

# NICAO Early Childhood Programs Enrollment Application

**School Year: 12**

**Center:**

- Early Head Start (Floyd and Mitchell Counties only - Birth to three)
- Head Start      Mason City and Buffalo Center only: Do you also need daycare before or after school? (please check below and list work hours)
  - Daycare: Work or school days/ hours \_\_\_\_\_
- Preschool Charles City (Mon - Fri)
- Preschool Buffalo Center      Day and Time preferences:     M-F 8:30 - 1:30       M/W/F 8:30 -1:30       T/Th 8:30 - 1:30
- Preschool Manly      Day and Time preferences:     M/W/F       T/TH       8:30 - 12:00       8:30 - 2:30

## Child/Family Information:

Child Legal Name:    Last: \_\_\_\_\_    First: \_\_\_\_\_

Birthdate: \_\_\_\_\_     Male     Female    Social Security #: \_\_\_\_\_

Race: \_\_\_\_\_    Primary Language: \_\_\_\_\_    Other Language: \_\_\_\_\_

Health Insurance information:     Medicaid: # \_\_\_\_\_     Private Ins     HAWK I     None

Doctor Name/address and phone: \_\_\_\_\_

Dentist Name/address and phone: \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_

Parent - Mother    \_\_\_\_\_    Gender: \_\_\_\_\_    Birthdate: \_\_\_\_\_    SS # \_\_\_\_\_

Race: \_\_\_\_\_    Primary Language: \_\_\_\_\_    Other Language: \_\_\_\_\_

Relationship to child? \_\_\_\_\_    Lives with family? \_\_\_\_\_

Parent - Father    \_\_\_\_\_    Gender: \_\_\_\_\_    Birthdate: \_\_\_\_\_    SS# \_\_\_\_\_

Race: \_\_\_\_\_    Primary Language: \_\_\_\_\_    Other Language: \_\_\_\_\_

Relationship to child? \_\_\_\_\_    Lives with family? \_\_\_\_\_

Other Adults    \_\_\_\_\_    Gender: \_\_\_\_\_    Birthdate: \_\_\_\_\_    SS # \_\_\_\_\_

Race: \_\_\_\_\_    Primary Language: \_\_\_\_\_    Other Language: \_\_\_\_\_

Relationship to child? \_\_\_\_\_    Lives with family? \_\_\_\_\_

Other Adults    \_\_\_\_\_    Gender: \_\_\_\_\_    Birthdate: \_\_\_\_\_    SS# \_\_\_\_\_

Race: \_\_\_\_\_    Primary Language: \_\_\_\_\_    Other Language: \_\_\_\_\_

Relationship to child? \_\_\_\_\_    Lives with family? \_\_\_\_\_

Number in Family: \_\_\_\_\_    Number In Household: \_\_\_\_\_    Child Lives with: \_\_\_\_\_

Who has legal custody of the child? \_\_\_\_\_    Who has physical custody? \_\_\_\_\_

Is there a no contact order in place?     Yes     No

Please send in a copy of custody orders and no contact orders.

Other children in family:

Name: \_\_\_\_\_    Birthdate: \_\_\_\_\_     Boy     Girl

Relationship to applicant? \_\_\_\_\_

Name: \_\_\_\_\_    Birthdate: \_\_\_\_\_     Boy     Girl

Relationship to applicant? \_\_\_\_\_

Name: \_\_\_\_\_    Birthdate: \_\_\_\_\_     Boy     Girl

Relationship to applicant? \_\_\_\_\_

Name: \_\_\_\_\_    Birthdate: \_\_\_\_\_     Boy     Girl

Relationship to applicant? \_\_\_\_\_

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

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

City: \_\_\_\_\_    State: IA    Zip: \_\_\_\_\_    County: \_\_\_\_\_

Phone:     Home     Cell     Message

Work     Cell    Email: \_\_\_\_\_

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Parental Status:  One parent family  Two Parent Family Primary Language spoken in home:  
 Homeless family  Military family  Referred by Child Welfare agency  
 Family receives SNAP  Family Receives SSI  Family Receives WIC

## Income: (for Early Head Start and Head Start applicants only) - PROOF of income must be attached to application

Household Member	Source (do not list amount here- only source)- Example: Wages, Child Support, FIP, SSI.

Does child have disability or special need?  No  Suspected  Yes If yes, attach most recent copy of IEP or IFSP

Does child currently receive services for disability?  No  Yes If yes, by Whom?

Was child referred to program?  No  Yes If yes, by Whom?

Any specific family need or crisis?  No  Yes If yes, please describe

Would you like us to send you information on resources in your county?  Yes  No

### Emergency Contact Information:

Name: Relationship to child:

Address:

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

It is ok to contact this person if we can not reach parent.  It is ok to release child to this person.

Name: Relationship to child:

Address:

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

It is ok to contact this person if we can not reach parent.  It is ok to release child to this person.

Name: Relationship to child:

Address:

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

It is ok to contact this person if we can not reach parent.  It is ok to release child to this person.

Name: Relationship to child:

Address:

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

It is ok to contact this person if we can not reach parent.  It is ok to release child to this person.

Application Notes:

North Iowa Community Action Organization – Head Start  
1190 Briarstone Drive, P.O. Box 1627  
Mason City, IA 50402-16727

**Authorization for Exchange of Information**

RE: \_\_\_\_\_  
Name of child

Center: \_\_\_\_\_

I, the undersigned, hereby grant permission for Head Start to exchange and discuss information now contained in their records and information which may be available in the future with:

Area Education Agency  
Department Of Human Services  
**Department of Public Health**  
Local School District  
North Iowa Community Action  
(WIC, Child Health, Family Planning, FaDSS, Community Partners,  
LIHeap, Weatherization, Early Head Start)

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 of information 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.*

North Iowa Community Action Organization – Head Start  
1190 Briarstone Drive, P.O. Box 1627  
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**Parent Permissions**

RE: \_\_\_\_\_  
Name of child

Center: \_\_\_\_\_

Please initial each line and sign at the bottom of the page:

\_\_\_\_\_ I give permission for my child to participate in the preschool programming.

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

\_\_\_\_\_ I give permission for my child to be included in class photos and media coverage of the program. This may include publication on the agency website.

\_\_\_\_\_ 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 project. Videos are viewed by staff for mentoring and training purposes only.

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.*