APPLICATION COVER SHEET

(Must be complete and attached to <u>all</u> applications/files sent to Corporate for enrollment)

●**CHILD NAME:** _____ ●**CHILD DATE OF BIRTH:**_____

●**HACAP HOUSING: Yes☐ No☐** ● **POINTS:** _____ ●**PROGRAM:** _____

●**APPLICATION COMPLETED AT:** _____ ●**DATE:** _____
(location)

●**SITE REQUESTED (1ST Choice)** _____**(2nd Choice)**_____

●**CURRENT SCHOOL DISTRICT** _____

FAMILY NEED HS Full Day (10 hr.)☐ HS School Day (8 hr.)☐ HS Part Day (4 hr) Mon-Fri☐
EHS Center Based (10 hr.)☐ EHS Home Based☐

FAMILY INFO (Misc.)

1. What is the best way to contact you? Email☐ Email Address:_____
   Phone☐ Phone No._____ Text☐ Letter ☐
   _____*Initial here to authorize this method of communication*

2. Health Insurance through_____ Policy Number: _____

3. DHS Child Care Assistance (DHS CCA): Applied☐ Receiving☐

4. How did you hear about Head Start? _____

ABBREVIATED NUTRITION ASSESSMENT – <u>Must be completed at time of application</u>

1. Parent concerns about child eating in the Head Start classroom? **Yes**☐ **No**☐

2. Any special diet modifications child must follow? **Yes**☐ **No**☐
(i.e. medical diet, food allergies)
If yes, a Food Allergy/Special Medical Diet Form must be completed and sent to the CACFP Manager. Please complete and attach.

3. Any religious dietary restrictions we should know about? **Yes**☐ **No**☐
If yes, explain _____

4. Are you participating in WIC? **Yes**☐ **No**☐
If yes, when was the child's last certification? _____

5. Are you receiving food stamps/SNAP? **Yes**☐ **No**☐

6. Are you able to provide adequate meals for your family? **Yes**☐ **No**☐
(i.e. do you run out of food*, does your refrigerator/stove work?) *Encourage community resources as needed

Needs – <u>Must be completed at time of application.</u>

1. **Do you have any concerns about your child's development** **Yes** ☐ **No** ☐

   If yes, please describe: _____

2. **Do you have any concerns regarding your child's behaviors?** **Yes** ☐ **No** ☐

   If yes, please describe:

   _____

   _____

3. **Is your child on an IEP or IFSP?:** _____ **Yes** ☐ **No** ☐
   In order to process the application, we will need to see documentation. Attached is an authorization to exchange information to the Agency/Provider, please sign.
4. **Does your child see any specialists?** **Yes** ☐ **No** ☐

   If yes, describe:

   _____

   _____

In order to process the application, we will need to see your child's current physical exam. Attached below is an authorization to exchange information with your child's medical provider.

AUTHORIZATION TO EXCHANGE INFORMATION – CHILD

I authorize the Hawkeye Area Community Action Program, Inc. (HACAP) Head Start/Early Head Start to release or exchange timely and relevant service information to or with _____ in regard to (whom) _____, (birthdate) _____, for the purpose of coordination of services. I understand that any information released to HACAP will be held in strictest confidence. I specifically authorize the release of data and information relating to: (sign by the appropriate services, if applicable:

1. Education: includes referrals, reports, treatment plans (ex. IEP/IFSP) social/emotional behavior — Signature: _____
2. Medical/Physical: status and implications for classroom or activity — Signature: _____

By signing this form, I understand that:

- This authorization to exchange information will expire one year from the date of this signature.
- I may revoke the consent granted by this authorization to exchange information at any time by notifying the Site Supervisor of my child's Head Start site – **in writing.**

Signature: _____ Date: _____

Parent/Legal Guardian (please circle one)

Hawkeye Area Community Action Program, Inc.
1515 Hawkeye Drive, PO Box 490, Hiawatha, IA 52233

Basic Intake Form – HS/EHS

Flag for Review
Red – Health
Blue – Disability
Yellow – Nutrition
Green – Other
ATTACH FLAG HERE

Child's Last Name_____ Child's First Name_____ MI____

Street Address_____ City_____ State_____ Zip_____

Mailing Address (if different) _____ City_____ State_____ Zip_____

Primary Phone # (home/cell) _____ Alternate Phone # (cell/work/message/emergency)_____

HOUSING: ❑Own or Buying ❑Renting ❑Homeless (complete back page) ❑Other explain _____(complete back page)

FAMILY TYPE: ❑Female single parent ❑Male single parent ❑Two parent Household

Total # of Household Members: _____ #of children _____ By age: 0-3____ 4-5 ____

Veteran in Family (indicate family member) _____ **Native language if other than English:**_____

HOUSEHOLD MEMBERS ***(including yourself; If more than 5 members please continue on the back of this form)***

	Name (first and last)	Relationship to Applicant	Date of Birth	Sex	Hispanic or Latino	Race	Ed. Level	Employment Status	Disability **Y** or **N**	Medical Insur.
Primary Adult					Yes ☐ No ☐					
Secondary Adult or Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					

