2023-2024

PIKEVILLE JUNIOR HIGH/HIGH SCHOOL ENROLLMENT PACKET

(IMPORTANT!! PLEASE SAVE THIS DOCUMENT TO YOUR COMPUTER BEFORE TYPING.)

Full Student Name: _____

Please enter today's date (MM/DD/YYYY): _____

Dear Parent/Guardian:

In an effort to streamline registration we are providing an electronic enrollment packet to be completed at your convenience. The electronic packet is designed so certain pieces of information (the most common ones) only need to be entered once. Please be sure to click SAVE frequently so information will not be lost. After completing the document please print and sign where appropriate. Signature areas are highlighted in yellow. Please bring the completed enrollment packet to registration to lessen wait time.

We apologize for the length of the enrollment packet but we must update information every school year. An enrollment packet must be completed for each child wishing to attend Pikeville Junior High/High School. Thank you for choosing Pikeville Junior High/High School!

FOR OFFICE USE ONLY	
Date Received:	

Student Information	School Year:		Tuition Student ☐ Yes ☐ No		Is this a new address? ☐ Yes ☐ No	
Full Name:			Grade:		Gender:	
Social Security #:			Birthdate:		Race:	
Cell #:			Email:			
Mailing Address:						
Physical Address:						

Parent/Guardian #1			**Relationship:**		
Student lives with this person? ☐ Yes ☐ No		If not the parent, do you have legal/court documents on file with us? ☐ Yes ☐ No			
Full Name:				Birthdate:	
Work Phone #:		Home Phone #:		Cell #:	
Mailing Address:					
Physical Address:					
Place of Employment:		Email:			

Parent/Guardian #2			**Relationship:**		
Student lives with this person? ☐ Yes ☐ No		If not the parent, do you have legal/court documents on file with us? ☐ Yes ☐ No			
Full Name:				Birthdate:	
Work Phone #:		Home Phone #:		Cell #:	
Mailing Address:					
Physical Address:					
Place of Employment:		Email:			

Other Household Members: Please list ALL Other individuals (adults and students) living in your home at this time.

Full Name	*Relationship To Student*	*Gender*	*Birthdate*	*Grade*	*School Attending*

Emergency Contacts: To ensure your child's safety, please list those individuals who may be contacted in an emergency situation and who are authorized to sign your child out from school *besides parents/guardians*.
*****Must be updated annually*****

Full Name	*Relationship To Student*	*Work #*	*Cell #*	*Home #*

Transportation: Student transportation will not be changed without written notification from parent/guardian.

	Rides Bus	*Is Transported By Parent*	*Drives Self*
To School	☐	☐	☐
From School	☐	☐	☐

If your child is transferring from another school:		**If transferring to PHS, has your child been previously identified or received services in any of the following.**					
School Attended:		☐	Special Education	☐	ESL	☐	Speech
School Address:		☐	Gifted & Talented	☐	504 Plan	☐	Vision
		School Phone #:					

Parent/Guardian Printed Name:			
Parent/Guardian Signature:		Date	

Student Information			
Full Name:		Grade:	

Media Release Form	
☐	I **DO** give permission to the school/news media to photograph/videotape my child. It is my understanding that this photograph/videotape or portions thereof may be used for public viewing. I agree to allow my child to participate in these projects without financial remuneration, and I understand that this releases the school/district from any future claims, as well as from any liability arising from the use of the said photograph/videotape.
☐	I **DO NOT** grant permission for the school/news media to photograph/videotape/interview my child or to post information on the Web about my child.

Student Usage of Computers, Network, Internet and Telephones

I, the student, understand and will abide by the Pikeville Independent School District's Acceptable Use Procedures for the Network, Internet and Telephone Usage. I further understand that any violation of the regulations stated in these procedures is unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked, school disciplinary action may be taken, and/or appropriate legal action may be pursued. This document shall be valid until revisions are made to the District Acceptable Use Policy or until the student, parent, or guardian makes a written request to change the access.

I, the parent/guardian have read and discussed the District Acceptable Use Procedures for the Network, Internet and Telephone Usage with my child. I understand that access to the Network and Internet is designed for educational purposes. The District has taken precautions to eliminate controversial materials; however, I recognize it is impossible to restrict access to all controversial materials. I will not hold the District/school responsible for materials my child acquires on the Network or Internet. Further, I accept full responsibility for supervision when my child's use is not in a school setting. I hereby give permission to issue an account for my child and certify that the information contained on this form is correct.

