



Special Start For Exceptional Children

Initial Application for Preschool Enrollment (ages 0-5 years only)

All fields must be filled out completely in order to process registration.

CHILD'S INFORMATION				
CHILD'S FIRST NAME	LAST	MIDDLE	GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male	BIRTH DATE
Physical Address		City		Zip
Mailing Address (if different)		City		Zip
Primary Phone		Cell Phone		E-mail Address

Does child have a current IEP/IFSP from the school district? Yes No District _____

FAMILY MEMBER INFORMATION				
PARENT/GUARDIAN NAMES				
FIRST	LAST	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Guardian
FIRST	LAST	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Guardian
Address			Address	
Employer			Employer	
Employer Phone			Employer Phone	
Family Type <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parents			Do all Parents/Guardians above have Legal Custody of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please be specific: _____	
Primary Language spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> Tagalog <input type="checkbox"/> Other _____				

OTHER CHILDREN LIVING IN THE HOME	BIRTH DATE	RELATIONSHIP	
			<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Male <input type="checkbox"/> Female

What expectations do you have for your child this year?

What are your child's greatest strengths and weaknesses?

Strengths:

Weaknesses:

Referring Agency _____ Contact Name _____ Phone _____