



33 Fulton Street
Montclair, NJ 07042
Office (973) 783-0220
Fax (973) 783-3040
mcdcnj.org

Ronald Murphy
Chairperson
Tanya L. Poteat
Executive Director

Pre-Registration Form for Head Start & Early Head Start

Application Date _____ Program (check one): Head Start Early Head Start
Child's Name _____ Date of Birth _____

Things to Bring with You for Registration

1. Proof of Income: W2 Forms, Tax Return, TANF / SSI Print Out, Unemployment Award letter
2. Your Child's Immunization Record
3. Current Proof of Residency (3): Phone bill, Cable bill, PSE&G bill, Lease, Notarized Letter from Landlord (*originals only*)
4. Your Child's Birth Certificate
5. Your Child's Social Security Card
6. Medicaid Card & HMO Card or Insurance Card

Head Start & Early Head Start

Child's Information

Child's Last Name _____ First _____ Middle Initial ____
Female _____ Male _____ Child's Social Security No. _____
Address _____
Telephone No. _____
Date of Birth _____ Place of Birth (City & State) _____

Ethnicity

Hispanic or Latino origin _____ Non-Hispanic or Non-Latino origin _____

Race

American Indian or Alaska Native _____ Asian _____ Black or African American _____
Native Hawaiian or other Pacific Islander _____ White _____ Bi-racial / Multi-racial _____
Other _____ Explain _____

Primary Language of Family at Home

English _____ Spanish _____ Native Central American, South _____
American and Mexican Languages _____ Middle Eastern & South Asian Languages _____
East Asian Languages _____ Pacific Island Languages _____ European & Slavic Languages _____
African Languages _____ Other _____

Family Information

Marital Status of Parent (s)

Single _____ Divorced _____ Separated _____
Widowed _____ Married _____ Other _____

Mother's / Guardian's Information

First Name _____ Last Name _____
Address _____
Home Telephone No. _____ Cell No. _____
Social Security No. _____ Are you an Expectant Mother? Yes _____ No _____
Employer's Name _____
Occupation _____ Business Telephone No. _____

Ethnicity

Hispanic or Latino origin _____ Non-Hispanic or Non-Latino origin _____

Race

American Indian or Alaska Native _____ Asian _____ Black or African American _____
Native Hawaiian or other Pacific Islander _____ White _____ Bi-racial / Multi-racial _____
Other _____ Explain _____

Father's / Guardian's Information

First Name _____ Last Name _____
Address _____
Home Telephone No. _____ Cell No. _____
Social Security No. _____
Employer's Name _____
Occupation _____ Business Telephone No. _____

Ethnicity

Hispanic or Latino origin _____ Non-Hispanic or Non-Latino origin _____

Race

American Indian or Alaska Native _____ Asian _____ Black or African American _____
Native Hawaiian or other Pacific Islander _____ White _____ Bi-racial / Multi-racial _____
Other _____ Explain _____

Head of Household

Father _____ Mother _____ Other _____ (Relationship) _____
Do you currently have a child / children in the program? Yes _____ No _____
Total No. of Adults Residing In Household _____ No. of Children _____

Siblings Living in the Home

Name _____	Male _____	Female _____	Age _____	D.O.B _____
Name _____	Male _____	Female _____	Age _____	D.O.B _____
Name _____	Male _____	Female _____	Age _____	D.O.B _____

Related Residents Residing in Home Over the Age of 18

Name _____ Male _____ Female _____ Age _____ Relationship with Child _____
Name _____ Male _____ Female _____ Age _____ Relationship with Child _____
Name _____ Male _____ Female _____ Age _____ Relationship with Child _____

Is There Anyone in the Home, Including the Child, with Disabilities? No _____ Yes _____

If yes, please explain _____

Name _____ Relationship _____

Has your child received speech, occupational, or physical therapy, within the last 12 months? _____

If yes approximately, When? _____

Name of person receiving services _____

Relationship to Child _____

Where? _____

What type of testing? _____

If parent cannot be reached, please contact the following person who has agreed to accept the responsibility of my child in case of an emergency

First Name _____ Last Name _____

Relationship to child: Relative _____ Friend _____ Neighbor _____

Address _____

Home Telephone No. _____ Cell No. _____

Escort Arrangement

(Person responsible for taking child to and from school, 16 years of age and over)

First Name _____ Last Name _____

Relationship to child

Relative _____ Friend _____ Neighbor _____

Address _____

Home Telephone No. _____ Cell No. _____

Statement

I have completed the Pre- Registration Form accurately and truthfully with full knowledge that Head Start / Early Head Start is an anti-poverty program. I believe our family income and / or the needs of my child make us eligible for the program under guidelines of the U.S. Department of Health and Human Services Office of Administration Children and Family.

Signature of Parent/Guardian

Registration Date

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.