

Teenage Parent Program – Supplemental Information Form

School Year 2011-12

New
 Update

Please print and fill form completely.

A. Teen Parent:

1.) Parent SSN : _____ (SSN – Social Security Number is optional) Student ID : _____ First Name : _____ Last Name : _____ Date of Birth : _____ Address : _____ : _____ City : _____ State : FL Zip : _____ Phone : _____ County : _____	2.) Sex (check one): <input type="checkbox"/> Male <input type="checkbox"/> Female 3.) Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian or Other Pacific Islander 4.) Ethnicity (check if applicable): <input type="checkbox"/> Hispanic or Latino
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B. Children Needing Care:

1.) Enrollment Dates	2.) Child Information (SSN – Social Security Number is optional ID – Student ID)	3.) Sex (check one)	4.) Race (check all that apply)
Start : _____ End : _____	SSN : _____ ID : _____ First : _____ Last : _____ DOB : _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Indian/Native <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian Ethnicity: <input type="checkbox"/> Hispanic or Latino
Start : _____ End : _____	SSN : _____ ID : _____ First : _____ Last : _____ DOB : _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Indian/Native <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian Ethnicity: <input type="checkbox"/> Hispanic or Latino

C. Child Care Provider:

1.) Provider Name : _____ Address : _____ : _____ City : _____ State : FL Zip : _____ Phone : _____	2.) Relative (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No 3.) In Parent's Home (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No
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D. Information supplied by: _____

Contact Phone: _____

Date: _____

(School District Personnel)

Submit this form to the local Coalition or designee for entry into the EFS system prior to date identified.