



tel: 919.743.6140

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[www.safechildnc.org](http://www.safechildnc.org)

## PROGRAM REGISTRATION

### PERSONAL INFORMATION

Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	E-mail Address		

### CHILDREN

FIRST NAME	LAST NAME	DATE OF BIRTH	AGE	SEX

Your children are invited to attend a children's group while you participate in our parents program. They will be grouped according to ages and will engage in fun activities that build skills and increase their cooperative behavior. Please supply us with the following information so we may serve your children well. This information will be shared with the children's group leaders only. Thank you for your assistance.

Medications your child takes: \_\_\_\_\_

Does your child have and food allergies?  Yes  No  
If "Yes" , which foods? \_\_\_\_\_

Does your child have asthma?  Yes  No

Other special medical needs we should be aware of: \_\_\_\_\_

### PARENTING CONCERNS


### PROGRAMS

<input type="radio"/> PLUS (Parents: Learning, Understanding, Sharing)	<input type="radio"/> STRENGTHENING FAMILIES PROGRAM (3 – 5 Years Old)
<input type="radio"/> THE SPANISH NURTURING PROGRAM	Would you be interested in meeting on an advisory board that meets twice a year? <input type="radio"/> YES <input type="radio"/> NO
<input type="radio"/> THE NURTURING PROGRAM (4 – 12 Years Old)	
<input type="radio"/>	<input type="radio"/> WELCOME BABY

**MEANS OF TRANSPORTATION:**

SELF                       BUS LINE                       FRIEND                       RELATIVE

**EMERGENCY CONTACT PERSON**

<b>NAME</b>		<b>TELEPHONE NUMBER</b>	
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**PARENTAL PERMISSION**

Please sign the statement below if your child wears diapers and you give permission to a SAFEchild staff person or volunteer to change his/her diaper when needed.

I give my permission for my child's diaper to be changed by a SAFEchild staff person or volunteer.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

**FOR STATISTICAL PURPOSES ONLY**

**NOTE:** Please fill out this section so that we may serve you better and fulfill our grant requirements. Your name and information will NEVER be used without your permission. If you have any questions please contact the coordinator for the program in which you are enrolled.

Birthdate: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status:  Married       Separated       Divorced  
 Single       Widowed

Name of Spouse or Significant other: \_\_\_\_\_

Race:  White       African-American       Hispanic  
 Asian -American       Native-American       Bi-Racial

Education:  
(Please state highest grade completed)

Employment Status:  Full-time       Part-time       Other  
 Not Employed       Student

Did you Graduate High School? \_\_\_\_\_  
Did you complete a GED? \_\_\_\_\_

If employed, name of Employer: \_\_\_\_\_

\_\_\_\_\_  
Approximate Annual Income:

Disability:  Separated

Explain: \_\_\_\_\_

Divorced

<b>REFERRAL INFORMATION:</b>	
<b>AGENCY NAME</b>	
<b>ADDRESS</b>	
<b>PHONE</b>	
<b>EMAIL</b>	
<b>CONTACT PERSON</b>	