EMERGENCY/STUDENT PARTICIPATION FORM 2018/2019 SCHOOL YEAR

NOTE: This information will accompany student in an emergency/crisis. **Date Form Completed**: _____

☐ **New Student** ☐ **Returning Student** **Start Date**:_____

STUDENT'S NAME: _____ **SEX:** _____ **HOME DISTRICT**:_____

DATE OF BIRTH: _____ **MEDICAID #**: _____ **SPEED SCHOOL**:_____

LIVING WITH: Natural Parent: Mother_____ Foster Parent _____ Other _____
Father_____

PHONE NUMBER(S) YOU WOULD LIKE US TO USE FOR OUR SCHOOL REACH SYSTEM (Automated messages regarding school closings, up-coming events, etc): _____

PRIMARY EMAIL ADDRESS FOR CONTACT: _____

NAME OF PARENT/GUARDIAN:

PARENT/GUARDIAN #1 NAME:_____

ADDRESS: _____

HOME PHONE #: _____ WORK PHONE #: _____

CELL PHONE #:_____ EMAIL: _____

PARENT/GUARDIAN #2 NAME:: _____

ADDRESS: _____

HOME PHONE #: _____ WORK PHONE #: _____

CELL PHONE #:_____ EMAIL: _____

WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?: _____

FOSTER PARENT INFORMATION: FOSTER AGENCY: _____

CASE WORKER'S NAME: _____PHONE NUMBER: _____

WILL YOUR CHILD REQUIRE BUS TRANSPORTATION: ☐ Yes ☐ No

Does your child participate in Day-Care? Yes ____ No ____ Contact Person at Day-Care _____

Day-Care Phone Number _____ **Pickup**: Home _____ Day Care _____

Day Care Address _____ **Drop off:** Home _____ Day Care _____

_____

Please list name, and phone number of three persons (neighbors, friends, or relatives) the school may contact and release your student to in an EMERGENCY if you cannot be contacted.

NAME	RELATIONSHIP TO CHILD	ADDRESS	PHONE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____

Signature of Parent/Guardian

STUDENT'S NAME: _____

DOCTOR'S NAME: _____ **PHONE NUMBER**: _____

1. Give diagnoses: _____

2. List all medications your child is receiving:

Medication	Dosage Given	Times Given	Reason
_____			
_____			
_____			

3. List treatments your child requires:

Treatment	Times Given	Reason
_____		
_____		
_____		

Special fluids required:_____

List food restrictions: _____

Dietary - please circle one: Regular Diet Chopped Foods Diet Blended (pureed) Diet

Tasting Only Nothing by Mouth

SPECIAL NEEDS/CAUTIONS: _____

_____

_____

Additional information that would assist in programming for your child. _____

_____

I hereby give my permission for the following licensed medical provider _____
(doctor or clinic)

and/or medical agencies_____ for exchange of confidential medical
(doctor or clinic)

information contained in the records(s) of my student _____, date of birth

_____, with SPEED S.E.J.A. #802 health services providers and/or administrators for one (1)

calendar year beginning 8/20/18 and ending 5/30/19.

_____
Signature of Parent or Guardian

STUDENT'S NAME: _____

PLEASE CHECK ALL THAT APPLY:

☐ Chicken Pox SPECIFY/PROTOCOL:_____

☐ Vision Impaired SPECIFY/PROTOCOL:_____

☐ Glasses SPECIFY/PROTOCOL:_____

☐ Hearing Impaired SPECIFY/PROTOCOL:_____

☐ Tubes in Ears SPECIFY/PROTOCOL:_____

☐ Verbal (talks) SPECIFY/PROTOCOL:_____

☐ Ambulatory (walks) SPECIFY/PROTOCOL:_____

☐ Activity Precautions SPECIFY/PROTOCOL:_____

☐ Wheelchair SPECIFY/PROTOCOL:_____

☐ Safety Vest SPECIFY/PROTOCOL:_____

☐ G-Tube SPECIFY/PROTOCOL:_____

☐ Shunt SPECIFY/PROTOCOL:_____

☐ Tracheotomy SPECIFY/PROTOCOL:_____

☐ Heart Condition SPECIFY/PROTOCOL:_____

☐ Skin Problem SPECIFY/PROTOCOL:_____

☐ Down Syndrome SPECIFY/PROTOCOL:_____

☐ Cerebral Palsy SPECIFY/PROTOCOL:_____

☐ Fragile X SPECIFY/PROTOCOL:_____

☐ Bladder/Bowel Control SPECIFY/PROTOCOL:_____

☐ Attention Deficit Disorder (ADHD) SPECIFY/PROTOCOL:_____

☐ Asthma SPECIFY/PROTOCOL:_____

☐ Diabetes SPECIFY/PROTOCOL:_____

☐ Seizures DATE OF LAST SEIZURE:_____

Describe activity during seizure (if applicable) _____

_____

Does your child have any allergies? (e.g., Food, Peanut, Bee Stings, Latex, etc.)_____

