HCS Head Start, Inc.

EDUCATING children. SUPPORTING families. BUILDING healthy communities.

Your NAME

First Name _____ Last Name _____

Your RELATIONSHIP to the Child (Parent, Guardian, etc.)

_____

Name of CHILD

First Name _____ Last Name _____

Date of CHILD'S BIRTH

_____

Month - Day - Year

Your ADDRESS

_____

Street

_____

Apartment Number

_____ _____

City Zip Code

Your PHONE NUMBER **Your EMAIL ADDRESS**

( ) - _____ _____

Choose the PROGRAM you are interested in

☐ Early Head Start (prenatal to 2.9 years)

☐ Head Start (2.9 years to 5 years)

☐ Migrant/Seasonal Head Start (prenatal to 5 years)

MAIL YOUR COMPLETED FORM TO:
Head Start Family Center
130 Maple Street, Suite 204
Springfield, MA 01105

OR DROP IT OFF AT AN ENROLLMENT CENTER:
662 High Street, Holyoke, MA *or*
130 Maple Street, Suite 204, Springfield, MA

OR SEND IT VIA FAX:
413-455-2786