Technology Information											
Do you have a computer at home?	**YES**	☐	**NO**	☐	Is the computer less than 5 years old?				**YES**	☐	**NO**	☐
What type of device(s) do you own? (Check all the apply):	Desktop	☐	Laptop	☐	Tablet	☐	Chromebook	☐				
Do you have Internet Access at home?	**YES**	☐	**NO**	☐								
If yes, what type?	Cable	☐	DSL	☐	Satellite	☐	Dial-Up	☐				
If no, do you use cellular service (i.e. 3G, 4G, LTE, etc.) to access the web, email, or social media?									**YES**	☐	**NO**	☐
If you have Internet capability, would you prefer communication via email?									**YES**	☐	**NO**	☐

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Student Information			
Full Name:		Grade:	

School-Related Student Trip Permission Slip and Medical Release Form	
Mode of Transportation: *SCHOOL BUS*	Cost to Student, if applicable: *$ VARIES PER TRIP TAKEN*
☐	I **DO** give permission for my child to participate in the above mentioned school-related student trip(s).
☐	I **DO NOT** give permission for my child to participate in the above mentioned school-related student trip(s).

In addition, in the event of accident or sudden illness while on the school-related student trip, I authorize school personnel to contact the physician(s) listed on my child's school enrollment data forms and authorize those physician(s) to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event physician(s), parent(s), or other persons designated by the parent cannot be contacted, school personnel are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of said child.

FERPA

The Family Educational Rights and Privacy Act (FERPA), a federal law, requires that the Pikeville Independent School District, with certain exceptions, obtain your written consent to the disclosure of personally identifiable information from your child's education records. However, Pikeville Independent Schools may disclose appropriately designated "directory information" without written consent, unless you have advised the District to the contrary in accordance with District procedures. The primary purpose of directory information is to allow the Pikeville Independent Schools to include this type of information from your child's education records in certain school publications. Examples include:

A playbill, showing your student's role in a drama production; The annual yearbook;
Honor roll or other recognition lists;
Graduation programs;
and
Sports activity sheets, such as for wrestling, showing weight and height of team members.

Directory information, which is information that is generally not considered harmful or invasion of privacy if released, can be disclosed to outside organizations without a parent's prior written consent. Outside organizations include, but are not limited to, companies that manufacture class rings or publish yearbooks. In addition, two federal laws require local educational agencies (LEAs) receiving assistance under the Elementary and Secondary Education Act of 1965 (ESEA) to provide military recruiters, upon request with three directory information categories-names, addresses and telephone listings-unless parents have advised the LEA that they do not want their student's information disclosed without their prior written consent.

If you do not want Pikeville Independent Schools to disclose directory information from your child's education records without your prior written consent, you must notify the District **in writing** by September 1st. Pikeville Independent School has designated the following information as directory information:

- Student Name
- Address
- Weight and height of members of athletic teams
- Photograph
- Date and place of birth
- Dates of attendance
- The most recent educational agency or institution attended
- Participation in official activities and sports
- Telephone listing
- Electronic mail address
- Degrees, honors and awards received
- Major field of study
- Grade level

Student Printed Name: _____

Student Signature: _____ **Date:** _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____

** PIKEVILLE HIGH SCHOOL ONLY **

Student Information			
Full Name:		Grade:	

Pikeville Independent Schools – Random Drug & Alcohol Testing Program – Consent To Test Form (Grades 9-12)

The student and his/her parent(s) or guardian(s) acknowledge that the Pikeville Independent School District ("District") has the right to perform random drug and alcohol testing on students who wish to exercise the privilege of participating in high school athletics, extracurricular activities or who wish to exercise the privilege of driving and/or parking on school property.

The student and his/her parent(s) or guardian(s) understand that as a condition of the student being allowed to participate on any Pikeville High School athletic team, extracurricular activity and/or as a condition of the student being allowed to drive and/or park on school property, the student may be required to undergo and successfully pass a random screening for alcohol, illegal drugs or other banned substances, as set forth in the District's Use of Alcohol, Drugs, and Controlled Substances Policy and Student Random Drug Testing Procedures (09.423 and 09.423 AP.1) which can be found and printed from the following website: http://policy.ksba.org/p07/. The student and his/her parent(s) or guardian(s) acknowledge that they have read and understand this policy and procedure and that they agree to all the terms and conditions contained in the policy and procedure.