If so, is an Epipen required? ☐ Yes ☐ No

Describe symptoms of allergies:_____

_____

Advise what care is necessary for symptoms of allergies: _____

What type of extra supportive equipment must be transported and secured with the student? (e.g. communication aides, oxygen tanks, suction machines, etc.)_____

_____

PLEASE DON'T FORGET TO SIGN THE FORM ON THE FRONT PAGE

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Illinois Department of DCFS Children & Family Services

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

																					Code:
Date																					
Age/ Grade																					**P = Pass** **F = Fail**
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	**U = Unable to test** **R = Referred**
Vision																					**G/C = Glasses/Contacts**
Hearing																					

Student's Name (Last / First / Middle)	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID #

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION (**List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **(NOT REQUIRED FOR DAY CARE)** **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed ☐** **Test performed ☐**
Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

Asthma and Allergy Foundation of America

CHILD CARE ASTHMA/ALLERGY ACTION CARD

ID Photo

Name: _____ _____

Grade: _____ DOB: _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W): _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W): _____

Other Contact Information: _____

Emergency Phone Contact #1 _____
Name

_____ _____
Relationship Phone

Emergency Phone Contact #2 _____
Name

_____ _____
Relationship Phone

Physician Child Sees for Asthma/Allergies: _____

Phone: _____

Other Physician: _____

Phone: _____

DAILY ASTHMA/ALLERGY MANAGEMENT PLAN

- **Identify the things that start an asthma/allergy episode**

(Check each that applies to the child)

— Animals — Bee/Insect Sting — Chalk Dust — Change in Temperature
— Dust Mites — Exercise — Latex — Molds
— Pollens — Respiratory Infections — Smoke — Strong Odors
— Food: _____
— Other: _____
Comments: _____
_____

- **Peak Flow Monitoring** (for children over 4 years old)

Personal Best Peak Flow reading: _____

Monitoring Times: _____ _____ _____

- **Control of Child Care Environment** (List any environmental control measures, pre-medications, and/or dietary restrictions that the child needs to prevent an asthma/allergy episode.) _____
_____

- **Daily Medication Plan for Asthma/Allergy**

	Name	Amount	When to Use
1			
2			
3			
4			

OUTSIDE ACTIVITY AND FIELD TRIPS

The following medications must accompany child when participating in outside activity and field trips:

	Name	Amount	When to Use
1			
2			
3			

Rev. 5/01

ASTHMA EMERGENCY PLAN

Emergency action is necessary when the child has symptoms such as _____

_____

or has a peak flow reading at or below _____

- **Steps to take during an asthma episode:**
  1. Check peak flow reading (if child uses a peak flow meter).
  2. Give medications as listed below.
  3. Check for decreased symptoms and/or increased peak flow reading.
  4. Allow child to stay at child care setting if: _____

     _____
  5. Contact parent/guardian
  6. Seek emergency medical care if the child has any one of the following:

→ No improvement minutes after initial treatment with medication.
→ Peak flow at or below _____.
→ Hard time breathing with:
  - Chest and neck pulled in with breathing.
  - Child hunched over.
  - Child struggling to breathe.

→ Trouble walking or talking.
→ Stops playing and cannot start activity again.
→ Lips or fingernails are gray or blue.

IF THIS HAPPENS, GET EMERGENCY HELP NOW!

- **Emergency Asthma Medications:**

	Name	Amount	When to Use
1			
2			
3			
4			

- **Special Instructions:**

_____

_____

ALLERGY EMERGENCY PLAN

- **Child is allergic to:** _____

_____

_____

- **Steps to take during an allergy episode:**
  1. If the following symptoms occur, give the medications listed below.
  2. Contact Emergency help and request epinephrine.
  3. Contact the child's parent/guardian.

- **Symptoms of an allergic reaction include**:

  (Physician, please circle those that apply)

→**Mouth/Throat:** itching & swelling of lips, tongue, mouth, throat; throat tightness; hoarseness; cough
→**Skin:** hives; itchy rash; swelling
→**Gut:** nausea; abdominal cramps; vomiting; diarrhea
→**Lung*:** shortness of breath; coughing; wheezing
→**Heart:** pulse is hard to detect; "passing out"
*If child has asthma, asthma symptoms may also need to be treated.

- **Emergency Allergy Medications:**

	Name	Amount	When to Use
1			
2			
3			
4			

- **Special Instructions:**

_____

_____

Physician's Signature **Date** **Parent/Guardian's Signature** **Date** **Child Care Provider's Signature** **Date**

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle			Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code			Telephone:
Name of School:		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:		Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

IOCI 0600-10 Printed by Authority of the State of Illinois

State of Illinois
Department of Public Health

DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address: Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):		

I am unable to obtain the required dental examination because:

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/All Kids).

☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All Kids).

☐ My child is enrolled in Medicaid/All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/All Kids.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature _____ Date _____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

December 2006

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			**Near**
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name _____ License Number _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

Address _____

_____

Phone _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

State of Illinois
Illinois Department of Public Health

Eye Examination Waiver Form

Please print:

Student Name _____ Birth Date _____
(Last) (First) (Middle Initial) (Month/Day/Year)

School Name _____ Grade Level_____ Gender: ❑ Male ❑ Female

Address _____
(Number) (Street) (City) (ZIP Code)

Phone_____
(Area Code)

Parent or Guardian _____
(Last) (First)

Address of Parent or Guardian _____
(Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision examination because:

❑ My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ ALL KIDS.

❑ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.

❑ Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations:

_____

_____

Signature _____ Date _____

(Source: Added at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois IOCI 13-378

SPEED S.E.J.A. #802
1125 Division Street
Chicago Heights, Illinois 60411-2491

Telephone: 708-481-6100
TDD: 708-481-6100
Fax: 708-481-5713

Physical Restraint Notification Form

The behavior management system utilized at SPEED Independence Program serves to assist students in gaining more self-control and assuming more responsibility for their behavior. The techniques employed are widely recognized as an effective intervention for strengthening appropriate student behavior and for weakening inappropriate behaviors. The behavior management system is designed to treat each student in a fair, reasonable, and systematic manner and to provide the student with a consistent and predictable school environment.

A child may be removed from the classroom to serve a brief time out for disruptive behavior, which interferes with other students' ability to learn. It is only when the student's behavior escalates to the point where the student is no longer in control of their behavior that a physical restraint may be implemented.

Physical restraint does not include momentary periods of physical restriction by direct person to person contact to prevent a student from completing an act that would result in potential physical harm to themselves or others, damaging property, or to remove a disruptive student who is unwilling to leave the area voluntarily.

A physical restrain will only be employed when:

a. The student poses a physical risk to himself, herself, or others.
b. There is no medical contraindication to its use.
c. The staff applying the restraint has been trained in its safe application.

It is our goal to manage our students' behaviors through positive means and through systematic, prescribed steps, which will largely eliminate the need for physical control. When physical restraint is employed, staff will utilize a minimal amount of force necessary to control the student and to ensure the student's safety and dignity.

A child will be released from physical restraint immediately upon determination by the staff member initiating the restraint that the student is no longer an imminent danger to cause physical harm to themselves or others.

The program will send written notice of any incident of physical restraint to parents/guardians within 24 hours of the incident. The notification will include the student's name, date of the incident, and a description of the intervention used, including the name of the contact person, for further information.

I have received a copy of the Behavior Management System and agree to the procedures used at the Independence Program. I understand that acceptance of these procedures is a necessary condition for admittance into the program or continuation of services.

_____ _____

Parent/Guardian Signature Date

Student's Name _____

English

Home Language Survey

The state requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency.

Please answer the questions below and return this survey to your child's school.

Student's Name: _____

1. Is a language other than English spoken in your home?

   Yes _____ No _____

   What language? _____

2. Does your child speak a language other than English?

   Yes _____ No _____

   What language? _____

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

_____ _____

Parent/Legal Guardian Signature Date

Spanish
Español

Encuesta del Idioma en el Hogar

El estado requiere que el distrito recoja información en una Encuesta del Idioma que se Habla en el Hogar (*Home Language Survey* o HLS por sus siglas en inglés) para cada estudiante nuevo. Esta información se usa para contar a los estudiantes cuyas familias hablan en el hogar un idioma que no es el inglés. También ayuda a identificar a los estudiantes que necesitan ser evaluados para la fluidez en el idioma inglés.

Por favor, conteste las preguntas a continuación y devuelva esta encuesta a la escuela de su niño.

Nombre del estudiante: _____

1. ¿Se habla en su casa otro idioma que no es el inglés?

   Sí _____ No _____

   ¿Cuál? _____

1. ¿Habla su niño(a) un idioma que no es el inglés?

   Sí _____ No _____

   ¿Cuál? _____

Si la respuesta a cualquiera de las preguntas es "Sí", la ley requiere que la escuela evalúe la fluidez de su niño en el idioma inglés.

_____ _____

Firma del Padre/Madre/Encargado/Tutor Legal Fecha

TO: SPEED Parents/Guardians
FROM: SPEED Administration
DATE: July 2, 2018
RE: Federal Community Education Opportunity Program

Hello SPEED Parents/Guardians and welcome to the start of the new school year! We are pleased to announce that SPEED will once again be participating in the Federal Community Education Opportunity Program for the FY 18-19 school year. Under this program, all students enrolled at SPEED will automatically by eligible for free meals.

Thank you for your continued support of the program and we look forward to a positive and productive school year!

