



COMMUNITY WOMEN AGAINST HARDSHIP-FAMILY SUPPORT CENTER

STUDENT ENRICHMENT PROGRAM APPLICATION FORM

The purpose of this form is to obtain information concerning the student and his/her family to establish criteria for eligibility into the program as well as personal information to be kept on file.

Date: _____

(Please Print)

Name of Parent/Guardian: _____
(last name) (first name) (middle initial)

If you are a guardian are you over age 18 yes no

Address: _____ City _____ State _____ Zip _____

Phone: _____ Cell _____ Alt No# _____

Occupation: _____ Place of Employment _____

Employer's Address: _____ Employer's Phone #: _____

Gross Annual Income: _____ (needed to establish eligibility) DOB _____ SS# _____

Contact person in case of emergency: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Cell: _____ Alt. No# _____

Child's Full Name	Date of Birth	Age	Grade
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____

If your child has an illness or special health needs that CWAH needs to know about please list:
(example: asthma) _____

****(Use the Back of this Page if More Space is Needed)****

Classes your child/children are interested in participating in:

(1) _____ (2) _____ (3) _____

Parent/Guardian Signature: _____ I certify that the above information is correct.

OFFICE USE ONLY: Accepted Not Accepted Staff Signature: _____

