



NEW STUDENT REGISTRATION

Welcome to the Irvington Union Free School District. The mission of the Irvington School District is to create a challenging and supportive learning environment in which each student attains his or her highest potential for academic achievement, critical thinking and lifelong learning. Our schools encourage the discovery and development of students' individual strengths, skills and talents, and foster social and civic responsibility.

To complete the enrollment process, safeguard the health of your child/children, to place your child/children in the most appropriate program, and to conform to New York State law and District Policy, we need certain information and records. Documentation of age, proof of residency and the District's registration packet must be completed and submitted in person by a guardian to the District Registrar.

The registration packet may be obtained at:

http://www.irvingtonschools.org/pages/Irvington_UFSD/Students_Parents/Forms_Library/Registration_Packets or from the District Registrar, 6 Dows Lane, Irvington New York 10533. These documents must be submitted at the time of registration or within two days of enrollment in order for the District to make a timely determination as to the student's entitlement to attend District schools. (Except for Kindergarten Pre-Registration)

When printing the forms from our website, please print them Single Sided and not Doubled Sided.

1. **New Student Registration Form** - All students between the age of 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition or immigration status. The Irvington U.F.S.D. collects information in line with New York State requirements. The collection and recording of the ethnic identity of students in the Irvington U.F.S.D. district is in accordance with the federal categories and definitions. The information will be used to :
 - a. **Report** information to the State and Federal Education Departments.
 - b. **Plan** educational programs and make sure that they are readily available to all students.
 - c. **Study** the movement of students in different ethnic groups as they move from school to school.
 - d. **Analyze** differences in academic performance, attendance and completion of school.

The Irvington U.F.S.D. understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal Student Privacy Laws and Regulations. If the information requested is not provided on the New Student Registration Form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging.

2. **Documentation of age** - In order to determine, for instance, the programming needs of your child/children, you will need to provide proof of age by providing one of the following:
 - a. An original or certified transcript of a birth certificate or record of baptism (including an original or certified transcript of a foreign birth certificate or record of baptism) giving the date of birth; or
 - b. passport (including foreign passport) giving the date of birth

Where the above are not available, the School District may consider certain other documents/records in existence two years or more to determine age. One or more of these documents may be necessary. The documents are the following:

- official driver’s license
- state or other government issued identification
- school photo identification with date of birth
- consulate identification card
- hospital or health records
- military dependent identification card
- documents issued by federal, state or local agencies (for instance, local social services agency, federal Office of Refugee Resettlement)
- court orders or other court-issued documents
- Native American tribal document
- records from non-profit international aid agencies and voluntary agencies
- Note: The School District may need to verify these documents/record

3. Proof of Residency is required. According to NY State Law, In order to register your child/children in the School District, you must be physically domiciled (live) at your address within the School District’s geographic boundaries

Proof of Residency is Required – You should provide at least one item from Section A and two items from Section B; if you cannot provide an item from Section A, you will need to provide four items from Section B.

Section A	Section B – Address must be clearly listed on form of proof.
<p>1) Copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage statement</p> <p>2) a statement by a third-party landlord, owner or tenant from whom the parent(s) or person(s) in parental relation leases or with whom they share property within the district</p> <p>3) such other statement by a third-party establishing parent(s) or person(s) in parental relation physical presence in the School District</p>	<p>1) pay stub</p> <p>2) income tax form(s)</p> <p>3) utility bill or other bills (e.g., power company, cable, National Grid, etc.).</p> <p>4) membership documents that are based upon residency that contain your address (e.g., library cards)</p> <p>5) voter registration document(s)</p> <p>6) official driver’s license, learner’s permit or non-driver identification</p> <p>7) documents issued by federal, state or local agencies (for instance, local social services agency, federal Office of Refugee Resettlement)</p> <p>8) evidence of custody of the child/children, including, but not limited to judicial custody orders or guardianship papers</p> <p>9) Other forms of documentation and/or information establishing parent(s) or person(s) in parental relation physical presence in the School District.</p>

If you have any questions regarding the fulfillment of the District’s residency requirements or are homeless, please contact the District Registrar.