SPEED S.E.J.A. #802
1125 Division Street - Chicago Heights, IL 60411
Phone (708)_____ Fax (708)_____ School Year _____

MEDICATION AUTHORIZATION FORM

Permit for SPEED Personnel to Administer Required Mediations during School Hours

Student Name _____School _____

(TO BE COMPLETED BY LICENSED PRESCRIBER)

Date _____

This student_____ is under my medical care for

_____ and medication is required

during the school day for the purpose of _____

Name of Drug	Dosage	Frequency	Time To Be Given At School/ Education Setting	Duration	Side Effects

Signature of Licensed Prescriber _____

Printed Name of Licensed Prescriber _____

Address _____

_____

(City) (State) (Zip Code)

_____

Telephone Number Fax Number

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

I, _____, give permission for my child to receive the above medication(s) as directed by the licensed prescriber. The medication will be sent to school/educational setting in a container appropriately labeled by the pharmacy. I will notify the school in writing if the medication is discontinued. I will also obtain a written order from the licensed prescriber if the medication dosage is changed. I will bring the medication to the school nurse or notify the school nurse if extenuating circumstances exist regarding transport of medication to the educational setting.

Parent/Guardian Signature_____ Date_____

Address/City/State_____

Home phone _____ Cell/Work Phone _____

SPEED S.E.J.A. #802
1125 Division Street
Chicago Heights, Illinois 60411-2491

Telephone: 708-481-6100
TDD: 708-481-6100
Fax: 708-481-5713

PARENT RELEASE AND PHYSICIAN'S PRESCRIPTION

*To be completed by **parent***: Today's Date: _____

STUDENT'S NAME: _____ DATE OF BIRTH: _____

SCHOOL DISTRICT: _____

Occupational Therapy ( ) and/or Physical Therapy ( ) services have been recommended for your child.
A yearly update on your child's "Release of Medical Information" form is required.
Please complete, sign, and return this entire form.

_____	_____
Parent/Guardian Signature and Date	Name of Physician and Agency
_____	_____
Address	Address
_____	_____
City, State	City, State
_____	_____
Telephone #	Telephone # Fax #

*To be completed by **physician.***
Please return to SPEED S.E.J.A. #802 Fax: _____

It has been determined that OT and/or PT services are appropriate for the above-named child. An annual physician's prescription is necessary in order for our staff to provide treatment. Please complete the bottom portion of this prescription and return it to our office. Please call if you have questions.

( ) Occupational Therapy ( ) Physical Therapy

Significant Medical concerns/diagnosis: _____

_____

Contraindications: _____

_____

Physician Signature: _____ **Printed Name**:_____

NPI #:_____ **Date**: _____

SPEED: Stu-014
11/18

Explanation of Parent/Guardian Permissions

(please keep for your records)

We, the administration of SPEED School District #802, have a website: http://www.speed802.org

We are asking for your permission to include a picture of your child that might be taken throughout the school year. Because the internet website is a public document your permission is required.

Whether you would or would not like for us to use your child's picture on the SPEED website, Facebook, in presentations and/or in the SPEED yearbook is determined by your choices made on the Permissions pages of this packet.

Thank you

As a part of your child's Adaptive Physical Education Program, we incorporate movement using the SPEED swimming pool. The water and air temperatures are kept at a warm level for the children so that they do not become chilled. This warm pool environment is conducive for one-on-one motor activity with your child, as well as small group instruction. We encourage you to check out our therapy pool on your next visit to SPEED.

Your permission is required for your child's participation in swimming.

PERMISSIBLE COMPUTER USE

Students and their parents should carefully review the agreement and the attached policy and procedures regarding internet safety and permissible use of SPEED computers and access to the internet using SPEED means of access. Parents and students should sign the agreement where indicated to evidence their agreement to follow the SPEED rules and regulations set forth in SPEED policy and procedures regarding internet safety and permissible computer use. Students will be allowed to use SEED computers and to access the internet using SPEED means pursuant to this policy and procedures after the agreement has been signed by the student and his/her parent or guardian. Please retain the attached policy and procedures for future reference.

Students can participate in community based trips to local area stores, restaurants, schools, parks, etc. These supervised learning experiences are part of the curriculum for our students. A school bus, SPEED van, public transportation or supervised walking will be used for transportation.

Your son/daughter's teacher will notify you in writing or by telephone of the location, day, time and mode of transportation prior to the trip. At this time, you have the option of not granting permission for your son/daughter to attend.

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1125 Division Street
Chicago Heights, Illinois 60411-2491

Telephone: 708-481-6100
TDD: 708-481-6100
Fax: 708-481-5713

Opt-Out Policy & Form

SPEED School District 802

As part of SPEED's community relations efforts, District 802 periodically publishes, photographs, audio and video recordings of students to be used in SPEED's Newsletters, SPEED's Website, SPEED's Social Media Page, and to the Public Media .

