Sabine Parish Ready Start Network
Coordinated Enrollment Application 2024 – 2025

REGISTRATION DATE: _____ Enrollment Date: _____

Child's First Name: _____Child's Last Name: _____
Middle Name: _____ Date of Birth_____

Social Security #_____ Gender: ___ Male ___ Female

Primary Language in the Home: _____ English _____ Other (please specify)

Ethnicity: ___White ___ Black/African American ___ Asian ___ Hispanic/Latino
___ American Indian ___ Native Hawaiian/Pacific Islander ___ Other

Physical Address_____
City_____ State: Louisiana Zip_____
Mailing Address: _____
Home Phone #_____ Cell #: _____

TRANSPORTATION: ___ Parent will bring ___ Ride Bus
Head Start Bus_____Bus Number 1_____ Bus Number 2 _____

My child has my permission to ride the bus to and from school_____
(Parent Signature)

COORDINATED ELIGIBILITY DETERMINATION:
___ SPSB UNIVERSAL PRESCHOOL ___ DAYCARE ___ BOTH

RECEIVED COPY OF:
___Child's Birth Certificate
___ Social Security Card
___ Immunization Records
___ Med/Insurance Cards
___ Verification of Residency
___ Income Verification
___ Louisiana Driver's License(parent/guardian)

ELIGIBILITY
___ Head Start
___ LA-4
___ 8G
___ Local

Faithlyn's Learning Academy
Birth – Age 6
___ CCAP
___ CCAP B-3
___ Full Day
___ After School

CERTIFICATION: I certify that this information is true. If any part is false, my participation in this agency's program may be jeopardized. I also understand the information in this application will be held in strict confidence with the Sabine Parish School Board. My signature below is in agreement that any person listed on the emergency list has my permission to receive my child from the bus or from school.

Parent/Guardian Signature:_____ Date_____

Person with whom the child lives:_____

MOTHER:

Last Name: _____ First Name:_____

Street Address:_____ City:_____Louisiana Zip_____

HOME PHONE: _____ Cell Phone:_____ Work #:_____

FATHER:

Last Name: _____ First Name:_____

Street Address:_____ City:_____Louisiana Zip_____

HOME PHONE: _____ Cell Phone:_____ Work #:_____

GUARDIAN:

Last Name: _____ First Name:_____

Street Address:_____ City:_____Louisiana Zip_____

HOME PHONE: _____ Cell Phone:_____ Work #:_____

FAMILY & HOUSEHOLD INFORMATION:

Brothers & Sisters	Date of Birth	
1		
2		
3		
4		
5		
Other members:	Date of Birth	Relationship
1		
2		
3		

Does your child have any suspected or identified disabilities? If so, please list them below.

___ No, my child does not have a suspected or identified disability.

___ Yes, Identified Disability:_____

Suspected Disability:_____

Behavioral Needs/Mental Health:_____

Does your child have any food allergies? ___ Yes ___ No

Does your child have any other allergies? ___ Yes ___ No

Does your child have any dietary restrictions? ___ Yes ___ No

Does your child have any special needs or health concerns? ___ Yes ___ No

Please explain any "Yes" answer here

Child's Doctor:_____Phone #_____

Child's Dentist:_____Phone #_____

INDIVIDUALS TO CONTACT IN CASE OF AN EMERGENCY:

NAME:	RELATIONSHIP:	PHONE NUMBER:

My child has permission to be released to the following individuals, childcare facilities or transportation services in addition to emergency contact persons listed above. (Please notify the individuals on the list that they may be asked to show proof of identity)

NAME (FIRST AND LAST)	RELATIONSHIP

Is there a parent/guardian that MAY NOT pick up your child? ___ Yes ___ No *MUST have a court order

Consent for Child's Emergency Medical/Dental Treatment – Screenings & Examinations

I give my consent for the emergency of medical or dental treatment for my child by any licensed physician or dentist while under the care of the Sabine Parish School Board preschool programs and for transport of the child to and from the source of emergency treatment. I also give my consent for my child to receive screenings to identify concerns regarding a child's vision, hearing, developmental, behavioral, mental health, motor, language, social, cognitive and emotional needs or concerns.

Parent Signature:_____ Date:_____

HOUSEHOLD INFORMATION/ELIGIBILITY WORKSHEET

Primary Parent/Guardian:_____
Live with Child ___ Yes ___ No
Employed or in School: ___ Employed ___ In School ____ Neither Employed or in School
Place of Employment_____ (must have 2 consecutive check stubs)

Secondary Parent/Guardian:_____
Live with Child ___ Yes ___ No
Employed or in School: ___ Employed ___ In School ____ Neither Employed or in School
Place of Employment_____ (must have 2 consecutive check stubs, if you live in the same household with the child)

Number of adults in the household contributing to income ____

Family Type:
___ 2 parent family
___ Single parent family
___ Foster Family
___ Other family type: Specify _____

Number of adults in family: _____ Number of children: _____

Income verified by:
____ 2 consecutive check stubs
How often do you receive pay:
___ Weekly ___ Twice a month ____ Every 2 weeks ___ Monthly
Yearly Gross income: $_____
____ An official letter from employer
____ SNAP/TANF (must include child's name and valid effective dates)
____ SSI benefits
____ Declaration of Income for Irregular Employment
____ Zero Income
____ Current foster care placement agreement from DCFS
____ Families in a temporary living arrangement due to loss of house or economic hardship
____ Other (Current year income tax documentation W2/Tax documentation)