4. Release for Records/Report Card (most recent) from the school the student is currently enrolled. Note: For high school students, please provide a transcript with all grade levels

attended as well as a schedule of current courses the student has taken within the current year. If applicable, please provide copy of IEP, 504 Accommodation Plan, or other applicable documents. A release for education records from the former school (if any) will also need to be completed.

5. **Health Info Packet/Immunizations records and physical exams** - Details of all public health requirements are outlined in the registration packet. The school nurse will review and approve immunization records prior to the enrollment of new students.
6. **Parent(s)/Guardian(s) shall provide proper proof of parental relationship** - The School District may require the parent(s) or person(s) in parental relation to provide the School District with an affidavit either: (1) indicating that they are the parent(s) with whom the child/children lawfully resides; or (2) indicating that they are the person(s) in parental relation to the child/children, over whom they have a total and permanent custody and control, and describing how they obtained total and permanent custody and control, whether through guardianship or otherwise. The School District may also accept other proof, such as documentation indicating that the child/children reside with a sponsor with whom the child/children have been placed by a federal agency. Please contact the District Registrar for additional information.
7. **Home Language Questionnaire** - this two page form is required by New York State and used for reporting purposes.
8. **Consent to Release Personally Identifiable Student Information.** This form is requested by the district and kept on file. With this consent your child/children would be included in our directory and on our social media postings. You have the right to change your selection at any time.
9. **Acceptable and Safe Use of the Technology and the Internet.** This form is requested by the district and kept on file. Please read and retain our policy for your records.
10. Please call 914-269-5011 to set up an appointment with the **District Registrar**, to enroll the student(s). The office of the District Registrar is located at 6 Dows Lane 2nd Floor, Irvington, New York. Follow up questions and documentation can be sent to Registration@irvingtonschools.org. Walk-ins are not encouraged as the District Registrar or Designee must review the registration packet with the family. (No appointment is needed during the February Pre-Registration dates.)

PLEASE BE ADVISED that in order for your child/children to attend the Irvington Union Free School District, you must be a resident of the School District.

Section 210.45 of the Penal Law of the State of New York prohibits the making of a false written statement. Therefore, your statements contained in your registration application must be true and accurate.

If the School District determines at any time that you are not a resident of the School District, your child/children will be excluded from the School District. Further, you will be liable to the School District for payment of tuition from their date of enrollment through their date of exclusion, as well as the costs of collection.

Thank you for your cooperation.

NEW STUDENT REGISTRATION FORM

PLEASE COMPLETE ALL QUESTIONS (Print Clearly) Please note: The student's legal name must be used

STUDENT INFORMATION

Student Last Name:	Gender: M - F
First Name:	DOB:
Middle Name:	Grade Level:
Home Phone:	
Address:	
Ethnicity: Hispanic/Latino or of Spanish origin? <input type="checkbox"/> Yes <input type="checkbox"/> No Race: (Choose all that apply) <input type="checkbox"/> (A) Asian <input type="checkbox"/> (B) Black or African American <input type="checkbox"/> (N) Native Hawaiian or Other Pacific Islander <input type="checkbox"/> (I) American Indian or Alaskan Native <input type="checkbox"/> (W) White	
Student resides with:	
<input type="checkbox"/> Both Parents <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Mother/Stepfather* <input type="checkbox"/> Father/Stepmother* <input type="checkbox"/> Foster parents <input type="checkbox"/> Other (Complete Special Home Circumstance Section on page 2)	
* Please indicate stepparent name: _____	

PARENT/GUARDIAN INFORMATION:

ADDRESS MAILING AS

Please Circle One Ms.; Mrs.; Mr.; Mr./Mrs.; Dr./Mrs.; Dr./Dr.; Other

Guardian 1 Last Name:	DOB:	Relationship:
First Name:	E-mail:	
Address:		
Home Phone:	Cell Phone:	Work Phone:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Active in the U.S. Armed Forces <i>(Please complete only where information is different from above)</i>		
Please Circle One Ms.; Mrs.; Mr.; Mr./Mrs.; Dr./Mrs.; Dr./Dr.; Other		
Guardian 2 Last Name:	DOB:	Relationship:
First Name:	E-mail:	
Address:		
Home Phone:	Cell Phone:	Work Phone:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Active in the U.S. Armed Forces		

PLEASE LIST SIBLINGS NAME(S)/AGE(S):

NAME	AGE/SCHOOL

SPECIAL HOME CIRCUMSTANCES: (Complete if a Single Parent, Legal Guardian, Foster Parent or Agency)

If separated or divorced, other parent will have the right to visit student in school and have access to student's records unless we have a legal document indicating otherwise. Please indicate any restrictions in the area below and provide a copy of legal document, if applicable.