IF YOU CONSENT TO ALLOWING YOUR STUDENTS PICTURE PUBLISHED, YOU DO NOT NEED TO COMPLETE THE FORM BELOW!

□ I do NOT allow SPEED School District 802 to publish, photographs and audio and video recordings of the named student below, to SPEED's Newsletters, SPEED's Website, SPEED's Social Media Page, on Displays, and to the Media .

(NOTE: SPEED School District 802 reserves the right to release or publish photos or videos where your student appears in the background, or in extracurricular activities that appear in public and Public Media.

I understand that by signing this form, the student named below, will not be featured in publicity about the achievements or activities of students at SPEED. Please complete, sign and return this form to your school.

Student Name _____

ID Number _____

Signature of Student _____Date _____

Signature of Parent/Guardian _____ Date _____

PERMISSIONS

I have read and I understand the SPEED's policy and procedures regarding **Internet safety and permissible use of SPEED computers and access to the Internet using SPEED means of access**. I understand that the SPEED's network and access to the Internet is for educational purposes only. I also recognize that it is impossible for SPEED to prevent access to all non-educational materials and that the responsibility for appropriate use of SPEED computers ultimately rests with the computer user. I agree to instruct my child accordingly. I will hold harmless the SPEED, its employees, agents, or Board members, for any harm caused by materials or software transmitted or obtained by using SPEED computers and/or SPEED means of access to the Internet. I accept full responsibility for supervision if and when my child's use of SPEED means of access to the Internet is not in a school setting.

_____ _____

Signature of Parent Date

____ ***Yes***, I hereby request that my child be allowed access to the Internet using SPEED means of access.

_____ _____

Signature of Parent Date

_____ ***No***, I request that my child ***not be allowed*** access to the Internet using SPEED means of access.

_____ _____

Signature of Parent Date

I, the parent/guardian of _____ grant permission for my son/daughter to participate in **community based trips** to local area stores, restaurants, schools, parks, etc.

□ **Yes** □ **No**

_____ _____

Parent/Guardian Signature Date

Student Authorization for Electronic Network Access

Dear Parents/Guardians:

Our School District has the ability to enhance your child's education through the use of electronic networks, including the Internet. Our goal in providing this service is to promote educational excellence by facilitating resource sharing, innovation, and communication. Students and their parents/guardians need only sign this ***Authorization/or Electronic Network Access*** once while the student is enrolled in the School District.

The District *filters* access to materials that may be defamatory, inaccurate, offensive, or otherwise inappropriate in the school setting. If a filter has been disabled or malfunctions it is impossible to control all material and a user may discover inappropriate material. Ultimately, parents/guardians are responsible for setting and conveying the standards that their child or ward should follow, and the School District respects each family's right to decide whether or not to authorize Internet access.

With this educational opportunity also comes responsibility. The use of inappropriate material or language, or violation of copyright laws, may result in the loss of the privilege to use this resource. Remember that you are legally responsible for your child's actions. If you agree to allow your child to have an Internet account, sign the form below and return it to your school.

Authorization for Electronic Network Access Form

Students must have a parent/guardian read and agree to the following before being granted unsupervised access:

All use of the Internet shall be consistent with the District's goal of promoting educational excellence by facilitating resource sharing, innovation, and communication. **The failure of any user to follow the terms of the *Acceptable Use of Electronic Networks* will result in the loss of privileges, disciplinary action, and/or appropriate legal action.** The signatures at the end of this document are legally binding and indicate the parties who signed have read the terms and conditions carefully and understand their significance.

I have read this *Authorization* form. I understand that access is designed for educational purposes and that the District has taken precautions to eliminate controversial material. However, I also recognize it is impossible for the District to restrict access to all controversial and inappropriate materials. I will hold harmless the District, its employees, agents, or Board members, for any harm caused by materials or software obtained via the network. I accept full responsibility for supervision if and when my child's use is not in a school setting. I have discussed the *Acceptable Use of Electronic Networks* with my child. I hereby request that my child be allowed access to the District's electronic network, including the Internet.

_____ Date _____

Parent/Guardian Signature

Students must also read and agree to the following before being granted unsupervised access:

I understand and will abide by the above *Authorization for Electronic Network Access.* I understand that the District and/or its agents may access and monitor my use of the Internet, including my email and downloaded material, without prior notice to me. I further understand that should I commit any violation, my access privileges may be revoked, and school disciplinary action and/or legal action may be taken. In consideration for using the District's electronic network connection and having access to public networks, I hereby release the School District and its Board members, employees, and agents from any claims and damages arising from my use of, or inability to use the District's electronic network, including the Internet.

