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CHILD INFORMATION - All information will be held confidential

Child's Name:	Date of Birth (DOB):	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Primary Language:
Address:	City:	State:	Zip:
Is your child enrolled in any other preschool? <input type="checkbox"/> Y <input type="checkbox"/> N	Edina School District (ISD 273) Resident: <input type="checkbox"/> Y <input type="checkbox"/> N		Sibling care needed? <input type="checkbox"/> Y <input type="checkbox"/> N
Racial Background: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black, not of Hispanic Origin <input type="checkbox"/> Hispanic <input type="checkbox"/> White, not of Hispanic origin			

ADDITIONAL CHILDREN IN HOUSEHOLD:

Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:

HOUSEHOLD SIZE: Number of Children _____ + Number of Parent/Guardians _____ + Other household members _____ = Total Family Size _____

PARENT/GUARDIAN INFORMATION

ADULT 1:	First name:	Last name:	Relationship:	Living with child: <input type="checkbox"/> Y <input type="checkbox"/> N
	Occupation:	Email:	Home Phone:	Cell Phone:
ADULT 2:	First name:	Last name:	Relationship:	Living with child: <input type="checkbox"/> Y <input type="checkbox"/> N
	Occupation:	Email:	Home Phone:	Cell Phone:
ADULT 3:	First name:	Last name:	Relationship:	Living with child: <input type="checkbox"/> Y <input type="checkbox"/> N
	Occupation:	Email:	Home Phone:	Cell Phone:

HOUSEHOLD INCOME INFORMATION - Write in each income and how often it is received: weekly, bi-weekly, twice per month, monthly, or yearly.

	Gross Annual Income before deductions	Public Assistance, Child Support, Alimony, Unemployment	Pension, Social Security, Retirement, Permanent Disability	Other income, including net self-employment	TOTAL
ADULT 1	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____
ADULT 2	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____
ADULT 3	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____
				TOTAL YEARLY INCOME:	\$ _____

Do you receive/qualify for: SNAP CCAP FRLP MFIP State Scholarship

CONTINUES ON REVERSE →

OFFICE USE ONLY	Class #:	Start Date:	<input type="checkbox"/> Monthly <input type="checkbox"/> Semester
	TOTAL FINANCIAL AID: \$	TOTAL BALANCE DUE: \$	MONTHLY/SEMESTER PAYMENT: \$
	ECFE AID: \$ _____ SR AID: \$ _____		

PARENT CHECKLIST ALL INFORMATION WILL BE HELD CONFIDENTIAL

FAMILY - PLEASE CHECK ALL THAT APPLY TO YOUR FAMILY SITUATION

<input type="checkbox"/> Y <input type="checkbox"/> N	Family does not speak English at home
<input type="checkbox"/> Y <input type="checkbox"/> N	Parent/guardian has no GED or high school diploma
<input type="checkbox"/> Y <input type="checkbox"/> N	Family has moved two or more times in the past year
<input type="checkbox"/> Y <input type="checkbox"/> N	Single-parent household
<input type="checkbox"/> Y <input type="checkbox"/> N	Parent has physical impairment (hearing, sight, etc...)
<input type="checkbox"/> Y <input type="checkbox"/> N	Older siblings who have had difficulty with school or are in special education
<input type="checkbox"/> Y <input type="checkbox"/> N	Family has experienced abuse, neglect or family violence
<input type="checkbox"/> Y <input type="checkbox"/> N	Family stress during past year (unemployment, divorce, death, incarcerations, etc...)
<input type="checkbox"/> Y <input type="checkbox"/> N	Mother below age 18 at birth of first child
<input type="checkbox"/> Y <input type="checkbox"/> N	Family qualifies for free or reduced lunch program and/or community services based on income



CHILD - PLEASE CHECK ALL THAT APPLY TO YOUR CHILD

<input type="checkbox"/> Y <input type="checkbox"/> N	Child has not had any previous preschool, nursery school or day care experience
<input type="checkbox"/> Y <input type="checkbox"/> N	Mild to moderate delays in speech emotional development or cognitive development skills
<input type="checkbox"/> Y <input type="checkbox"/> N	Child has physical, hearing or vision problems
<input type="checkbox"/> Y <input type="checkbox"/> N	Medical problems (frequent or chronic illness)
<input type="checkbox"/> Y <input type="checkbox"/> N	Child's behavior is a problem at home
<input type="checkbox"/> Y <input type="checkbox"/> N	Foster child or in "out-of-home" placement
<input type="checkbox"/> Y <input type="checkbox"/> N	Has completed early childhood developmental screening Location: _____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DEVELOPMENT? PLEASE DESCRIBE BELOW

I certify that all the information provided on this application is true and correct. Because state funds are used on the basis of this information, I understand that school and state officials may verify this information.

Printed Name: _____ Signature: _____ Date: _____

PLEASE RETURN TO:  **BY MAIL:** Edina Family Center | 5701 Normandale Road | Edina, MN 55424  **BY FAX:** 952-848-3951
For questions, please call 952-848-3908 or visit www.edinaschools.org/familycenter