Legal Custody of child is with _____ . Is there a joint custody agreement? _____

List any restrictions other parent has regarding child _____

List type and date of legal document provided _____

If you are a Guardian please complete the following:

Name of child's natural parent(s) _____

Address or whereabouts of natural parent(s) _____

Official document indicating custody and restrictions, etc., if any _____

If you are a Foster Parent or Foster Care Agency you must complete the following or registration will be held until all missing information is provided. Also, a DSS-2999 Form and a letter verifying information below are required or registration will be held.

Name of Foster Parent(a) _____

Name of Agency _____ Agency Code # _____

Agency Address _____ Type of Agency _____

Case Worker and/or Social Worker _____ Phone No. _____

DSS Case # _____ CIN # _____ CB# _____

Date child was placed at current location _____ Date at previous location _____

PREVIOUS ADDRESS INFORMATION

<u>Dates To/From</u> (most recent first)	<u>Address</u>	<u>Location: Country/City/State/Zip</u> <u>Code</u>

PREVIOUS SCHOOL INFORMATION

<u>Schools Attended</u>	<u>Dates To/From</u> (most recent first)	<u>Location: City/State/Country</u>	<u>Special Programs</u> (E.S.L., Special Education, etc)

EMERGENCY CONTACTS

Name:		Relationship:
Address:		
Home Phone:	Cell Phone:	Work Phone:
Name:		Relationship:
Address:		
Home Phone:	Cell Phone:	Work Phone:
Name:		Relationship:
Address:		
Home Phone:	Cell Phone:	Work Phone:

ADDENDUM TO REGISTRATION OF NEW STUDENT:

Does your child have a known or suspected disability that substantially impacts his/her learning? Yes No
If so, describe: _____

Has your child been evaluated for a disability? Yes No
If so, please describe: _____

Has your child been classified by a Committee on Special Education as a student eligible for Special Education Services? Yes No
If so, please describe: _____

Has your child received any special services (i.e.) Speech, OT, PT, AIS, ESL, etc.) in a previous school? Yes No
If so, Please describe: _____

This questionnaire is intended to address the McKinney-Vento Homeless Assistance Improvement Act. Your responses to this questionnaire will help our district determine which services your child may be eligible to receive,

1. Is your current address a temporary living arrangement? Yes No

2. If so, is this temporary living arrangement due to loss of housing or economic hardship? Yes No

If you answered **YES** please complete the remainder of this form.
If you answered **NO**, please **STOP HERE**.

Please check what best describes where this student is currently living:

<input type="checkbox"/> In a shelter	<input type="checkbox"/> awaiting foster placement
<input type="checkbox"/> in a motel or hotel	<input type="checkbox"/> in a single room occupancy building
<input type="checkbox"/> in a transitional housing program	<input type="checkbox"/> in a car, trailer or campsite
<input type="checkbox"/> temporarily in another family's house or apartment due to loss of housing	

PARENT OR LEGAL GUARDIAN OATH:

I, _____, say that I am the parent/guardian of _____, and that I have read the foregoing application and know the contents thereof; that the same are true to my own knowledge and that I have given the answers set forth above knowing that the Irvington School District will rely upon them in determining whether the child is to be admitted to its school system.

Signature of Parent/Guardian *Date*

IRVINGTON UNION FREE SCHOOL DISTRICT SCHOOL HEALTH SERVICES

Dows Lane Elementary
914-269-5150, fax 914-591-6863

Main Street School
914-269-5250, fax 914-591-3099

Middle School
914-269-5350, fax 914-591-2643

High School
914-269-5450, fax 914-591-1956

Dear Parents/Guardians:

2018-2019 School Year

Welcome to the Irvington School District. As school nurses we understand how important good health is to academic performance. We look forward to partnering with you to keep your child as healthy as possible. With that common goal in mind, the requirements for school outlined below are in place to support your child's health and well being.