The student and his/her parent(s) or guardian(s) hereby consent to participate in the random drug and alcohol testing program and to the disclosure of testing results to designated District personnel and parent(s) or guardian(s). The student and his/her parent(s) or guardian(s) further understand that the student's refusal to submit to a drug screening will be treated in the same manner as if the student had tested positive for banned substances.

No student shall be penalized academically for testing positive for banned substances during random drug testing.

The privilege of being allowed to participate on any Pikeville High School athletic team, extracurricular activity, and/or being allowed to drive to and/or park on school property is contingent on the signing of this consent form.

This consent form shall remain in effect for a period of twelve (12) months from the date it is executed. Any revocation of this consent form shall disqualify the student from participating in extracurricular activities or driving to and from school for a period of twelve (12) months.

I plan to participate in the following (please mark all that may apply):					
Athletic Program (any PHS team)	☐	*Extracurricular Activities (clubs or organizations)*	☐	*Student Driver*	☐

Student Printed Name: _____

Student Signature: _____ **Date:** _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Kentucky Migrant Education Program

Parent Employment Survey

<u>Versión en español en el otro lado de la hoja</u>

The Migrant Education Program (MEP) is authorized by Title 1, Part C of the Elementary and Secondary Education Act (ESEA). The **KEDC Regional Migrant Education Program** (606-547-1414) provides a variety of educational services to families who work in agriculture, **<u>regardless of their nationality</u>** or legal status. This program is **<u>free of charge</u>** to all eligible families and **<u>may</u>** include tutoring, free lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed. A program employee may contact you for further information if needed.

Child's Name: _____

Birthdate: _____ Grade: _____ School: _____

1. In the past three years, has your family lived in another Kentucky school district, another state, and/or another country?

Yes____☐____**(continue to #2)** **No**___☐___**(stop here)**

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2. In the past three years, has anyone in your household had a job working with any of these products **(not including your own property)** on a farm, in a field, in a greenhouse, in a nursery, or in a factory? Please circle all that apply.

Livestock (cattle, pigs, sheep, dairy, etc). ☐

Eggs ☐

Chickens ☐

Crops (wheat, corn, soybeans, etc.) ☐

Vegetables ☐

Processing (meat, fruit, vegetables, trees, etc.) ☐

Tobacco ☐

Fruits ☐

Hay ☐

Nursery, Sod, Greenhouse ☐

Trees, Timber, Plants, Flowers ☐

Soil Preparation ☐

If you circled one or more, continue to #3. **None of these**_____**(stop here)**

---

3. Parents' Names: _____

Address: _____

City:_____State:_____Zip Code:_____Telephone: _____

Please list all children in the household less than 22 years of age:

Name	Date of Birth	Grade	School

Home Language Survey

Dear Parent/Guardian:

The purpose of the home language survey (HLS) is to determine the primary or home language of the student. This information is essential in order for schools to provide meaningful instruction for all students. The HLS is part of the statewide identification process required under Section 3113(b)(2) of the Every Student Succeeds Act (ESSA) and 703 KAR 5:070 and the related Inclusion of Special Populations Guidance.

The HLS must be given to all students in grades K-12 upon their initial enrollment in the district as a first screening process to identify potential English learner students. The HLS is administered one time, upon initial enrollment in grades K-12 and remains in the student's cumulative file.

Please note that the answers to the survey below are student-specific. **If a language other than English is recorded for ANY of the required survey questions below, the district is legally obligated to do further assessment of your child to determine if they are eligible for language support.**

Answers will not be used for determining legal status or for immigration purposes. If your child is identified for English language services, you may decline some or all of the services offered to your child.

If you have any questions on how to complete the HLS, please contact your child's school.

Student Information (required):

Name: _____ **Grade:** _____

Student Language Background (required):

1. What is the language most frequently spoken at home? _____
2. Which language did your child learn when they first began to talk? _____
3. What language does your child most frequently speak at home? _____
4. What language do you most frequently speak to your child? _____

Language for School Communication (not required):

5. In which language would you prefer to receive all school information: _____

Parent/Guardian Signature: _____ **Date:** _____

By signing here, you certify that responses to the four required questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for language support services, to help them become fluent in English. Students qualifying for language support services are entitled to services as an English learner and will be tested annually to determine their English language proficiency as required by ESSA 1111(b)(2)(G).