_____ _____

Student Signature Date

SPEED S.E.J.A. District #802
1125 Division Street
Chicago Heights, Illinois 60411-2491

Telephone: 708-481-6100
TDD: 708-481-6100
www.speed802.org

Student/Parent Handbook Acknowledgement and Pledge 2018/2019

Name of Student: _____

Student Acknowledgement and Pledge

I acknowledge receiving and/or being provided electronic access to the Student/Parent Handbook and School Board policy on student behavior. I have read these materials and understand all rules, responsibilities and expectations. In order to help keep my school safe, I pledge to adhere to all School and School District rules, policies and procedures.

I understand that the Student/Parent Handbook and School District policies may be amended during the year and that such changes are available on the School District website or in the school office.

I understand that my failure to return this acknowledgement and pledge will not relieve me from being responsible for knowing or complying with School and School District rules, policies and procedures.

_____ _____
Student Signature Date

Parent/Guardian Acknowledgement

I acknowledge receiving and/or being provided electronic access to the Student/Parent Handbook and School Board policy on student behavior. I have read these materials and understand all rules, responsibilities and expectations.

I understand that the Student/Parent Handbook and School District policies may be amended during the year and that such changes are available on the School District website or in the school office.

I understand that my failure to return this acknowledgement will not relieve me or my child from being responsible for knowing or complying with School and School District rules, policies and procedures.

_____ _____
Parent/Guardian Signature Date

SPEED S.E.J.A. DISTRICT 802

MANDATORY FORM TO BE RETURNED TO CAFETERIA

Child Nutrition Programs
PHYSICIAN STATEMENT FOR MEAL ACCOMMODATIONS

CHILD'S NAME	AGE	DATE

SCHOOL/FACILITY NAME	ADDRESS (Street, City, State, Zip Code)

Parent/Guardian:

This school/facility participates in a federally-funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable meal accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable meal accommodations may be made for children without disabilities who may still have special dietary needs; a medical statement may be required. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form. If you have any questions, please contact _____ *Name* at _____ *Telephone (Include Area Code)*.

PHYSICIAN STATEMENT

1. Is this accommodation being requested on the basis of a:
   - ☐ preference
   - ☐ mental or physical impairment or disability according to ADA Amendments of 2008?

   List the impairment or disability: _____
   _____

2. How does this physical or mental impairment restrict the child's diet?

3. What accommodations are being requested? For the safety of the child and because most school/child care centers do not have access to a registered dietician, please be as specific as possible. Attach additional sheet if needed.
   - ☐ Timing of meal service: _____
     _____
   - ☐ Alteration of meal preparation method: _____
     _____
   - ☐ Variation from meal pattern (must include foods to be omitted as well as foods to be substituted; you may attach a menu).
     _____
     _____

4. _____ *Date* _____ *Signature of Physician* _____ *Printed Name*

5. _____ *Date* _____ *Signature of Parent/Guardian* _____ *Printed Name*

FOR SCHOOL/FACILITY USE ONLY:

- ☐ Form received on _____.
- ☐ Form incomplete. Parent contacted on _____.
- ☐ Form complete. Accommodation will not be made. ☐ Child does not have a disability ☐ Request not reasonable
- ☐ Form complete. Accommodations will begin on _____.

_____ *Date* _____ *Signature of Food Service Director/Contact* _____ *Printed Name*

Dear Parent/Guardian:

Children need healthy meals to learn. _____ offers healthy meals every school day. Breakfast costs $_____; lunch costs $_____. Your children may qualify for free meals or for reduced price meals. Reduced price is $_____ for breakfast and $_____ for lunch. To apply for free or reduced-price meals, use the Household Eligibility Application, which is enclosed. We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: _____.

Your children may qualify for free or reduced price meals if your household income falls at or below the limits on this chart.

Income Eligibility Guidelines
Effective from July 1, 2018 to June 30, 2019
Reduced-Price Meals
185% Federal Poverty Guideline

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	22,459	1,872	936	864	432
2	30,451	2,538	1,269	1,172	586
3	38,443	3,204	1,602	1,479	740
4	46,435	3,870	1,935	1,786	893
5	54,427	4,536	2,268	2,094	1,047
6	62,419	5,202	2,601	2,401	1,201
7	70,411	5,868	2,934	2,709	1,355
8	78,403	6,534	3,267	3,016	1,508
For each additional family member, add	7,992	666	333	308	154

1. DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD? No. Complete the application to apply for free or reduced price meals. Use one Household Eligibility Application for all students in your household per district. We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to the school.

2. WHO CAN GET FREE MEALS? All children in households receiving benefits from Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and/or are foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals regardless of your income. Also, your children can get free meals if your household's gross income is within the free limits on the Federal Income Eligibility Guidelines. Children who meet the definition of homeless, runaway, or migrant also qualify for free meals. If you haven't been told your children will get free meals, please contact your school to see if your child(ren) qualifies.

3. WHO CAN GET REDUCED PRICE MEALS? Your children can get low cost meals if your household income is within the reduced price limits on the Federal Eligibility Income Chart, shown above.