New York State Education Law requires a physical examination of all students new to the Irvington School District and effective 7/1/2018, all students in grades K, 1, 3, 5, 7, 9, and 11. All physical exams must be performed within 12 months from the start of the school year (i.e. Physicals dated on or after September 4, 2017 will be accepted.) The physical exam form and documentation of required immunizations must be completed, signed and stamped by your physician, physician assistant or nurse practitioner authorized to practice in New York State or within a state that has standards of licensure and practice comparable to those of New York State. A dental certificate is requested for students new to the district and only in the following grades: Kindergarten, 1st, 3rd, 5th, 7th, 9th, and 11th.

The physical examination form must be handed in within 30 days of entrance into school or required Grade.

New York Public Health Law 2164 requires all students to be fully immunized against Polio, Diphtheria, Tetanus, Pertussis, Measles, Mumps, Rubella (MMR), Hepatitis B and Varicella (Chicken Pox) or a physician's documented record of disease or positive titer (blood test). Students entering 6th-12th grade and who are 11 years of age or older are required to receive a Tdap vaccine (Tetanus, Diphtheria and acellular Pertussis). Meningococcal (Meningitis) vaccine is required for Grades 7, 8, 9 and 12 for the 2018-2019 school year. These immunizations are required for school entrance and attendance. The immunization record must be submitted within 14 days of attendance. **Exclusion from school will result if the above requirements are not met.**

We appreciate your compliance with these regulations. If you have any concerns or questions regarding your child's health, please contact us during school hours.

Sincerely,
Irvington School Nurses

HEALTH FORMS CHECKLIST

- School Health Examination form- (recommended form) signed by healthcare provider
- Health History- completed and signed by parent/guardian
- Current Immunization Record-signed by healthcare provider
- Dental Certificate- signed by dentist
- Medication Authorization (if applicable)-signed by healthcare provider and parent/guardian
- Emergency Information form- signed by parent/guardian

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Anaphylaxis Care Plan Attached <input type="checkbox"/> Environmental
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Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	<input type="checkbox"/> Asthma Care Plan Attached
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Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type: _____	<input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: _____
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Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached Date Drawn: _____
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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 **Hypertension:** No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	Negative	Positive	Referral	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics. <input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications <input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling <input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field <input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> Developmental Stage for Athletic Placement Process ONLY Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports Student is at Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain <input type="checkbox"/> Brace*/Orthotic <input type="checkbox"/> Colostomy Appliance* <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Insulin Pump/Insulin Sensor* <input type="checkbox"/> Medical/Prosthetic Device* <input type="checkbox"/> Pacemaker/Defibrillator* <input type="checkbox"/> Protective Equipment <input type="checkbox"/> Sport Safety Goggles <input type="checkbox"/> Other:				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIS Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No				
HEALTH CARE PROVIDER				
Medical Provider Signature:			Date:	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				

IRVINGTON UNION FREE SCHOOL DISTRICT

STUDENT HEALTH HISTORY

Name:	DOB:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: <small>(person completing this form)</small>	Home Phone:	Date:	
	Cell Phone:		

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

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | |
|--|---|---|
| <input type="checkbox"/> ADHD
<input type="checkbox"/> Asthma/trouble breathing
<input type="checkbox"/> Autism/Asperger
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ear Infections
<input type="checkbox"/> GI Conditions (ulcer, reflux, IBS, Crohn's, Celiac) | <input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Heart Conditions
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Mental Health Condition
(depression, eating disorder, anxiety, OCD, ODD, etc.) | <input type="checkbox"/> Scoliosis
<input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle)
<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Speech Condition
<input type="checkbox"/> Urinary Condition |
|--|---|---|

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> 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: _____

IRVINGTON UFSD
Irvington, NY 10533

Dows Lane Health Office: 914-269-5150 (fax. 914-591-6863)

Middle School Health Office: 914-269-5350 (fax. 914-591-2643)

Main Street School Health Office: 914-269-5250 (fax. 914-591-3099)

