Prairie Five Head Start

PO Box 166 ● 422 5th Avenue ● Madison, MN 56256

Phone: 320-598-3118 ● Fax: 320-598-3025

An Equal Opportunity Program

Collaborative Preschool Application

Applicant (child applying for services)				
1st choice center location _____ 2nd choice: _____				
First Name	Middle	Last Name	Birthday	Gender
			/ /	□M □F

Hispanic/Latino	Race	Primary Language
□Yes □No	□White □American Indian □Asian □Black/African American □Multi/Bi-racial □Native Hawaiian/Other Pacific Islander	□English □Spanish □Chuukese □Other

Child's Custody Status
□Both Parents   □Mother Only   □Father Only   □Parent Appointed Guardianship   □Foster Care
□Court Ordered Guardianship/Department of Human Services   □Other _____

Parent/Guardian 1 (Primary) Lives with family? □Yes □No		
First Name	Middle	Last Name

Birthday	Gender	Marital Status	Hispanic/Latino
/ /	□M □F	□Married □Single □Divorced □Separated	□Yes □No

Race	Highest Grade Completed
□White □American Indian □Asian □Black/African American □Multi/Bi-racial □Native Hawaiian/Other Pacific Islander	□High School Graduate □GED □Grade 9 of less □Grade 10 □Grade 11 □No Education □Associate's □Bachelor's □Master's

Current Employment Status	Currently Enrolled In School	Relationship To Child
□Full-time □Part-time □Seasonal □Unemployed □Retired/Disabled	□Yes □No	□Parent □Grandparent □Foster Parent □Aunt/Uncle □Other:_____

Parent/Guardian 2 (Secondary) Lives with family? □Yes □No		
First Name	Middle	Last Name

Birthday	Gender	Marital Status	Hispanic/Latino
/ /	□M □F	□Married □Single □Divorced □Separated	□Yes □No

Race	Highest Grade Completed
□White □American Indian □Asian □Black/African American □Multi/Bi-racial □Native Hawaiian/Other Pacific Islander	□High School Graduate □GED □Grade 9 of less □Grade 10 □Grade 11 □No Education □Associate's □Bachelor's □Master's

Current Employment Status	Currently Enrolled In School	Relationship To Child
□Full-time □Part-time □Seasonal □Unemployed □Retired/Disabled	□Yes □No	□Parent □Grandparent □Foster Parent □Aunt/Uncle □Other:_____

ADDITIONAL Family & Household Members Living With Child (Do Not List Applicant, Parent 1 & Parent 2)						
First & Last Name	Birthday	Social Security (REQUIRED)	Gender	Race	Hispanic	Relationship To Child
	/ /		□M □F		□Yes □No	
	/ /		□M □F		□Yes □No	
	/ /		□M □F		□Yes □No	
	/ /		□M □F		□Yes □No	
	/ /		□M □F		□Yes □No	
	/ /		□M □F		□Yes □No	

Family Information					
Living Address		**Apt or Lot #**	**City**	**State**	**Zip**
Mailing Address (If Different Than Living)		**Apt or Lot #**	**City**	**State**	**Zip**

Primary Adult	Cell _____-_____-_____ Home_____-_____-_____Work_____-_____-_____
Secondary Adult	Cell _____-_____-_____ Home_____-_____-_____Work_____-_____-_____

Health & Wellness			
Child's Primary Medical Home Clinic Name	**Clinic Phone Number**	**Child's Primary Dental Home Dental Office Name**	**Dental Office Phone Number**

Does your child have any allergies to food or medications?

If yes, please list: _____
_____
_____

Are you concerned about celebrating any holidays due to religious or ethnic beliefs?
_____
_____
_____

In Case Of An Emergency List Two Local Contacts In The Area If Parents Are Not Available. Must List Two People Who Are Not Child's Parents				
	Name	**Address**	**Phone Number**	**Relation To Child**
Contact #1				
Contact #2				

To the best of my knowledge the information I have given is accurate and true.

_____   _____
(Parent/Guardian Signature)   (Date)

_____   _____
(Staff Signature)   (Date)

Authorization

An Equal Opportunity Program

Collaborative Prairie Five Head Start Program

I give permission to have my child (child's name):_____

_____ Have pictures and videos taken and published while in the program such as local newspapers, newsletters, and other community events during the program year.

_____ Go on field trips with the class.

_____ Participate in classroom observations with a mental health professional.

_____ Receive first aid and/or CPR by certified personnel if needed.

_____ To be taken by a Collaborative/Head Start personnel for emergency medical or dental treatment when his/her parents or guardians cannot by contacted and will be taken to nearest local hospital or dentist. (911 will be used)

This permission is granted only for the child's current enrollment year in the Head Start program and will need to be signed yearly

Parent/Guardian Signature: _____ Date: _____

Signature Witness: _____