

2018-2019

Head Start Preschool

Application Packet

You will also need to provide:

- Current immunization card (with application)
- Copy of birth certificate (with application)
- Proof of income for 2017 (with application)
  
- Current physical exam form (prior to school starting)
- Current dental exam form (prior to school starting)

**If your child is accepted**, physical and dental exam forms will be mailed to you after May 1

# 2018-2019 Head Start/Preschool Application

ALL applications must include a copy of the child's immunization card, birth certificate, and proof of income for the last calendar year or the last 12 months.

## Enrollment Information

Center applying for: \_\_\_\_\_

Child name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Gender: M or F Social Security # \_\_\_\_\_

Race: \_\_\_\_\_ Language: \_\_\_\_\_

Home address: \_\_\_\_\_

Mother's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Race: \_\_\_\_\_ Language: \_\_\_\_\_ Lives with child? Yes or No

Home address: \_\_\_\_\_

Father's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Race: \_\_\_\_\_ Language: \_\_\_\_\_ Lives with child? Yes or No

Home address: \_\_\_\_\_

**Phone numbers to contact parents:** (cell phone #'s will be used also for emergency notification systems. Text messages with emergency information will be sent as needed regarding closings and other information)

Mother: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Father: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Was your child referred to our program? \_\_\_ No \_\_\_ Yes If yes, by who? \_\_\_\_\_

## Family Information:

Total # in household: \_\_\_\_\_ Total # in family: \_\_\_\_\_

Parental status: \_\_\_ One parent family \_\_\_ Two parent family

Does your child live with \_\_\_ Mother \_\_\_ Father \_\_\_ Both parents \_\_\_ Guardian

Who has legal custody of your child? \_\_\_\_\_ Physical custody? \_\_\_\_\_

(Please provide a copy of any legal documentation of custody).

Other adults in household: (name, birth date and relationship to child)

Other children in household: (name, birth date, and relationship to child)

Is there any specific family need or crises? \_\_\_\_\_

Household Income Sources (Check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> EMPLOYMENT INCOME        | <input type="checkbox"/> SELF EMPLOYMENT/FARM INCOME                 | <input type="checkbox"/> SOCIAL SECURITY RETIREMENT INCOME  |
| <input type="checkbox"/> SSDI (DISABILITY INCOME) | <input type="checkbox"/> VA CONNECTED DISABILITY COMPENSATION        | <input type="checkbox"/> SSI (SUPPLEMENTAL SECURITY INCOME) |
| <input type="checkbox"/> PENSION                  | <input type="checkbox"/> VA NON-SERVICE CONNECTED DISABILITY PENSION | <input type="checkbox"/> PRIVATE DISABILITY INSURANCE       |
| <input type="checkbox"/> WORKERS' COMPENSATION    | <input type="checkbox"/> UNEMPLOYMENT INSURANCE/BENEFITS             | <input type="checkbox"/> TANF/FIP ASSISTANCE                |
| <input type="checkbox"/> GENERAL RELIEF           | <input type="checkbox"/> CASH CONTRIBUTIONS FROM FAMILY/FRIENDS      | <input type="checkbox"/> ALIMONY/OTHER SPOUSAL SUPPORT      |
| <input type="checkbox"/> CHILD SUPPORT            | <input type="checkbox"/> NO INCOME                                   | <input type="checkbox"/> OTHER _____                        |

Household Non-Cash Benefits (Check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> SNAP (FOOD ASSISTANCE PROGRAM)  | <input type="checkbox"/> HCV (HOUSING CHOICE VOUCHER) | <input type="checkbox"/> HUD-VASH (VA SUPPORTIVE HOUSING) |
| <input type="checkbox"/> WIC (WOMEN, INFANT, & CHILDREN) | <input type="checkbox"/> PUBLIC HOUSING               | <input type="checkbox"/> CHILDCARE VOUCHER                |
| <input type="checkbox"/> LIHEAP                          | <input type="checkbox"/> PERMANENT SUPPORTIVE HOUSING | <input type="checkbox"/> AFFORDABLE CARE ACT SUBSIDY      |
| <input type="checkbox"/> FREE/REDUCED LUNCHES            | <input type="checkbox"/> NONE                         | <input type="checkbox"/> OTHER _____                      |

Check all that apply:  Foster child  Homeless family

Annual family income:  \$0 to \$25,000  \$25,000 to \$35,000  \$35,000 to \$45,000  Over \$45,000

Please provide verification of your income for the last calendar year or the last 12 months with your application.