High School Health Office: 914-269-5450 (fax. 914-591-1956)

NYS Immunization Requirements for School Entrance/Attendance

New York State Required Physical Assessments: Grades K, 1, 3, 5, 7, 9, and 11

New York State Required Immunizations: **DTaP, Polio, MMR, Hepatitis B, Varicella (chicken pox), Tdap, Meningococcal**

Student's Name _____ Date of Birth _____

Immunization Report

	#1	#2	#3	#4	#5	#6	#7
*DPT/DTaP							
*Polio (IPV/OPV)							
*MMR							
*Hep B							
*Varivax							
*Meningococcal							
*Measles							
*Mumps							
*Rubella							
*Tdap							
Td (Tetanus/diphtheria)							
Hib (H influenza)							
Hep. A							
Human Papillomavirus (HPV)							
Pneumococcal							
PPD							
BCG							
<u>Date of Chicken pox disease</u>							
<u>Titer report</u>							

*Required by New York State Law

Physician's Signature _____ **Date** _____

Healthcare provider stamp

1/2018

Irvington Union Free School District
School Health Services

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: K, 1, 3,5,7,9 & 11. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Sex: Male Will this be your child's first oral health assessment? Yes No
 Month Day Year Female

School: Name _____ Grade _____

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? Yes No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date _____

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ on _____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

- Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
- No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

- Yes No Caries Experience/Restoration History – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes No Untreated Caries – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits 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 Dental Sealants Present

Other problems (Specify): _____

II. Treatment Needs (check all that apply)

- No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
- May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
- Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

IRVINGTON UNION FREE SCHOOL DISTRICT SCHOOL HEALTH SERVICES

MEDICATION AUTHORIZATION FORM

This form is valid for the current school year for both prescription and over the counter (OTC) medication.
Students may not carry any medication unless indicated on this form.

A. To be completed by parent/guardian:

I request that my child _____ grade ____ receive the medication(s) as prescribed below by our licensed health care prescriber. ALL medication, including OTC, is to be furnished by me in a **properly labeled original container from the pharmacy.**

Parent/Guardian Signature: _____ (Tel #) _____ Date: _____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication(s):

Student Name: _____ DOB: _____

Diagnosis: _____

Parameters for Medication to be administered: _____

****MEDICATIONS NOT ORDERED IN PROPER DOSAGE NOTATION (i.e. mg, concentration) WILL NOT BE ACCEPTED****

Medication: _____	Dosage: _____	Time: _____	Frequency: _____	Route: _____
Medication: _____	Dosage: _____	Time: _____	Frequency: _____	Route: _____
Medication: _____	Dosage: _____	Time: _____	Frequency: _____	Route: _____
Medication: _____	Dosage: _____	Time: _____	Frequency: _____	Route: _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

- Allergy and requires Epinephrine Auto-injector
- Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- Other _____ which requires rapid administration of _____
(State Diagnosis) (Medication Name)

Signature of Prescriber: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: _____ Date: _____

Licensed Prescriber: _____ Date _____ Stamp:
 Name and Title (print): _____
 Signature: _____
 Address: _____

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IRVINGTON UFSD

Health Office Emergency Form
(Please print and complete all sections)

Date of Birth / /
 Mo Day Year

Home Room Teacher _____

LAST NAME OF STUDENT FIRST NAME HOME phone GRADE

ADDRESS _____

Parent/Guardian NAME (1) _____ Parent/Guardian NAME (2) _____

Reside with Student (Yes) (No) Reside with Student (Yes) (No)
DAY OR WORK PHONE # () _____ - _____ DAY OR WORK PHONE # () _____ - _____

CELL PHONE # () _____ - _____ CELL PHONE # () _____ - _____

Email _____ Email _____

Doctor's Name _____ Phone _____

MEDICAL INFORMATION ;(Confidential)

Allergies to medication, food, insect _____ epipen required yes ___ no ___

Health Condition (asthma, heart, seizures, diabetes, etc.) _____

Medications currently used (please update accordingly) _____

REQUIRED INFORMATION**

*In case of illness or injury, and your child **cannot** remain in school, a parent/guardian will be notified and your child **must** be picked up. We will **not** send your child home on the bus or if applicable to an after-school program. A child cannot leave school without an adult.*

In the event a parent/guardian cannot be reached, please list at **LEAST 2** adults who may pick up and assume temporary care of your child.

