



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

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Choose the PROGRAM you are interested in

Early Head Start (prenatal to 2.9 years)

Head Start (2.9 years 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