4. A MEMBER OF MY HOUSEHOLD RECEIVED SNAP OR TANF BENEFITS. THE SCHOOL SENT A LETTER STATING THAT MY CHILD IS AUTOMATICALLY APPROVED FOR FREE MEALS BASED ON DIRECT CERTIFICATION. DO I NEED TO DO ANYTHING MORE TO ENSURE THAT MY CHILD RECIEVES FREE MEALS? No. You do not need to do anything more to receive free meals for your child. If you have students not listed on the letter, contact the school immediately. If you do not wish to receive the free meals, you should follow the steps outlined in the letter from the school to notify school personnel immediately.

5. HOW DO I KNOW IF MY CHILDREN QUALIFY AS HOMELESS, MIGRANT, OR RUNAWAY? Do the members of your household lack a permanent address? Are you staying together in a shelter, hotel, or other temporary housing arrangement? Does your family relocate on a seasonal basis? Are any children living with you who have chosen to leave their prior family or household? If you believe children in your household meet these descriptions and haven't been told your children will get free meals, please contact your school.

6. MY CHILD'S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT ANOTHER ONE? Yes. Your child's application is only good for that school year and for the first few days of this school year. You must send in a new application unless the school told you that your child is eligible for the new school year.

7. I GET WIC. CAN MY CHILD(REN) GET FREE MEALS? Children in households participating in WIC may be eligible for free or reduced price meals. Please fill out the enclosed application.

8. WILL THE INFORMATION I GIVE BE CHECKED? Yes. We may also ask you to send written proof.

9. IF I DON'T QUALIFY NOW, MAY I APPLY LATER? Yes, you may apply at any time during the school year. For example, children with a parent or guardian who becomes unemployed may become eligible for free and reduced price meals if the household income drops below the income limit.

10. WHAT IF I DISAGREE WITH THE SCHOOL'S DECISION ABOUT MY APPLICATION? You should talk to school officials. You also may ask for a hearing by calling or writing to the person listed above.

11. MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN? Yes. You or your child(ren) do not have to be U.S. citizens to qualify for free or reduced price meals.

12. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD? You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro-rated share of expenses), do not include them.

13. WHAT IF MY INCOME IS NOT ALWAYS THE SAME? List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only made $900, put down that you made $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

14. WHAT IF SOME HOUSEHOLD MEMBERS HAVE NO INCOME TO REPORT? Household members may not receive some types of income we ask you to report on the application, or may not receive income at all. Whenever this happens, please write a 0 in the field. However, if any income fields are left empty or blank, those will also be counted as zeroes. Please be careful when leaving income fields blank, as we will assume you meant to do so.

15. WE ARE IN THE MILITARY. DO WE REPORT OUR INCOME DIFFERENTLY? Your basic pay and cash bonuses must be reported as income. If you get any cash value allowances for off-base housing, food, or clothing, it must also be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income. Any additional combat pay resulting from deployment is also excluded from income.

16. MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR? To find out how to apply for SNAP, TANF or other assistance benefits, contact your local Department of Human Services office or call (800) 843-6154 (voice) or (800) 447-6404 (TTY)

Sincerely,

INSTRUCTIONS FOR APPLYING – COMPLETE ONE APPLICATION PER HOUSEHOLD PER SCHOOL DISTRICT

IF YOUR HOUSEHOLD RECEIVES SNAP OR TANF BENEFITS, FOLLOW THESE INSTRUCTIONS AND RETURN THE COMPLETED FORM TO YOUR SCHOOL:

Part 1: List all household members, school and grade for each student, and a SNAP or TANF case number for any household member including adults receiving such benefits. (Attach another sheet of paper if necessary.) .

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Sign the form. (The last four digits of a Social Security Number are not necessary.)

Part 5 & 6: Contact Information, and Children's Racial and Ethnic Identities: Answer these questions if you choose to. (Optional)

IF NO ONE IN YOUR HOUSEHOLD GETS SNAP OR TANF BENEFITS AND IF ANY CHILD IN YOUR HOUSEHOLD IS HOMELESS, A MIGRANT OR RUNAWAY OR HEAD START/EVEN START, FOLLOW THESE INSTRUCTION AND RETURN THE COMPLETE FORM TO YOUR SCHOOL:

Part 1: List all household members and the name of school for each child.

Part 2: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your school.

Part 3: Complete only if a child in your household isn't eligible under Part 2. See instructions for All Other Households.

Part 4: Sign the form. Only if part 3 is completed, please include the last four digits of a Social Security Number. (or mark the box if s/he doesn't have one).

Part 5 & 6: Contact Information, and Children's Racial and Ethnic Identities: Answer these questions if you choose to. (Optional)

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS AND RETURN THE COMPLETED FORM TO YOUR SCHOOL:

If <u>all</u> children in the household are foster children that are the legal responsibility of a foster care agency or court:

Part 1: List all foster children and the school name for each child. Check the "Foster Child" box for each foster child.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Sign the form. The last four digits of a Social Security Number are not necessary.