**Home Language Information**

1. Is your child's first language or home language anything other than English? Yes or No

If yes, please answer the following:

- What language did your child learn when he/she first began to talk? \_\_\_\_\_
- What language does your child most frequently speak at home? \_\_\_\_\_
- What language do you most frequently speak at home? \_\_\_\_\_
- What language do you most frequently speak to your child?  
Father: \_\_\_\_\_ Mother: \_\_\_\_\_

2. What language is spoken by you and your family most of the time at home? \_\_\_\_\_

3. In what language would you prefer to receive communication from the school? \_\_\_\_\_

4. Please describe the language UNDERSTOOD by your child (check one):

- Understands only the home language and no English
- Understands mostly the home language and some English
- Understands the home language and English equally
- Understands mostly English and some of the home language
- Understands only English

**Emergency contacts and Child pick up information**

Please list at least two people, other than parents that we can call in case of an emergency

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

(list additional names on separate page)

I give the people above permission to pick up my child/children from preschool. It is the responsibility of the parent/guardian to notify the school, in writing, if this changes. All emergency contact information will be kept current in the Child Plus data base used by the program.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Person who may NOT pick up my child (provide legal documentation if applicable):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Emergency Treatment Release**

I give my permission and direct the staff of North Iowa Community Action and support staff to secure and authorize such emergency medical and dental care as may be required for my child while under their supervision.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Child Health Information**

Child's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Has your child ever seen a dentist? \_\_\_ Yes \_\_\_ No If yes, date of last visit: \_\_\_\_\_

If no, name of dentist we should contact in case of emergency \_\_\_\_\_

Health Insurance  Private  Hawk I  Medicaid # \_\_\_\_\_  None

Dental Insurance  Private  Hawk I  Medicaid # \_\_\_\_\_  None

**Applicant Health Information (to be completed by parent)**

Does your child have any special needs \_\_\_\_\_

Is your child currently being treated for any of the following? (check all that apply):

- |                                    |   |  |
|------------------------------------|---|--|
| <input type="checkbox"/> Asthma*   | <input type="checkbox"/> Heart trouble    | <input type="checkbox"/> Anemia          |
| <input type="checkbox"/> Diabetes* | <input type="checkbox"/> High Lead Level  | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Seizures* | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Other _____     |

***\*children who have asthma, seizures, or diabetes will need an action plan completed by physician on file @ school.***

Was this a full term pregnancy?  Yes  No

Has your child had any of the following?  Whooping Cough  Measles  Hepatitis  
 German measles  Mumps  Other \_\_\_\_\_

To your knowledge, is there any family history (on either side of the family) of:

Learning problems  Seizures  Diabetes  Mental health concerns  Other: \_\_\_\_\_

Is your child currently on any medications?  No  Yes

If yes, what medication? \_\_\_\_\_

**\* If your child receives medication at school, we need a medication permission form completed**

Does your child have any allergies diagnosed by a physician?  No  Yes

If yes, what are they allergic to & how do they react: \_\_\_\_\_

**\* If your child carries epinephrine an action plan will need to be completed by physician**

**\* If your child has a food allergy, an Allergy/Food Exemption form needs to be completed by a physician**

Is your child toilet trained?  No  Yes If no, what size diapers are they currently in? \_\_\_\_\_

Do you have any concerns about your child's health? \_\_\_\_\_

**Authorization for Exchange of Information/Parent Permissions**

Child's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

I have provided information to apply for Head Start/Preschool and I give permission for my child to participate in the preschool programming.

