



Sheltering Arms 2020 Application for Enrollment

Date: _____ Center Preference (may list up to 3): _____

Parent/Guardian Name: _____ Email Address: _____

Address: _____ City _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent/Guardian Name: _____ Email Address: _____

Address: _____ City _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

CHILD(REN) *(List only those for whom you are applying):*

Name: _____ Male Female Date of Birth _____

Name: _____ Male Female Date of Birth _____

Name: _____ Male Female Date of Birth _____

Child(ren) Lives With: Both Parents Mother Father Grandparent(s) Other Guardian(s): _____

Enrollment Status: New Currently Enrolled Sibling Enrolled Transitioning out of EHS Preschool to PreK

Nutrition/Health:

Does your child have any of the following health/nutrition concerns? *(Please indicate which child if you are applying for more than one.)*

- Food Allergies (Please list: _____) Epipen ___ Yes ___ No
- Dietary Restrictions (Please list: _____)
- Other Allergies (Please list: _____) Epipen ___ Yes ___ No
- Asthma
- Seizures
- Diabetes
- Other health concern (Please specify: _____)

Special Needs:

Has your child been diagnosed with or are you concerned about any of the following?

- Speech/Language Delay
- Visual Impairment
- Orthopedic Impairment
- Hearing Impairment
- Autism
- Developmental Delay
- Emotional/Behavioral Concern
- Other (Please specify: _____)

Provider:

- Babies Can't Wait
- School System/LEA
(District: _____)
- Private Provider
(Name: _____)

Status:

- Current IFSP or IEP
- Referral or transition in process
- Need help with referral

STAFF SIGNATURE

DATE

PARENT / GUARDIAN SIGNATURE

DATE

Completed: In Person Phone Online