

**Sabine Parish Ready Start Network  
Coordinated Enrollment Application 2023 - 2024**

REGISTRATION DATE: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

Child's First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's Social Security # \_\_\_\_\_ Gender: ☐ Male ☐ Female

Primary Language in the Home: \_\_\_\_\_

Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino  
☐ American Indian ☐ Native Hawaiian or other Pacific Islander \_\_\_\_\_ Other

Parent's Email Address: \_\_\_\_\_

Physical Address \_\_\_\_\_

City \_\_\_\_\_ State: Louisiana Zip \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell #: \_\_\_\_\_

TRANSPORTATION: ☐ Parent will bring ☐ Ride Bus

My child has my permission to ride the bus to and from school \_\_\_\_\_

(Parent Signature)

<b>COORDINATED ELIGIBILITY DETERMINATION:</b> <input type="checkbox"/> SPSB Universal Preschool		
<input type="checkbox"/> Faithlynn's Learning Academy	<input type="checkbox"/> Sarah Little, Family Child Care Provider	
<b>RECEIVED COPY OF:</b>		
<input type="checkbox"/> Child's Birth Certificate	<b>ELIGIBILITY</b>	<b>Faithlyn's Learning Academy Birth – Age 6</b>  <input type="checkbox"/> CCAP <input type="checkbox"/> After School <input type="checkbox"/> Local
<input type="checkbox"/> Social Security Card	<input type="checkbox"/> Head Start	
<input type="checkbox"/> Immunization Records	<input type="checkbox"/> LA-4	
<input type="checkbox"/> Med/Insurance Cards	<input type="checkbox"/> 8G	
<input type="checkbox"/> Verification of Residency	<input type="checkbox"/> Local	
<input type="checkbox"/> Income Verification	<input type="checkbox"/> B-3	
<input type="checkbox"/> Louisiana Driver's License(parent/guardian)		

**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, Sabine Parish Early Childhood Community Network and/or Sabine Ready Start Network. 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:**

<b>NAME:</b>	<b>RELATIONSHIP:</b>	<b>PHONE NUMBER:</b>

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 that they may be asked to show proof of identity)

<b>NAME (FIRST AND LAST)</b>	<b>RELATIONSHIP</b>

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 program, Sabine Parish Early Childhood Community Network and/or Sabine Ready Start Network 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:** \_\_\_\_\_

Parent DOB: \_\_\_\_\_ 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:** \_\_\_\_\_

Parent DOB: \_\_\_\_\_ 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)

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: \$ \_\_\_\_\_ Number of adults contributing to 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)

☐ Hire Account/Actively Seeking Employment

☐ Unemployment Benefits