Family Advocate: ___________________
Date: ___________________

Early Head Start Child Enrollment Information

Child: ___________________________ ___________________________ _____ **Sex:**_____ **DOB:** ___ / ___ / ___
(Last) (First) (MI) Mo Day Yr

Birth Mother: ___________________________ ___________________________ _____ **DOB:** ___ / ___ / ___
(Last) (First) (MI) Mo Day Yr

Birth Father: ___________________________ ___________________________ _____ **DOB:** ___ / ___ / ___
(Last) (First) (MI) Mo Day Yr

Child lives with (circle all that apply): Mother Father Grandparents Relatives Friends Other:____________

Ethnicity of Child (Please Circle): Hispanic/Latino Non-Hispanic/Non-Latino

Race of Child (Please Circle): American Indian Alaska Native Asian Black/African Amer.
Native Hawaiian Pacific Islander White Biracial/Multi-Racial Unspecified Other (specify)________________

Child's Health/Medical Coverage:

MA Number: ______________________ ***Private Insurance:*** __________________________
HMO (circle one): GHC Dean Unity None ***Group Number:*** ___________________________
Child's Social Security #: ________-_____-________ ***Employer:*** ________________________________

Where was the child delivered? ____ ____________________
Hospital City

Type of delivery: ☐ Vaginal ☐ C-Section **Child's birth weight:** _____ lbs. _____oz. **Length:** ______ in

Was child born? ☐ more than 2 months early ☐ 3 weeks to 2 months early ☐ on time ☐ more than 3 weeks late ☐ unsure

How long did child stay in hospital at birth? _____________________________
(*Include reasons for any non-routine stay:* ____)

Has this child returned to emergency room or office for any problems? ☐ Yes ☐ No

Name of child's physician: ____ ☐ No regular provider
Address of child's physician: ____ *Phone:* ____________________

Dates of child's check-ups: ___ / ___ / ___ ___ / ___ / ___ ___ / ___ / ___

Has this child started immunizations? ☐ Yes ☐ No *Location:* ______________________________

Does this child have any medical conditions or are they receiving services for any special needs? ☐ Yes ☐ No
If so, what: ____

Is this child taking any medication? ☐ Yes ☐ No

Does this child have any confirmed allergies? ____

Child's eating frequency (*times per day*): _______ **Amount consumed per feeding:** _______ oz.
Amount consumed in 24 hours: _______ oz.

Type of food consumed: ☐ Breast milk ☐ Formula ☐ Other (specify) ________________________________

White: Master File
Yellow: Family Advocate File