North Iowa Community Action Organization - Early Head Start
218 5th Street SW, Mason City IA 50401
Phone 641-494-1891 Fax 641-494-1894

2018-2019

Early Head Start

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)

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2018-2019 Early Head Start 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 ____ **Manly** ____ **Clear Lake**

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).

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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)

☐EMPLOYMENT INCOME	☐SELF EMPLOYMENT/FARM INCOME	☐SOCIAL SECURITY RETIREMENT INCOME
☐SSDI (DISABILITY INCOME)	☐VA CONNECTED DISABILITY COMPENSATION	☐SSI (SUPPLEMENTAL SECURITY INCOME)
☐PENSION	☐VA NON-SERVICE CONNECTED DISABILITY PENSION	☐PRIVATE DISABILITY INSURANCE
☐WORKERS' COMPENSATION	☐UNEMPLOYMENT INSURANCE/BENEFITS	☐TANF/FIP ASSISTANCE
☐GENERAL RELIEF	☐CASH CONTRIBUTIONS FROM FAMILY/FRIENDS	☐ALIMONY/OTHER SPOUSAL SUPPORT
☐CHILD SUPPORT	☐NO INCOME	☐OTHER_____

Household Non-Cash Benefits (Check all that apply)

☐SNAP (FOOD ASSISTANCE PROGRAM)	☐HCV(HOUSING CHOICE VOUCHER	☐HUD-VASH(VA SUPPORTIVE HOUSING)
☐WIC (WOMEN, INFANT, & CHILDREN)	☐PUBLIC HOUSING	☐CHILDCARE VOUCHER
☐LIHEAP	☐PERMANENT SUPPORTIVE HOUSING	☐AFFORDABLE CARE ACT SUBSIDY
☐FREE/REDUCED LUNCHES	☐NONE	☐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

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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 the Early Head Start program. 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: _____

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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):

☐ Asthma* ☐ Heart trouble ☐ Anemia
☐ Diabetes* ☐ High Lead Level ☐ Vision problems
☐ Seizures* ☐ Hearing problems ☐ 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?_____

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Authorization for Exchange of Information/Parent Permissions

Child's Name: _____ Date of birth: _____

I have provided information to apply for Early Head Start and I give permission for my child to participate in the 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
Well Source of North Iowa
Local School District
North Iowa Community Action Organization
Iowa Department of Public Health

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.

Revised January 2018

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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 Early Head Start Program
218 5th 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: _____

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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 Early Head Start program
2185th Street SW
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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.

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Printed name of parent/guardian: _____

Signature of parent/guardian: _____Date: _____