Reprint 05-26

Application for Child Safety Seat

Primary Parent/Legal Guardian Information

First Name | Middle | Last Name

Birth Date ___ / ___ / ___ | Last 4 Social Security Numbers

Street Address | Mailing Address

City | City

State | Zip | State | Zip

Check if mailing address is the same as the Street Address ◯ Yes ◯ No (If No, provide mailing address.)

Virginia Resident ◯ Yes ◯ No | Unhoused ◯ Yes ◯ No | Primary Language

Relationship of Primary Parent/Guardian to Child ◯ Mother ◯ Father ◯ Legal Guardian | Court Documentation Description

Email Address

Home Phone | Mobile | Work

Related Parent/Legal Guardian Information

First Name | Middle | Last Name

Birth Date ___ / ___ / ___ | Last 4 Social Security Numbers

Street Address | Mailing Address

City | City

State | Zip | State | Zip

Check if mailing address is the same as the Street Address ◯ Yes ◯ No (If No, provide mailing address.)

VDH VIRGINIA DEPARTMENT OF HEALTH

Related Parent/Legal Guardian Information (continued from page 1)

Virginia Resident ◯ Yes ◯ No Unhoused ◯ Yes ◯ No Primary Language

Relationship of Related Parent/Guardian to Child ◯ Mother ◯ Father ◯ Legal Guardian Court Documentation Description

Email Address

Home Phone Mobile Work

Unborn Child Due Date / /

Child's Information

Child's First Name Middle Last Name

Birth Date / / Age Years Age Months Weight ◯ oz ◯ g Height ◯ in ◯ cm

Medical Conditions

Ethnicity ◯ Hispanic ◯ Non-Hispanic

Child's Race ◯ African American ◯ Caucasian ◯ Asian ◯ Native American ◯ Biracial ◯ Other

I or my child receives ◯ Medicaid ◯ WIC ◯ FAMIS ◯ TANF ◯ SNAP ◯ Meets Program Income Level Guidelines

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Applicant is willing to sign a waiver and complete a safety seat training session ◯ Yes ◯ No

Applicant Signature _____ Date / /