ABORIGINAL HEAD START REGISTRATION APPLICATION

DATE OF APPLICATION: ____

1. CHILD INFORMATION

Last Name: ________________ **First Name:** __________________ **Middle Name:** ______________________

Gender: □ M □ F Date of Birth: _____________________

First Nation/Band: _________________________________

Language spoken in the home: First: ______________________ Second: _____________________________

2. OTHER SERVICES

Has your child received services from any of the following:

□ Early Childhood Intervention Program (ECIP) □ Speech and Language Pathologist

□ Occupational Therapist □ Early Childhood Psychologist □ ICFS □ Other Services

Medical Information

Does your child have any medical conditions: □ Yes □ No If yes, please explain.

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Other information that should be known about the child?

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3. PARENT/GUARDIAN INFORMATION

Parent/Guardian Last Name: ___________________________ First Name: ___________________________

Phone: ____________________________________ Cell: __________________________________

Parent/Guardian Last Name: _________________________ First Name: ___________________________

Phone: ____ Cell: _________________________________