For School Use Only

School personnel who administered and explained the HLS and potential placement of a student into an English language development program if a language other than English was indicated:

Name: _____ **Date:** _____

Pike County Health Department
Consent for School Health Services and Medication Administration for Pikeville Independents Schools

Demographic Information:

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

Gender: _____ **Race:**_____ **Child's Social Security #:**_____

Address:_____

Parent / Guardian / Emergency Contact Information:

Parent / Legal Guardian Name:_____ **Email Address:**_____

Phone Numbers: (H)_____**(C)**_____**(W)**_____

Emergency Contact (other than parent):_____**Phone:**_____

Insurance Information:

Does your child have a Medicaid Card? (Check one) _____Yes _____No _____ Applied / Pending _____ KCHIP

If yes, please provide the Medicaid Card Number:_____

If yes to Medicaid, check one: _____ AETNA _____Anthem _____Humana _____Molina _____Passport ____United Healthcare ____Wellcare

Other Medical Providers:

Student's Doctor: _____ **Phone Number:**_____

Student's Dentist:_____ **Phone Number:**_____

Medical Information (This information will aid the nurse in making an accurate assessment of your child in case of illness, injury, or emergency):

Does You child have Allergies / Asthma? This includes foods, medications, latex, fluoride, insects, etc. (check one) _____Yes _____No

If yes, please list all:_____

If yes, does your child require an epi-pen prescription for any allergies? (check one) _____Yes _____No

Does your child have seizures? (check one) _____Yes _____No

List all current medications: _____

List all chronic health conditions: _____

List all significant medical / social history (including injuries): _____

Does anyone in the immediate family have the following: (check all that apply) _____High Blood Pressure ____High Cholesterol ____Diabetes

Please check if your child has had any of the following (check ALL that apply):

___Anemia	**___Asthma**	**___Persistent Cough**	**___Exposed to Tuberculosis (TB)**
___Birth Defect	**___chest Pain**	**___Leukemia / Cancer**	**___Shortness of Breath**
___Diabetes	**___Seizures**	**___Sleep Problems**	**___Head, Eyes, Ears, Throat Problems**
___Chicken Pox	**___Unexplained Weight Loss/Gain**	**___Stomach or Bowel Problems**	**___Blood Transfusions**
___Rheumatic Fever	**___Unexplained Tiredness**	**___Joint / Muscle Pain or Stiffness**	**___Anaphylactic Episodes**

Please check any of the following, which you will *allow* your child to be given by the school nurse (Check ALL that apply) :

All doses will be given according to the child's age, weight, and manufacturers guidelines.

___Advil/Motrin (Ibuprofen)	**___Benadryl**	**___Cough drops**
___Aloe Vera (for burns)	**___Cold Remedies (cough syrup,**	**___Orajel (toothache)**
___Antacids (Maalox, Tums, etc.)	**decongestant)**	**___Chloraseptic (sore throat)**
___Antibiotic Ointment (Neosporin)	**___Diarrhea Medication**	**___Topical Antiseptics**
___Anti nausea / vomiting	**___Eye Drops (Visine, Murine)**	**___Tylenol (acetaminophen)**
___Anti-itch spray/lotion (insect bites, etc.)	**___Hydrocortisone Cream (for itching)**	

IF THIS MEDICAL INFORMATION SHOULD CHANGE, PLEASE NOTIFY THE SCHOOL NURSE IMMEDIATELY!

Consent for Services:

I consent to care at the school provided by the Pike County Health Department (PCHD) which may include screenings such as scoliosis, vision and hearing, health assessments, lab tests, treatment, first aid, over the counter medicine, and any other health service given to my child by staff or agents of PCHD. I understand that no guarantees are being made as to the effect of any exam or treatment on my child. I like-wise release the staff from any liability related to the administering of the above medications to my child as long as the treatment is provided according to the above instructions. I authorize the school health clinic to release medical information about my child, as permitted by the Health Insurance and Portability and Accountability Act of 1996 (HIPPA), to his/her primary care provider, and to share pertinent medical information with school staff who may need to provide care to my child in an emergency. I understand that the sharing of this information is on a need to know basis only. I understand that the information obtained for the school physicals and immunizations will be shared between the school and the school nurse. If my child has Medicaid or KCHIP, I also authorize the school clinic to release this information to those agencies so the insurance may be billed for those visits to the school clinic. This permission can be revoked at any time. No services will be provided unless this form is signed and returned. I agree to provide the nurse an order from my child's physician for any prescription medications before they can be given. I agree to provide all prescription medications in the bottle received from the pharmacy. I also understand by signing this consent, I acknowledge that I may request a copy of the PCHD Privacy notice by calling the PCHD main office at 606-437-5500 or access a copy of the website at www.pikecountyhealth.com.