Codes

Education Level
COL-College/Advanced Training
CTG-Training Cert.
HSG-High School Grad
GED-General Education Diploma
G9-Grade 9 or less
G10-Grade 10
G11-Grade 11
G12-Grade 12

Employment Status
F-Full Time (28+hrs/wk)
P-Part Time
R-Retired or Disabled
T-Training or School
B-Full Time & Training
L-Part Time & Training
S-Seasonally Employed
U-Unemployed

Medical Insurance
XIX
Hawk-I
Private
None
Other

INCOME SOURCES

****Proof of Income will be required to process application**

Income received in the last year (check all that apply)

	Primary Adult	Secondary Adult
Work	☐	☐
SSI	☐	☐
Social Security	☐	☐
FIP/TANF/SNAP	☐	☐
Unemployment	☐	☐
Scholarships	☐	☐
Grants	☐	☐
Child Support	☐	☐
Other (explain)	☐_____	☐_____

Emergency Contacts

(Other than parents)

#1
Name: _____Relationship _____
Address: _____
City/State/Zip_____
Phone: H/C/M/W: ( )_____
Emergency Contact? ☐Yes ☐No
Release To? ☐Yes ☐No

#2
Name: _____Relationship _____
Address: _____
City/State/Zip_____
Phone: H/C/M/W: ( )_____
Emergency Contact? ☐Yes ☐No
Release To? ☐Yes ☐No

Doctor:
Name_____ Phone: _____
Address:_____ City:_____ State:_____

Dentist:
Name_____ Phone: _____
Address:_____ City:_____ State:_____

Hospital Preference: _____ Phone: _____
Address:_____ City:_____ State ____

I have carefully reviewed the information in this form and by signing this application, certify to the best of my knowledge and belief that all information in this application is true and correct. I further understand that this is an application for services that are paid with federal funds and that intentionally providing misleading, inaccurate or untruthful information of a material nature could result in dis-enrolling my child from Head Start Early Head Start and is considered fraud and could have serious legal consequences for me.

Parent/Guardian signature: X_____ Date: _____

Verifying Staff Member: X_____ Date: _____

APPLICANT'S NAME:_____

ADDITIONAL HOUSEHOLD MEMBERS

	Name (first and last)	Relationship to Applicant	Date of Birth	Sex	Hispanic or Latino	Race	Ed. Level	Employment Status	Disability **Y** or **N**	Medical Insur.
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					
Child					Yes ☐ No ☐					

Codes

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COL-College/Advanced Training	G9-Grade 9 or less
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XIX	Other
Hawk-I	
Private	
None	

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Parent/Guardian signature: **X**_____ Date: _____

Verifying Staff Member: **X**_____ Date: _____

HACAP HEAD START NUTRITION ASSESSMENT

CHILD'S NAME _____ **AGE**_____**DATE**_____

COMPLETED BY_____ **CENTER**_____
CLASSROOM_____

2ND YEAR REVIEWED BY_____
CENTER_____**CLASSROOM**_____ **DATE**_____

1. How would you describe your child's appetite? (Check one)	☐ GOOD ☐ FAIR ☐ POOR		Comment:
2. How do you see your child's weight? (Check one)	☐ NORMAL ☐ UNDERWEIGHT ☐ OVERWEIGHT		Comment:
3. Do you have any concerns about your child's eating habits? What?	YES	NO	EXPLANATION
	Y	N	
4. Does your child have the following:			
a. food allergy? Type:_____	Y	N	a. If yes, Diet Modification/Food Allergy Action forms required.
b. special diet? Type:_____	Y	N	b. If yes, Diet Modification form required.
c. religious food preferences? (Please describe)	Y	N	c.
d. dental problems affecting eating? (Please describe)	Y	N	d.
e. trouble chewing or swallowing? (Please describe)	Y	N	e.
f. frequent constipation?	Y	N	f.
g. frequent diarrhea?	Y	N	g.
h. regular medication? Type:_____	Y	N	h.
i. regular vitamin/mineral supplement? Type:_____How often?_____	Y	N	i.
5. Has your child recently been diagnosed with anemia (low iron)?	Y	N	If yes, are there measures currently being taken to correct this?
6. Does your child eat things that are not food?	Y	N	What?
7. Does your child use a knife, fork, and spoon? Drink from a cup or glass? Sit at a table to eat?	Y Y Y	N N N	
8. Are you participating in: SNAP? Food pantry? WIC?	 Y Y Y	 N N N	Comment:
9. Do you run out of food at the end of the month or pay period?	Y	N	Resources offered:
10. Do you have a working stove and refrigerator?	Y	N	**If NO (please check which one)** ☐ **stove** ☐ **refrigerator**
11. Is there anything else you want to share with us about your child's/family's eating habits?	Y	N	Explain:

Reviewed/Updated 6/2024

HACAP Child Health History

Child's Name:_____ **Date:**_____

Gender: _____ **Birthdate:**_____

1. Child's doctor: _____
2. Clinic name: _____ **When child was last seen?** _____
3. Child's dentist: _____ **Date of last appointment:** _____
4. Child's eye doctor:_____ **Date of last appointment:** _____

