Sheltering Arms

2021 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 (Circle One) Date of Birth _____

Name: _____ ☐ ☐ Male/Female (Circle One) Date of Birth _____

Name: _____ ☐ ☐ Male/Female (Circle One) 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 Pre-K

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:

Does your child have any of the following concerns? (*Please indicate if the concern is diagnosed or suspected.*)

DIAGNOSED	*PARENT CONCERN*	
☐	☐	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 ☐Virtually