I give permission for my child to participate in health and nutrition screenings.

I give permission for my child to participate in mandated screenings to include developmental, social-emotional, vision, speech and hearing.

I give permission for my child to participate in optional screening services – Iowa Kid Sight program for vision screening and I Smiles program for dental screening and fluoride application. These programs will require an additional screening permission form to be signed.

I give permission for my child and family to be included in class photos and media coverage of the program. This may include publication on the agency website, agency Facebook page and See Saw application.

I give permission for my child to participate in field trips.

I give permission for my child to be videotaped in classroom activities as part of a CLASS learning program. Videos are viewed by staff for mentoring and training purposes only.

I give permission for preschool staff to exchange and discuss information now contained in their records and information which may be available in the future with:

Area Education Agency  
Turning Leaf Counseling  
Local School District  
North Iowa Community Action Organization  
Department of Education

Such information may include, but is not limited to: name, address, phone number, date of birth, screening results, and assessment data. Information shared may include any records in the child's educational file. This includes both written and verbal exchange of information as needed. In addition, all files are subject to review as required by funding sources and regulatory agencies. This includes but is not limited to state and federal auditors, DHHS Federal Review Teams, and State Licensing staff. I have read the above request and understand why the request for exchange is being made. I voluntarily sign this exchange of information form.

Signed: \_\_\_\_\_

Effective Date: \_\_\_\_\_

This authorization will expire 12 months after the date of child's last attendance.  
*A photocopy, FAX copy, or exact reproduction of this authorization, as duly executed, shall have the same force and effect as this original.*

**Authorization to Obtain/Release Protected Health Information**

Child's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

I authorize the health care provider/clinic, \_\_\_\_\_, to use and/or disclose protected health information about the child above in communication with the following:

North Iowa Community Action Organization Head Start/Preschool Program  
218 5<sup>th</sup> Street SW  
Mason City IA 50401  
Phone: 641-494-1891, Fax 641-494-1894

I authorize the program staff to obtain and/or release protected health information to the health professional listed above.

The protected health information covered by this authorization includes the following:

- Most recent physical exam and general health status of the child listed, including immunizations given, lab results, and screening test results (EXCEPT substance abuse, mental health and AIDS/HIV info)
- Health problems/conditions pertinent to the child's enrollment in a child care program/school
- Recommendations for care that would assist caregivers/teachers to meet the needs of the child or could affect the care of the other children/adults with whom the child has contact.

I understand that information regarding my child will only be shared with the individuals listed on this form. If a need to disclose information to others is identified, another form will need to be completed and filed. I have the right to revoke this authorization for future communications any time I provide written/dated notice to all individuals listed. I understand that I cannot revoke this authorization when disclosure has already occurred.

This authorization is valid while the child is enrolled in the program and will expire after May 31, 2020.

Printed name of parent/guardian: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Obtain/Release Protected Dental Health Information**

Child's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

I authorize my dental health care providers, \_\_\_\_\_, to use and/or disclose protected health information about the child above in communication with the following:

North Iowa Community Action Organization Head Start/Preschool program  
218 5<sup>th</sup> Street SW  
Mason City IA 50401  
Phone: 641-494-1891 Fax 641-494-1894

I authorize the program staff to obtain and/or release protected health information to the health professional listed above and any providers that my child is referred to for additional dental treatment/care.

The protected health information covered by this authorization includes the following:

- Dental health records of the child listed, including routine dental exams and information related to any treatment/follow up of dental care (EXCEPT substance abuse, mental health, and HIV/AIDS information)
- Health problems/conditions pertinent to the child's enrollment in a child care program/school
- Recommendations for care that would assist caregivers/teachers to meet the needs of the child or could affect the care of the other children/adults with whom the child has contact.

I understand that information regarding my child will only be shared with the individuals listed on this form. If a need to disclose information to others is identified, another form will need to be completed and filed. I have the right to revoke this authorization for future communications any time I provide written/dated notice to all individuals listed. I understand that I cannot revoke this authorization when disclosure has already occurred.