1) _____
Name Relationship Tel. # Cell#

2) _____
Name Relationship Tel. # Cell#

3) _____
Name Relationship Tel. # Cell#

Information may be shared with appropriate staff members.

I, the undersigned, parent or guardian having legal custody of the above-named minor, hereby authorize officials of the Irvington Union Free School District to contact directly the persons named herein, and do authorize the named physician to render such treatment as may be deemed necessary in an emergency, for the health of said child. This form is to be used **only** in an **Emergency**, when I cannot be reached.

Parent/Guardian signature _____ Date _____



IRVINGTON

UNION FREE SCHOOL DISTRICT

Irvington High School
Counseling Department
Heather Attenello
Emily Colman, Chairperson
Andrew Lund
Claudia Rodriguez

Date: _____

To: _____

Re: _____

The above named student has recently transferred to us from your _____ grade. Please send copies of the following items from the student's records.

- ___ Report Cards
- ___ High School Transcript
- ___ Standardized Test Scores
- ___ IEP/504 Records
- ___ Psychological Testing Report(s)
- ___ Health Records
- ___ Specialists' Reports:
 - ___ Reading
 - ___ Speech
 - ___ Learning Difficulties

In addition, we would appreciate any other information about the student which might assist us in arranging class placement, or if necessary, referral for special services.

Thank you for your prompt attention to this matter.

Sincerely,

Emily Colman
Chairperson

Parental Release _____(signature)

IRVINGTON UNION FREE SCHOOL DISTRICT
Irvington, N.Y. 10533

Policy for the Acceptable and Safe Use
of Technology and the Internet

The Board of the Irvington UFSD recognizes that the use of computer technology and the Internet ("technology") has become an increasingly important aspect of our educational environment. The Board wishes to promote the appropriate use of technology so as to maximize the positive educational benefits for our students and our staff. These uses include the access and exchange of information; communications and the organization, analysis and presentation of information. Therefore, the Board established the following principals and rules for the safe and appropriate use of the District's technological resources:

1. Acceptable Use

- While the Board respects the principles of academic freedom and freedom of speech, the access or transmission of materials using district technology resources which are inappropriate in the school environment is strictly prohibited. These materials include but are not limited to the following: those which are obscene or pornographic, prejudicial or discriminatory, lewd or profane.
- The use of district technology to knowingly violate United States or New York State regulations is prohibited. Users of district technology must respect copyrights and trademarks and are prohibited from plagiarizing information found on the Internet.
- The use of district technology for commercial purposes is prohibited.

2. Personal Safety

- The posting of an individual student's photograph with his or her name, or any student's telephone number or address on the Internet is strictly prohibited.
- District technology may not be used for chat rooms or personal E-mail, other than for school-sponsored educational purposes. Students will not post personal information about themselves or others such as address or telephone number. Students will not meet with anyone contacted online without their parent's prior approval and supervision.
- Users of District technology are responsible for safekeeping of their user ID and password. Accessing another person's files is strictly prohibited.

3. System Safety

- Purposely misusing the District's technology resources which results in damage to the system or data will result in suspension of privileges and financial liability equal to the cost of repairing the system. Misuse of the system includes, but is not limited to knowingly importing viruses into the system or "spamming" (the replication and mass distribution of large messages).
- Irvington UFSD technology resources are school district property. The District reserves the right to review any files and communications on its system at any time to insure compliance with this policy. Any violations discovered by the system operator will be reported immediately to the Superintendent.
- The primary use of the District's technology is the promotion of educational objectives.
- Users will promptly notify a system operator or district administrator of any violation of this policy.

Each user of the technology resources of the Irvington UFSD, including students, faculty, staff or community member will be required to complete and return the attached form before access to the system will be granted.

Failure to abide by the above rules and regulations will result in a suspension of technology access privileges, financial liability for damages or other disciplinary action.

