Lincoln Public Schools
5901 O Street
Lincoln, NE 68510

Lincoln Public Schools
Early Childhood Program

For children ages 3 or 4 on or before October 15, 2009

Referred by _____

Child's First Name:	Child's Last Name:
Date of birth:	Sex: ☐ Male ☐ Female
Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Native American ☐ Multi-Racial	
Do you speak English? ☐ Yes ☐ No Do you need a translator? ☐ Yes ☐ No	Primary Home Language
Does child receive Medicaid? ☐ Yes ☐ No	Medicaid # Plan
Other Health Insurance?	Dental Insurance?
Parent/Guardian Name(s):	
Address	Zip Code
Home Phone: / Cell Phone:	Work Phone: / Email:
Child lives with: ☐ Mother ☐ Father ☐ Foster Parent ☐ Other If other, relationship to child _____	
Number in family: / Number of children:	Number in household:

Which program option would you prefer?

☐ **Home Base** Children and families receive services through weekly home visits and participation in group socialization activities.

☐ **Center Base** Children attend half-day center experiences four or five days per week.

☐ **Full Day/Full Year** This Head Start program option is only offered by Lincoln Action Program. If you are interested in this program, your child's application will be shared with their center director. For more information, please call their center at 471-7474.

Is your child in child care? ☐ Yes ☐ No

If yes, what days and hours does your child attend? _____

Child care center/provider name:

How will your child get to the program? ☐ Parent ☐ School Bus ☐ Other

If by bus, what is the pick-up address:

What is the drop-off address:

Family Member Information

Please list all adults living in the household

First & Last Name	Date of Birth	Sex	Last grade completed	Working part time or full time, student full time or part time, unemployed:	Relationship to child
		M F			
		M F			
		M F			

Please list all children living in the household

First & Last Name	Date of Birth	Sex	If attending school, what grade & where?	Relationship to child
		M F		
		M F		
		M F		
		M F		
		M F		
		M F		
		M F		

Emergency Contacts

Name	Address	Phone	Relationship to child

Lincoln Public Schools is a Head Start Delegate Agency of Lincoln Action Program

ACTION

 Child's Name _____

The following information helps the program staff better understand the needs of your family. All information is **confidential** and is not shared outside of Lincoln Public Schools.	YES	NO
Do you have a concern about your child's development? If yes, describe your concern:	☐	☐
Is your child currently receiving Early Childhood Special Education Services?	☐	☐
Was your child born more than three weeks early?	☐	☐
Did your child weigh less than 5 pounds at birth? If yes, birth weight _____lb. _____oz.	☐	☐
Has your child had four or more ear infections during the past year?	☐	☐
Does your child have any of the following health concerns? (If so, please check) ☐ Asthma ☐ Heart Problems ☐ Kidney Problems ☐ Diabetes ☐ Weight Problems ☐ Cancer ☐ Epilepsy or Seizures ☐ Vision ☐ Other	☐	☐
Is there any food your child cannot eat for medical or religious reasons? What?_____ Reason _____	☐	☐
Is your child on a special diet? What kind? _____ Reason _____	☐	☐
Have you or a family member identified a need or been involved in counseling in any of the following areas: (If so, please check) ☐ Child Abuse/Neglect ☐ Sexual Abuse ☐ Alcohol/Drug Issues ☐ Anger Control ☐ Domestic Violence ☐ Parenting Needs ☐ Other_____	☐	☐
Has your family had an open case with Child Protective Services in the past three years?	☐	☐
Is there an immediate family member currently incarcerated or involved with the legal system?	☐	☐
Does either parent need to complete their high school education?	☐	☐
Does either parent need to learn to speak English?	☐	☐
Do you have an immediate family member with a life threatening disease or serious chronic illness? (ex. Cancer, diabetes, tuberculosis)	☐	☐
Do you have an immediate family member with a mental or emotional disability?	☐	☐
Have you been divorced or separated from your spouse or significant other within the last year?	☐	☐
Has there been a death in the immediate family? If yes, how was the person related to the child?	☐	☐
Do you have dependable transportation for your daily needs?	☐	☐
Are you an immigrant or refugee in the last 5 years? If so, from where? _____	☐	☐
Does your family have enough food to meet your daily needs?	☐	☐
Is the parent/guardian currently deployed with the military?	☐	☐
Income verification submitted: ☐Income Tax Return ☐W-2 ☐Check stub ☐Other	☐	☐
Do you receive any of the following type of assistance? ☐TANF/ADC ☐SSI Caseworkers name: _____	☐	☐
Are you currently homeless or have you been homeless in the last year? Homeless is defined for our program purposes as living in a shelter, on the street, or temporarily staying in a residence not your own.	☐	☐
If there is anything else you would like to tell us about your family, please write your comments here.		

I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence with the agency and will be accessible to me during business hours.

Parent Signature _____Date _____