other

Contact Person: _____ Home/Cell #_____

Parent/Guardian ***(Print Name)*** _____ Date: _____

Parent/Guardian Signature_____ Staff Signature_____

**Revised 2025**

**CHECK TYPE OF SERVICES THAT FAMILY IS CURRENTLY RECEIVING:**

[] FITAP []Food Stamps []WIC []Medicaid []SSI []Pension []Unemployment []Insurance
Medical ____
Dental ____

[] Housing __Rent __Own Homeless is defined as: __Living with other people(family/friends)
__Residing at a Homeless Shelter
__Living in a Hotel/Car

Are you or anyone in your household pregnant? []Yes []No

If so, are you/she currently receiving pre-natal care or services? []Yes []No

Does your child have any identified health conditions? []Yes []No If so specify:_____

Has the health condition been diagnosed by a physician? []Yes []No

Does your child receive disability services from a Public School System or any other Community Agency? []Yes []No If so specify: _____

Has family been referred for services from a Community Agency? []Yes []No
If so specify: _____

Are you or any family member experiencing any problems or unusual circumstances at this time?
[]Yes []No Please describe: _____

## OFFICE USE ONLY

**COMMENTS**: _____

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**If it is determined that false information was provided in an effort to benefit from Head Start services, the child/family would receive automatic dismissal from the program.**