5. Is your child participating in WIC Services? ☐ Yes ☐ No
Approximate date of last re-certification_____

Allergies	**Yes**	**No**	**Explain "Yes" Answers**
6. Does your child have any allergy problems? (rash, itching, swelling, difficulty breathing, sneezing)	☐	☐	
A. When eating any foods	☐		What foods?
B. When taking any medications?	☐		What medications?
C. When near animals, furs, insects, dust, cleaning supplies, or seasonal, outdoor, etc.	☐		Reaction?
Asthma	**Yes**	**No**	
7. Has your child been **diagnosed** with asthma? Does your child have other breathing problems?	☐	☐	
What triggers it? _____	What helps it? _____		
Medications	**Yes**	**No**	If yes, Name and reason for taking
8. Is your child taking any medications?	☐	☐	
Other Health Concerns	**Yes**	**No**	**Explain "Yes" Answers**
9. Does your child have any physical or mental disabilities?	☐	☐	
10. Has your child ever had lead poisoning? Last tested?	☐	☐	

Communication

11. Please check and/or answer.
My child:
- ☐ wears glasses
- ☐ has speech problems that are a concern to me because_____
- ☐ uses gestures to communicate rather than talk
- ☐ seems to have trouble hearing what is said to him/her
- ☐ consistently turns the TV up loud
- ☐ talks loudly
- ☐ has frequent ear infections
- ☐ has drainage from ears
- ☐ has been treated for ear problems
- ☐ has tubes in his/her ears When_____

Hospitalizations and Illnesses	**Yes**	**No**	**Explain "Yes" Answers**
12. Has your child ever been hospitalized or had surgery?	☐	☐	
13. Has your child ever had a serious accident or emergency room visit (broken bones, head injuries, falls, burns, poisoning)?	☐	☐	
14. Has your child ever had a serious illness?	☐	☐	

15. Has your child experienced any of the frequent or serious health problems listed below?

☐ Constipation	☐ Headaches	☐ Sickle Cell
☐ Daytime/ Bed Wetting	☐ Head Injury	☐ Skin rashes
☐ Ear Problems	☐ Head Lice	☐ Strep Throat
☐ Emotional/Behavioral Problems	☐ Nightmares/Trouble Sleeping	☐ Urinary Infection
☐ Eye Problems	☐ Nose bleeds	☐ Seizures – epilepsy/fever

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Can only be reviewed one time at beginning of 2nd year of attendance unless going from EHS to HS.

Reviewed by Parent: _____ Date: _____

Reviewed by Staff: _____ Date: _____

HACAP Child Health History

Child's Name:_____ **Date:**_____
Center: _____ **Birthdate:**_____

16. How much screen time does your child have per day? _____
(i.e. TV, computers, Ipad, Ipod, playing on phone, gaming systems)

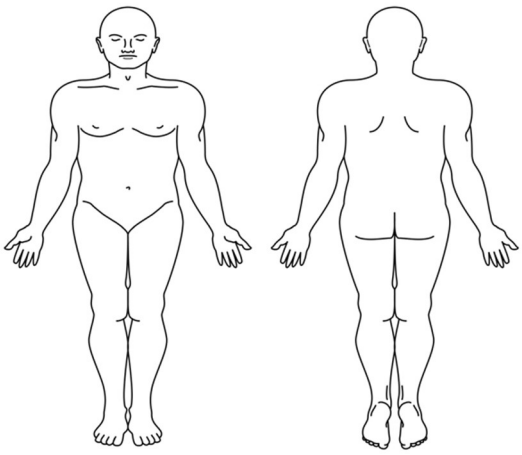
How much physical activity does your child have per day? _____

17. Does your child or any one in your family have any of the following conditions? (Please circle and list family member)

☐ Attention Deficit/Hyperactivity	☐ Eating Disorders	☐ Learning Problems
☐ Cancer	☐ Hearing or Vision Problems	☐ Mental Illness
☐ Diabetes	☐ Heart Disease	☐ Other conditions

18. Has your child ever had any of the following? (Please circle)
Chicken Pox RSV Whooping Cough Tuberculosis (TB)

19. **Skin Markings** Describe any skin markings or body characteristics including: birthmarks, scars, Mongolian spots, hair, fingernails or toenails; scars



_____

20. Any other concerns:

Early Head Start Only

Pregnancy/Birth History	Yes	No	Explain "Yes" Answers
21. Did the mother have any health problems during the pregnancy or during delivery?	☐	☐	
22. Was the child born more than 3 weeks early or late?	☐	☐	
23. What was your child's birth weight?			_____ lbs. _____ Oz.
24. Did your child have any problems at birth or after delivery?	☐	☐	

Parent Signature: _____ Date: _____
Staff Signature: _____ Date: _____
Can only be reviewed one time at beginning of 2nd year of attendance unless going from EHS to HS.
Reviewed by Parent: _____ Date: _____
Reviewed by Staff: _____ Date: _____