Head Start Registration Application

1. CHILD INFORMATION

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Gender: ☐ M ☐ F **Date of Birth:** _____

First Nation/Band: _____

Language spoken in the home: **First:** _____ **Second:** _____

2. OTHER SERVICES

Has your child received services from any of the following:

- ☐ Early Childhood Intervention Program (ECIP)
- ☐ Occupational Therapist
- ☐ ICFS
- ☐ Speech and Language Pathologist
- ☐ Early Childhood Psychologist
- ☐ Other Services

Medical Information

Does your child have any medical conditions: ☐ Yes ☐ No If yes, please explain.

_____

_____

Other information that should be known about the child?

_____

Does your child have any Allergies?

_____

3. PARENT/GUARDIAN INFORMATION

Parent/Guardian Last Name: _____ **First Name:** _____

Phone: _____ **Cell:** _____

Parent/Guardian Last Name: _____ **First Name:** _____

Phone: _____ **Cell:** _____

Your Privacy

Moosomin First Nation collects the information on this form to deliver to Health Services and Head Start to keep your child safe. Health and medical information is seen only by the staff who care for your child in this program. We will not share it outside Moosomin First Nation without your written consent, unless the law requires it or there is an emergency. We store your form securely and keep it only as long as the program needs it. You may ask to see or correct your information at any time. Read our full Privacy Policy at moosomin.ca or call (306) 386-2206.