

HEAD START AUXILIARY
SAN MATEO COUNTY
P. O. Box 588
San Mateo, California 94401

REFERRAL AND APPLICATION FOR SCHOLARSHIP

Name of Child Birthday Parent or Guardian

Address Telephone No. in family

Referred by: -----

for Head Start Auxiliary financial support for the following reasons:

1. Social Deprivation ---- (Brief description):
2. Language Disability----(Brief description):
3. Physical Disability----(Brief description):
4. Financial Need----(Brief Description):
5. Other----(Please describe):

Is this family receiving public assistance at this time?-----

This referral has been discussed with me and I request this application be submitted to the Head Start Auxiliary,

I will pay ----- per month toward tuition.

I will participate -----days per week as needed. How? -----

Date:-----

Parent's signature

Date:-----

Nursery School Official

Telephone-----

Date Approved----- By whom-----

Date Enrolled-----