



Bright Beginnings Recruitment/Enrollment Record

(This section for office use only)

School District _____ Date Entered _____

Parent Educator Name _____

Service Level 1 2 3 4 5 **Check box if change to current record:**

Child's name: _____ **Gender:** M/F **Phone:**(____) _____
(Complete name required) First Middle Last (circle one)

Date of birth _____ **Child's due date:** _____ **Date of enrollment:** _____
mm/dd/yy (prenatal enrollments) mm/dd/yy mm/dd/yy

Child's address: _____
Street City Zip

Multiple Birth? No **OR** Twin Triplet Quad Other _____

How did you hear about Bright Beginnings? Friend/Relative *Early On* School Doctor
(please check one) Health Department Other _____

What, if any, additional birth to five services are you receiving? _____

Race of child: American Indian/Alaska Native Asian American Black/African American
(Please check all applicable) White Hispanic/Latino Native Hawaiian/Other Pacific Islander

Family Information:

Marital status: Married Separated Divorced Widowed Single

Mother	Father
Name: _____	_____
Address: _____	_____
Birth date: _____	_____

Work Status: <input type="checkbox"/> Part-Time <input type="checkbox"/> Full Time	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full Time
<input type="checkbox"/> Unemployed-looking	<input type="checkbox"/> Unemployed-looking
<input type="checkbox"/> Medical Leave/Disability	<input type="checkbox"/> Medical Leave/Disability
<input type="checkbox"/> At home with Children	<input type="checkbox"/> At home with Children

Last grade completed: Mother	Last grade completed: Father
<input type="checkbox"/> Doctorate <input type="checkbox"/> Masters	<input type="checkbox"/> Doctorate <input type="checkbox"/> Masters
<input type="checkbox"/> Bachelors <input type="checkbox"/> Associates	<input type="checkbox"/> Bachelors <input type="checkbox"/> Associates
<input type="checkbox"/> Some College <input type="checkbox"/> HS Graduate or GED	<input type="checkbox"/> Some College <input type="checkbox"/> HS Graduate or GED
<input type="checkbox"/> Some HS <input type="checkbox"/> No HS <input type="checkbox"/> Other _____	<input type="checkbox"/> Some HS <input type="checkbox"/> No HS <input type="checkbox"/> Other _____

(This information is required by our grant funders)

Family E-mail address: _____

Please check the boxes below if you prefer to receive program information at this email address.

Monthly Newsletter Annual Program Survey

Total number of household members, including all adults and children: _____

Annual Household income: \$ _____
(This information is used for statistical purposes only and is required by our funders)



Bright Beginnings Recruitment/Enrollment Record

Language used most frequently in home: _____

Does anyone in the family have a disability or delay? _____ Describe _____

Siblings living in the home	M/F	Age: _____	Birth date: _____	Name _____
	M/F	Age: _____	Birth date: _____	Name _____
	M/F	Age: _____	Birth date: _____	Name _____
	M/F	Age: _____	Birth date: _____	Name _____

Residents in home other than siblings and parents	M/F	Age: _____	Birth date: _____	Name _____
	M/F	Age: _____	Birth date: _____	Name _____
	M/F	Age: _____	Birth date: _____	Name _____

Child Information:

Child's Place of Birth (City, State): _____

Baby's birth weight: _____

Duration of hospital stay for infant at delivery (days): _____

Any illness or complications during pregnancy or delivery?

Has the child been hospitalized since delivery? Yes No If yes, for what reason? _____

Name(s) of child's medical physician _____

Date of last exam by a physician: _____

Additional comments or information (attach sheet if necessary): _____