This authorization is valid while the child is enrolled in the program and will expire after May 31, 2020.

Printed name of parent/guardian: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_



### Nutrition Assessment Survey

**Child's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

	Yes	No	Explain:
Do you have any concerns about your child's eating habits? (picky eater, eats too little, eats too many sweets, eats too much, snacks too much, etc)			
Do you have any concerns about your child's weight? (looks too thin, looks overweight, etc)			
Is your child on a special diet for any reason? (religious, cultural, health conditions, allergies, etc) If yes, complete the allergy exemption form.			
Does your child have any difficulties chewing or swallowing?			
Does your child eat or chew on things that are not food (dirt, paper, crayons, pet food, paint chips, etc?)			
Do you offer snacks?			If yes, how often?
Do you have set times for meals and snacks?			
Does your child take any vitamins, minerals or other supplements?			If yes, what? _____ How often? _____ Does it contain iron? _____
In the last month, were there days when your family had no food in the home?			If yes, why did your family not have food? ____ I did not have enough money, food stamps or WIC checks to buy food. ____ I did not have a ride or car. ____ I did not have a working stove or refrigerator. ____ Other: _____
Is your child in the WIC program?			
Does your child regularly have problems with:	Circle one: Diarrhea    Constipation    Neither		
Where in your home does your child usually eat?			

**Please list any questions you have for the dietician:**

**On average how many times a day does your child eat/drink:**

	0	1	2	3	4	5	5+
<b>Dairy</b> milk, cheese, yogurt, cottage cheese							
<b>Meat/Meat Alternative:</b> pork, hamburger, chicken, beef, turkey, fish, eggs, peanut butter, dried beans/peas/lentils, ham							
<b>Grains:</b> bread, cold cereal, rice, grits, tortillas/tacos, muffins, pancakes, waffles, crackers, pasta, noodles, bagels, pita, popcorn, pizza crust, biscuits, hot cereal, etc							
<b>Vegetables:</b> Potato, corn, peas, green beans, cauliflower, celery, cabbage, cucumbers, lettuce, tomatoes, mixed vegetables, okra, bell pepper, asparagus, zucchini, tomato based sauces, carrots, sweet potato, broccoli, squash, dark green leafy vegetables, etc							
<b>Fruit:</b> oranges, tangerines, grapefruit, cantaloupe, watermelon, honeydew, strawberries, kiwi, raspberries, apples, applesauce, grapes, pineapple, bananas, pears, apricots, nectarines, fruit cocktail, prunes, mangoes, peaches, etc.							
<b>Sweets:</b> cookies, cakes, donuts, candy, candy bars, snack cakes, gummy fruit snacks, pudding, ice cream, sherbet. etc							
<b>Added Fats:</b> butter, margarine, oil, salad dressing, mayo, sour cream							
<b>Sweetened beverages:</b> Kool aid, sports drinks, soda pop, lemonade, sweetened tea, fruit flavored drinks							
<b>Fruit Juices:</b> 100% fruit juice							
<b>Other foods:</b> potato chips, French fries, pretzels							

**Would you like information on any of the following topics?**

- |   |   |
|---|---|
| <input type="checkbox"/> Physical Activity    | <input type="checkbox"/> Portion sizes for children     |
| <input type="checkbox"/> Overweight child     | <input type="checkbox"/> Kids in the kitchen            |
| <input type="checkbox"/> Food Safety          | <input type="checkbox"/> Trying new foods               |
| <input type="checkbox"/> Healthy snacks       | <input type="checkbox"/> Juice or Fruit drinks?         |
| <input type="checkbox"/> Choking hazard foods | <input type="checkbox"/> Is my child's appetite normal? |
| <input type="checkbox"/> Picky/choosy eater   | <input type="checkbox"/> Teaching good food habits      |
|   | <input type="checkbox"/> Other _____                    |

**Do you prefer information in English \_\_\_\_\_ or Spanish \_\_\_\_\_ ?**

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

No follow up needed  Education provided  Follow up @ WIC