Part 5 & 6: Contact Information, and Children's Racial and Ethnic Identities: Answer these questions if you choose to. (Optional)

If some of the children in the household are foster children that are the legal responsibility of a foster care agency or court:

Part 1: List all household members and the name of school for each child. Check the "Foster Child" box for each foster child.

Part 2: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your school.

Part 3: Follow these instructions to report total household income from this month or last month.

- **Box 1–Name**: List all household members with income.
- **Box 2 –Gross Income and How Often It Was Received**: For each household member, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month or monthly. For earnings, be sure to list the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. For other income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits. Under All Other Income, list Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from SNAP, FDPIR, WIC, Federal education benefits and foster payments received by the family from the placing agency. For ONLY the self-employed, under Earnings from Work, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 4: Adult household member must sign the form and list the last four digits of their Social Security Number (or mark the box if s/he doesn't have one).

Part 5 & 6: Contact Information, and Children's Racial and Ethnic Identities: Answer these questions if you choose to. (Optional)

ALL OTHER HOUSEHOLDS INCLUDING MEDICAID AND WIC HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the name of school for each child.

Part 2: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your school.

Part 3: Follow these instructions to report total household income from this month or last month.

- **Box 1–Name**: List all household members with income.
- **Box 2 –Gross Income and How Often It Was Received**: For each household member, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month or monthly. For earnings, be sure to list the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. For other income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits. Under All Other Income, list Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from SNAP, FDPIR, WIC, Federal education benefits and foster payments received by the family from the placing agency. For ONLY the self-employed, under Earnings from Work, report income after expenses. This is for your business, farm, or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 4: Adult household member must sign the form and list the last four digits of their Social Security Number (or mark the box if s/he doesn't have one).

Part 5 & 6: Contact Information, and Children's Racial and Ethnic Identities: Answer these questions if you choose to. (Optional)

Privacy Act Statement: **This explains how we will use the information you give us.** 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, 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 adult household member who signs the application. The last four digits of 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.

APPLICATION FOR FREE MILK/MEAL AND REDUCED-PRICE MEALS—Complete One Application Per Household Per School District. Instructions on back.

SCHOOL USE ONLY

☐ Check if Error Prone Application

1. All Household Members (Attach another sheet of paper if necessary.)

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	(for Student only) School Name	(for Student only) Grade	**SNAP OR TANF CASE NUMBER ONLY** Skip to Part 4 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below. If you receive Medicaid and were not directly certified for free meals, you **MUST** apply based on household size and income.	**Check if Foster Child***
				☐
				☐
				☐
				☐
				☐
				☐

* A foster child is the legal responsibility of a welfare agency or court.

2. Homeless, Migrant, Runaway, or Head Start (Categorically eligible)

☐ Homeless ☐ Migrant ☐ Runaway ☐ Head Start

Signature of Your School Homeless Liaison, Migrant Coordinator, or Head Start Director _____ Date _____

3. Total Household Gross Income (before deductions) You must tell us how much and how often.

A. NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	**GROSS INCOME AND HOW OFTEN IT WAS RECEIVED** (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)							
	B. Earnings From Work (Before Deductions)		**C.** Welfare, Child Support, Alimony		**D.** Pensions, Retirement, Social Security		**E.** Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

4. Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her social security number or mark the *I do not have a social security number* box.

X X X - X X - _ _ _ _
Social Security Number

☐ I **do not** have a social security number.

I certify (promise) all information on this application is true and all income is reported. I understand the school will get Federal funds based on the information I give. I understand school officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits and I may be prosecuted.

Date _____ *Printed Name of Adult Household Member* _____ *Signature of Adult Household Member* _____

5. Contact Information (Optional)

Work Telephone Number (Include Area Code) _____ *Home Telephone Number (Include Area Code)* _____ *Home Address (Number, Street, City, State, Zip Code)* _____

6. Children's Racial and Ethnic Identities (Optional)

Mark one ethnic identity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Mark one or more racial identities:
☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ American Indian or Alaska Native

– THE FOLLOWING SECTIONS ARE FOR SCHOOL USE ONLY –

INITIAL DETERMINATION

TOTAL INCOME $ _____ **Per:** ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** _____ **CHANGE IN STATUS:** _____ Date _____

LEAs must annualize income only when multiple incomes, at varying frequencies, are reported.
Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12

☐ **Free based on:**
- ☐ homeless
- ☐ migrant
- ☐ runaway
- ☐ Head Start
- ☐ SNAP or TANF
- ☐ foster child
- ☐ household's income

☐ **Reduced based on:**
- ☐ household's income

☐ **Denied—Reason:**
- ☐ income too high
- ☐ incomplete application
- ☐ Non-qualifying SNAP/TANF

Date Withdrawn: _____

Signature of Determining Official _____ Date: _____