

GSRP: _____

TITLE I: _____

OTHER: _____

DETROIT PUBLIC SCHOOLS
FOUNDATION FOR EARLY LEARNERS

PREKINDERGARTEN PROGRAMS

FOR OFFICE USE ONLY:
 SCHOOL: _____
 TEACHER: _____ ROOM #: _____
 STUDENT ID#: _____ CHILD'S AGE AS OF 9/1: _____

DATE OF APPLICATION: _____

DATE OF ENROLLMENT: _____
(First actual date of attendance)

DATE DROPPED: _____

CHILD APPLICATION FORM

PARENTS / GUARDIANS COMPLETE THIS SECTION

CHILD'S NAME: _____ BIRTHDATE: _____ SEX: F M

CHILD'S ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE NUMBER: _____ ALTERNATE PHONE NUMBER: _____

BIRTH CERTIFICATE #: _____ BIRTHPLACE (city, state or nation): _____

Special Needs/Disabling Condition: _____ Diagnosed: Yes No IEP Date: _____ MET Date: _____
If Special Needs/Disabling Condition has been diagnosed by an Agency/Physician, complete Release of Information Form

Parent/Guardian Name: _____ Relationship to Child: _____

Mother's Age at 1st Pregnancy: _____ Marital Status: Single Married Separated

Ethnic Group: _____ (please use code from the chart below)

- | | |
|---------------------------|---------------------------------------------------|
| 1= Native American | 2a= Asian <i>or</i> 2b= Pacific Islander |
| 3= Black/African American | 4a= Hispanic, White <i>or</i> 4b= Hispanic, Black |
| | 5= White/Caucasian |

List ALL household members for whom the child's parent is financially responsible:

NAME	BIRTHDATE	NAME	BIRTHDATE

Is your child's native language a language **other than** English? Yes No What is the language? _____

Is the primary language used in your child's home a language other than English? Yes No

If yes, what is the language? _____

My child is (check all that apply): Anemic Lead Poisoned

I receive (check all that apply): Food Assistance WIC Focus Hope Medicaid Child Care Assistance

PARENTS / GUARDIANS COMPLETE THIS SECTION

IF NOT PARENT, PROOF OF GUARDIANSHIP CASE#: _____

	FATHER	MOTHER	Foster Parent(s)/Stepparent(s) or Guardian(s) /Relationship
Name:			
Birthdate:			
Birthplace: <i>city, state or nation</i>			
Home Language:			
Date Naturalized:			
Last Grade or Degree Completed:			
Occupation:			
Home Address:			
Home Phone:			
Cell Phone:			
Business Address: <i>(Street Address, City, Zip Code)</i>			
Business Phone:			
Employer:			
Work/School Schedule: <i>(Days and Times)</i>			

STAFF COMPLETE THIS SECTION

Indicate date documentation received:

Birth Certificate: _____

Income: _____

Immunizations: _____

Health Appraisal: _____

Has the family been informed of Head Start Eligibility? Yes No

Has the family completed an Early Childhood Programs Referral? Yes No

Date child entered the United States (if birth documents are from a foreign country): _____

RISK FACTORS: CHECK <u>ALL</u> THAT APPLY	DOCUMENTATION:
1. Low family income	
2. Diagnosed disability or identified developmental delay	
3. Severe or challenging behavior	
4. Primary home language other than English	
5. Parent(s) with low educational attainment	
6. Abuse/neglect of child or parent	
7. Environmental risk	

ATTACH INCOME VERIFICATION FORM

Type of MEDICAID Insurance: _____ Case #: _____ Child's Recipient ID#: _____

OTHER Medical Insurance: (Type): _____ Claim Number: _____

The above information is true and correct to the best of my knowledge. I understand that if any of this information changes, or is found to be incorrect, I am obligated to immediately notify this program. I understand that the above information and all information contained in the child's folder will remain **CONFIDENTIAL**. I hereby make application for my child and myself to be enrolled in a Detroit Public School Preschool Program based on all the information on the Child Application Form.

Signature of Parent/Guardian Date

Signature of Staff Verifying and Auditing Form Date

Signature of Teacher Date