Washington Academy
SALEM CENTRAL SCHOOL DISTRICT HEALTH OFFICE
41 East Broadway Salem, NY 12865
Phone: 518-854-6023 Fax: 518-854-6973
Sheryl A Chambers RN
E-mail: schambers@salemcsd.org

June 2020

Dear Parents/Guardians,

Once again it is time to think about the new school year. There haven't been any major changes in state requirements this year, but I'll give a quick review of current ones.

*A student that is enrolling for the first time and students entering Pre-Kindergarten, Kindergarten, 1st, 3rd, 5th, 7th, 9th and 11th grade must have a physical and updated immunizations to be compliant with the state requirements. The physical needs to be completed by a licensed physician, physician assistant or nurse practitioner. A copy of the completed form must be turned in so it can be on file in their health folder.

*Immunizations are big this year again. The following must be done to be compliant:
5th graders going into 6th grade must have the Tdap (Tetanus, Diphtheria and Pertussis) update.
7th, 8th, 9th, 10th and 11th grade students must receive the menactra (meningococcal) update.
12th grade students need to have their second dose of menactra. They all should have received their first dose. If not, please see that they get their first dose now then the second after school has started.
Please remember your child could be excluded from school until these requirements are met.

Communication between private and school health staff is important for safe and effective care at school for your child. Your healthcare provider may not share pertinent health information (basically just immunizations and physicals) without your signed permission. A signature form is included.

As always, if you have any questions, please feel free to call me at home 518 – 854 – 3496 over the summer and back at school starting August 19th 518-854-6023.

Sincerely,

Sheryl Chambers, RN
Salem Central School Nurse

SALEM CENTRAL SCHOOL DISTRICT

41 East Broadway
Salem, New York 12865

HOUSING QUESTIONNAIRE

Name of LEA: ______________________________

Name of School: ______________________________

Name of Student: ______________________________
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ (*Month Day Year*) Grade: ____ (*preschool-12*) ID#: ________ (*optional*)

Address: ______________________ Phone: ______________

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please check* ***one*** *box.*)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): ______________________
- ☐ In permanent housing

____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

____
Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

____
Date

SALEM CENTRAL SCHOOL DISTRICT STUDENT DATA FORM

For Office Use Only

☐ New Student
☐ Re-Entry

Effective Date: ____________
Teacher: ____________
1st Year Entered 9th Grade: ____________

Bus #: ____________
Services: ____________

Student Information

Student's Last Name	First	MI	Grade	Sex	Birth Date (mm / dd / yyyy)	City of Birth	State or Country of Birth

Residence Address	City/State/Zip	Home Phone	Students Born Outside the United States: # of years in US Schools	

Mailing Address (If different from residence address)	City/State/Zip	Emergency Phone	Home Language Spoken	

Parent / Guardian Information

Relation	Address (If different from student address)	Cell Phone	Employer Name & Phone	E-mail Address	CHECK ANY THAT APPLY: Reside w/ student	Receive Mailings	May pick up Student
Father's Name							
Mother's Name							
Step Father's Name							
Step Mother's Name							
Legal Guardian's Name							

Before/After School Child Care Provider: Address: Phone:

CUSTODY LIMITATIONS: (must be documented with legal papers in district folder)
Limitations ☐ Yes ☐ No Legal papers filed in district folder ☐ Yes ☐ No

Notes:

Previous School Attended:
Name ____________
Address ____________

Name of Guidance Counselor or Principal at Previous School: ____________
Date last attended classes at previous school ____________
Has student ever attended school in Salem? ☐ Yes ☐ No ____________

Ethnicity: Please indicate ethnicity. If you choose not to enter this information, NYS requires the district to choose.

Hispanic: ☐ Yes ☐ No

Primary Ethnic Code Check one (If Hispanic you may indicate additional)
☐ White ☐ Native Hawaiian/Pacific Islander ☐ Asian
☐ American Indian/Native Alaskan ☐ Black/African American

Additional Race/Ethnicities: (Check all that apply)
☐ White ☐ Native Hawaiian/Pacific Islander ☐ Asian
☐ American Indian/Native Alaskan ☐ Black/African American

List brothers and sisters that are part of the family unit:

Name	Date of Birth	Sex	Grade	Name	Date of Birth	Sex	Grade

Other than parent, in case of emergency, who can we call:

Name	Relationship	Home Phone	Cell Phone	Work Phone	CHECK ANY THAT APPLY		
					Reside w/ student	Request Mailings	May pick up student