IRVINGTON UNION FREE SCHOOL DISTRICT
Irvington, N.Y. 10533

Acceptable and Safe Use
of Technology and the Internet

I have read the Irvington UFSD Policy for the Acceptable and Safe Use of Technology and the Internet. I understand and will abide by this policy. I also understand that violation of this policy could result in suspension of my access privileges, financial liability for damages or other disciplinary action.

Irvington Network User Name _____ Date _____
(please print)

User Signature _____

School: ___ Dows Lane K-3 ___ 4-5 Teacher _____
 ___ IMS ___ IHS Year of Grad. _____
 ___ Student ___ Faculty/Staff ___ Community member

.....

Parent or Guardian: (For users under 18 years of age.)

As the parent or guardian of _____, I have read and reviewed with my child, the Irvington UFSD Policy for Acceptable and Safe Use of Technology and the Internet and accept its provisions. I also give permission for my child to utilize the technology resources of the Irvington UFSD.

Name of Parent or Guardian: _____
(please print)

Signature of Parent of Guardian: _____

Date: _____

IRVINGTON UNION FREE SCHOOL DISTRICT

Consent to Release Personally Identifiable Student Information 2018-19

During the school year, the District may use individual student photographs, student works, and/or audio or video recordings of students in any of several types of publications, including but not limited to, District newsletters, yearbooks, calendars, web sites, newspapers, radio and/or television. As the District takes its responsibility to protect our students' privacy very seriously, the District requires your written consent in order to allow your child to participate in these publications.

YES

I CONSENT to my child's participation in publications, including but not limited to District Newsletters, yearbooks, websites, newspapers, radio and/or television.

NO

I DO NOT CONSENT to my child's participation in publications, including but not limited to District Newsletters, yearbooks, websites, newspapers, radio and/or television.

Print Student's Name: _____ Date: _____

Print Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Relation to Student: _____

Grade: _____ Homeroom: _____ Homeroom Teacher: _____

COMMENTS: _____



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:		GENDER:
Month	Day	Year
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)	
1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <small>specify</small>
2. What was the first language your child learned?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <small>specify</small>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother _____ <input type="checkbox"/> Father _____ <small>specify</small> <small>specify</small> <input type="checkbox"/> Guardian(s) _____ <small>specify</small>
4. What language(s) does your child understand?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <small>specify</small>
5. What language(s) does your child speak?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <input type="checkbox"/> Does not speak <small>specify</small>
6. What language(s) does your child read?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <input type="checkbox"/> Does not read <small>specify</small>
7. What language(s) does your child write?	<input type="checkbox"/> English <input type="checkbox"/> Other _____ <input type="checkbox"/> Does not write <small>specify</small>

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:	
SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
<input type="text"/> <small>District Name (Number) & School</small>	<input type="text"/>
<input type="text"/> <small>Address</small>	

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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *If yes, please explain: _____ How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* <i>*Please complete 10b below</i>
10b. <i>*If referred for an evaluation,</i> has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____
Age at which services received <i>(Please check all that apply):</i> <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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? _____

_____ <i>Signature of Parent or of Person in Parental Relation</i>	Month:	Day:	Year:
_____ <i>Date</i>			
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small style="display: block; text-align: center;">MO DAY YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small style="display: block; text-align: center;">MO DAY YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____	

Date Withdrew _____

Attachment Va F ___ R ___ D ___

2018-2019 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 914-269-5052, if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: Irvington UFSD Business Office 6 Dows Lane Irvington, NY 10533

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

Table with 5 columns: Student Name, School, Grade/Teacher, Foster Child, Homeless Migrant, Runaway. Includes checkboxes for Foster Child and 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.

Table with 6 columns: Name of household member, Earnings from work before deductions, Child Support, Alimony, Pensions, Retirement Payments, Other Income, Social Security, No Income. Includes dollar amounts and frequency.

Total Household Members (Children and Adults)

Two empty boxes for total household members.

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

I do not have a SS# checkbox.

"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: [] 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. Includes checkboxes for SNAP/TANF/Foster, Income Household, Free Meals, Reduced Price Meals, Denied/Paid, and Signature of Reviewing Official.

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 Irvington UFSD, Business Office, 6 Dows Lane, Irvington, NY 10533

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 914-269-5052 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.