Lincoln Public Schools
PO Box 82889
Lincoln, NE 68501

Lincoln Public Schools
Early Childhood Program

For children age 3 or 4 on or before October 15, 2011

Office Use Only
___ Birth Certificate
___Immunizations
___Income Verification

Referred by _____

Child's First Name:	**Child's Last Name:**
Date of birth:	**Sex:** ☐ Male ☐ Female

Ethnicity/Race: Is this child Hispanic/Latino? ☐ Yes ☐ No
What is the child's race: (Choose one or more)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

Do you speak English? ☐ Yes ☐ No **Do you need a translator?** ☐ Yes ☐ No	**Primary Home Language**
Does child receive Medicaid? ☐ Yes ☐ No	**Medicaid #**
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(s) 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 in a classroom.
☐**Full Day/Full Year** **This Head Start program option is only offered by Community Action Partnership Lancaster and Saunders Counties.** See cover sheet for detailed information about this option.

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
Community Action Partnership Lancaster and Saunders Counties

Helping People. Changing Lives. Community Action PARTNERSHIP LANCASTER AND SAUNDERS COUNTIES

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? (If so, please check) ☐ Asthma ☐ Heart Problems ☐ Kidney Problems ☐ Other ☐ Diabetes ☐ Weight Problems ☐ Cancer ☐ Vision ☐ Epilepsy or Seizures ☐ Skin markings, ie: birth marks, scars, Mongolian spots	☐	☐
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 document(s) submitted: ☐Income Tax Return ☐W-2 ☐Check stub ☐Other		
Do you receive any of the following type of assistance? If yes, verification is required. ☐TANF/ADC ☐SSI Caseworkers name: _____	☐	☐
I have included all income in the verification document(s) I have provided to the Lincoln Public Schools ExCITE/Head Start Program. (If you answer no, you must complete an Income Verification Worksheet which will be provided on request.)	☐	☐
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 _____