

NOTE: Priority given to
low income students



Child Development Lab
Associated Students Chico State

EMAIL: ascdl@csuchico.edu

PH# 530-898-5865

FAX# 530-898-5639

APPLICATION (25 months to 5 years)

Date of Application _____

Number in Family _____

Application for admission Fall / Spring of _____ Anticipated graduation date: _____

Parent (guardian) Status ☐ CSUC Student ☐ Butte College ☐ Community

CHILD'S NAME _____ **DATE OF BIRTH** _____ **Sex** _____

PARENT #1 _____ **PARENT #2** _____

College/Employment _____ Living in home with child? YES NO

College/Employment _____

Siblings Living at Home: Name _____ M/F DOB _____

Name _____ M/F DOB _____ Name _____ M/F DOB _____

Name _____ M/F DOB _____ Name _____ M/F DOB _____

Household GROSS monthly income (for both live in parents) including wages from:

Employment, Child/Spousal Support, Unemployment, Worker's Comp.... \$ _____ **per month**

(Proof of income will be required prior to enrollment)

Do you receive Public Assistance, Cal Works or TANF? YES NO \$ _____ **per month**

Do you receive (SNAP) Cal Fresh? YES NO Cal Fresh ID# _____

Are you or your child covered by Medi- Cal? YES NO

Do you receive the Pell Grant? YES NO

What is your child's primary home language? _____

Does your child have exceptional needs and/or have an IFSP, IEP? YES NO

Explain _____

Does your child have any allergies or dietary restrictions? YES NO

Explain: _____

How did you hear about the Associated Students Child Development Lab?

Please Note: * The ASCDL does not offer drop in care and requires a 2 day / 10 hour minimum to enroll. *

Share any additional information relevant to enrolling your child-

PARENT SIGNATURE _____ PHONE# _____

Address _____ EMAIL _____