Languages, other than English, spoken at home (specify) ____________

Has the student ever been retained? ☐ Yes ☐ No Grade(s) ______

Is the student receiving any support services in any areas? ☐ Yes ☐No

If yes, description ____________________

Armed Forces: Is parent/guardian currently on **active duty** with the armed forces? Yes or No

If yes, please provide the entry date in armed forces ____________
Active duty means full time duty in an active military serve of the U.S. (Army, Navy, Air Force, Marines, Coast Guard, and National Guard)

Does the student have a 504 Plan on file with the previous district? ☐ Yes ☐ No

Does the student have an IEP on file with the previous district? ☐ Yes ☐ No

If you would like to identify the student as physically disabled, please check here ⇨ ☐

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed. such as proof of residency, school records, immuz. records, or birth cert. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Living Arrangements: Are you living in a shelter; with relatives or others due to lack of housing; in an abandoned apartment/building, in a motel/hotel, camping ground, car, train/bus station or other similar situation due to the lack of alternative, adequate housing; or temporarily housed in a shelter awaiting an Office of Children and Family Services permanent foster care placement?

☐ Yes ☐ No

Activity Permission: I give my permission for this student to participate in any activity of the Salem Central School District, such as field trips, pictures, etc. during the school year if under school supervision.

☐ Yes ☐ No

______________________________ ______________________________ __________
Parent/Guardian PRINT NAME Parent/Guardian SIGNATURE Date

***Note**: The Salem Central School District may occasionally use student photographs, video recordings or work on the district website and/or in district and community publications. Any parent or guardian who does not wish to have his/her child(ren)'s picture or work used for these purposes must notify the building principal in writing.*

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First ______ Middle ______ Last ______

DATE OF BIRTH:

Month ______ Day ______ Year ______

GENDER:
❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name ______ First Name ______ Relation to Student ______

HOME LANGUAGE CODE ______

Language Background
(Please check all that apply)

Question			
1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other ______ specify	
2. What was the first language your child learned?	❑ English	❑ Other ______ specify	
3. What is the Home Language of each parent/guardian?	❑ Mother ______ specify	❑ Father ______ specify	❑ Guardian(s) ______ specify
4. What language(s) does your child understand?	❑ English	❑ Other ______ specify	
5. What language(s) does your child speak?	❑ English	❑ Other ______ specify	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other ______ specify	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other ______ specify	❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School ______ Address ______	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school ______

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ☐ *No* ☐ *Not sure* ☐ *If yes, please explain: ______

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ☐ No ☐ Yes* **Please complete 10b below*

10b. *If referred for an evaluation,* has your child ever *received* any special education services in the past?
☐ No ☐ Yes – Type of services received: ______

Age at which services received *(Please check all that apply)*:
☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

______

______

12. In what language(s) would you like to receive information from the school? ______

______ *Signature of Parent or of Person in Parental Relation*

Month: Day: Year: ______ *Date*

Relationship to student: ☐ Mother ☐ Father ☐ Other: ______

Official Entry Only – Name/Position of Personnel Administering HLQ

NAME: ______ POSITION: ______

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

Name/Position of Qualified Personnel Reviewing HLQ and Conducting Individual Interview

NAME: ______ POSITION: ______

ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes

**DATE OF INDIVIDUAL INTERVIEW: ______ MO DAY YR

OUTCOME OF INDIVIDUAL INTERVIEW: ☐ ADMINISTER NYSITELL ☐ ENGLISH PROFICIENT ☐ REFER TO LANGUAGE PROFICIENCY TEAM

Name/Position of Qualified Personnel Administering NYSITELL

NAME: ______ POSITION: ______

DATE OF NYSITELL ADMINISTRATION: ______ MO. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

SALEM CENTRAL STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐ No ☐ Yes: ______________________________

Please list any additional concerns: (use back of sheet if necessary) ______________________________

____

Parent/Guardian Signature: ______________________________ Date: ______________

Washington Academy
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41 East Broadway Salem, NY 12865
Phone: 518-854-6023 Fax: 518-854-6973
Sheryl A Chambers RN
E-mail: schambers@salemcsd.org

2020 - 2021

HEALTHCARE PROVIDER AUTHORIZATION TO ADMINISTER OVER – THE – COUNTER MEDICATION AT SCHOOL.

As the **Healthcare Provider** of the above child(ren), the following medication has been prescribed for the School Nurse to administer in the following doses, at the indicated intervals, when she feels they are indicated by the child's condition, without obtaining further permission from us.

Doctor's Signature: ______________________________ Date: __________________

PARENT AUTHORIZATION TO ADMINISTER OVER-THE-COUNTER MEDICATION AT SCHOOL

As the Parent/Guardian of ______________________, I hereby authorize the School Nurse to administer the medication described below to my child(ren).

Signature: ________________________________ Date: _________________

ACETAMINOPHEN (Tylenol) - Give 10-15mg per kilogram per dose, every 4 hours for pain or fever by mouth.
IBUPROPHEN (Advil, Motrin) – Give 10mg per kilogram per dose, every 6 hours for pain or fever by mouth.
MIDOL or generic form – for ages 12 years and older – 1 or 2 tablets every 4 to 6 hours as needed.
DIPHENHYDRAMINE (Benadryl) - Give 1 to 1.5mg per kilogram, by mouth, every 6 hours for itchiness, allergic reaction and allergy symptoms.
TUMS - Give 1 or 2 tablets as needed by mouth, every 2-4 hours for stomach ache or indigestion.
BISMUTH SUBSALICYLATE (Pepto Bismol) – Give as directed per age and bottle label.
Cough Drops – Sucrets – Cepacal lozenges – as needed for cough or sore throat.
Benadryl or other anti-itch creams – apply as directed for relief of bug bites and itchy areas on the skin surface.
Triple Antibiotic ointment or First Aid cream – as needed for scrapes.

Salem Central School Health Office
41 East Broadway
Salem, NY 12865
Sheryl A Chambers R.N.
E-mail: schambers@salemcsd.org
Phone: (518) 854-6023 Fax: (518) 854-6973

RELEASE TO EXCHANGE CONFIDENTIAL MEDICAL INFORMATION

I, ______________________ authorize the Salem Central School Nurse to exchange medical
(Name of Parent/ Guardian)
information regarding______________________ with their Doctor's office / Medical Care
(Student's name)
Center for the purpose of updating their school health records with the information from previous and recent physical examinations and immunization updates.

List any information you would like restricted here: ______________________

____.

This authorization will be in force and in effect for one of the following time periods:
(Please check one)

____ **Throughout the current school year only**
____ **Until your child graduates**
____ **Unless you decide to cancel this in writing**

Doctor's / Health Care Provider's office name:______________________

Address : ______________________

____

Telephone Number: ______________ Fax Number:______________

This release has been authorized by:

Signed by & Relationship: ______________________

Telephone Number ______________________

Date of Signature ______________________

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached	☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached	Date of last seizure: ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached	☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI________kg/m2

Percentile (Weight Status Category): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥5 μg/dL			

List Other Pertinent Medical Concerns
(e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code

*Required only for students with an IEP receiving Medica

Name:				DOB:
SCREENINGS				
Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process __**ONLY**__ **required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : ____________

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.

Date Withdrew__________ F____R_____D_____

2019-2020 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call **518-854-6040**, if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **Salem CSD**
PO Box 517
Salem, NY

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. **Skip to Part 4, and sign the application.**

Name: ______________________________ CASE #: ____________________________

3. Report all income for ALL Household Members (Skip this step if you answered 'yes' to step 2)

All Household Members (including yourself and all children that have income).
List all Household members not listed in Step 1 (including yourself) **even if they do not receive income.** For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐

Total Household Members (Children and Adults) ☐☐

***Last Four Digits of Social Security Number:** XXX-XX- __ __ __ __

I do not have a SS# ☐

*When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#), or mark the "I do not have a SS# box" before the application can be approved.

4. Signature: An adult household member must sign this application before it can be approved.
I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school will get federal funds; the school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: ________________________________ **Date:** ______________
Email Address: ________________________________
Home Phone: ______________ Work Phone: ______________ Home Address: ______________________

5. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Race (Check one or more) : ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

☐ SNAP/TANF/Foster
☐ Income Household: Total Household Income/How Often: ____________/____________ Household Size: ____________
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid
Signature of Reviewing Official________________________________ **Date Notice Sent:**____________

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, complete only one application for your household using the instructions below. Sign the application and return the application to ___________________.
If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help: __________________. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

(1) Print the names of the children, including foster children, for whom you are applying on one application.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

PART 2 HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

(1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

PART 3 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 4.

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.
(3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
(4) The application must include the last four digits only of the social security number of the adult who signs **PART 4** if Part 3 is completed. If the adult does not have a social security number, check the box. **If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.**
(5) An adult household member must sign the application in PART 4.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

USE OF INFORMATION STATEMENT

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs.
We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

DISCRIMINATION COMPLAINTS

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.