X_____ _____ _____

Signature of Parent / Legal Guardian | **Printed Name of Parent / Legal Guardian** | **Date**

Pike County Health Department *Bright Smiles @ School*
Patient Registration and Consent Form

Please complete form and return to your child's teacher if you would like for your child to have the services listed below. Please print. All questions refer to the child for whom the services are being requested. With your permission, a dental hygienist will provide your child with:

- A dental assessment of the condition of the mouth and teeth
- An age appropriate dental cleaning
- Fluoride Varnish (to prevent future cavities
- Dental Sealants (long lasting plastic coatings over the back teeth
- Oral Hygiene Instruction including nutrition counseling
- A personal Dental Report Card

(If *no* services are needed, please complete CHILD'S NAME ONLY)

1. _____ 2. _____-_____-_____ 3. ____/_____/_____
Child's Name: Last First MI Social Security# Birthday

5. _____ 4. Sex (Check One) ____Girl ____Boy
Mailing Address City State Zip County

6. _____ 7. _____ 8._____ 9. Ethnicity (Check One) _____Hispanic/Latino ____Not Hispanic/Latino
School Grade Teacher

10. Race (Check One) ____White _____Black/African American _____American Indian or Alaska Native ____Asian
_____Native Hawaiin or Other Pacific Islander _____Other

11. Parent/Guardian Name: _____Relationship to Child_____

12. Phone(Home)_____(Cell)_____(Work)_____

13. Does your child have a dentist? ____Yes ____No If so, who?_____Date of Last Cleaning:_____

14. Does your child require an antibiotic before a cleaning? ____Yes ____No

15. Does your child have any allergies to food or medicines? ___Yes ___No

If yes, please list all allergies_____

16. List any current medication your child takes (include prescribed, over the counter, and herbal):_____

17. Does your child have any illnesses, disease or conditions including ADHD, heart, diabetes, contagious diseases? ___Yes _____No

If yes, please explain:_____

18. Does your child have a Medicaid Card? (Check one) ____Yes ____No _____Applied/Pending ____KCHIP

If yes, Medicaid Card Number: _____

If yes to Medicaid, check one: ____AETNA ____Anthem ____Humana ____Molina ____Passport ____United Healthcare ____Wellcare

Consent to Health Services: (Expires 1 year from date signed)

On my own free will, I give consent to care for my child which may include screenings, exams, treatment, and other health services given to my child by staff or agents of this health department. I understand that no guarantees are being made as to the effect of any exams or treatment on my child. I also understand that staff may consult with me in regards to my child being tested for HIV, Hepatitis, or any other diseases carried by blood or bodily fluids if a healthcare worker is exposed to my child's blood, bodily fluids, or tissues. The program does not take the place of routine dental check-ups at a dental office. The preventive dental services are being done by a Public Health Registered Dental Hygienist without the on-site presence of a dentist, according to KRS 313.040. The Dentist Board member for your county is Dr. Aaron Stanley of Appalachian Periodontics, who is supportive of the standards of practice of the public health hygienists and work with your Board of Health to develop and adopt protocols for these services.

X_____ _____
Signature of Parent/Guardian or other Authorized Person ***Date***

Payment for Service/Assignment of Benefits - Please sign this section if you have MEDICAID ONLY

I request that payment of authorized medical insurance benefits be made to the local health department on my behalf for services my child received. I also authorize the local health department to release medical information about my child to Medicaid, Insurance, and other third party payors to determine payment of services. I have read the above and have had an opportunity to ask questions. I understand the above statements as it applies to me and my child. My signature below indicates I do consent, authorize, or declare as stated above.

X_____ _____
Signature of Parent/Guardian or other Authorized Person ***Date***

Privacy Notice

This form when signed and completed, contains Protected Health Information and the information is to be protected according to the Health Insurance Portability and Accountability Act (HIPAA). I understand by signing the Consent to Health Services, I also acknowledge that I have access to a copy of the Pike County Health Departments Privacy Notice located at www.pikecountyhealth.com or I may request a copy by calling the Pike County Health Departments main office at 606-437-5500.

Please return to your child's homeroom teacher.
If you have any questions, please contact the Pike County Health Department at (606)437-5500

Pike County
Health Department

Prototype Household Application for Free and Reduced Price School Meals

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
RETURN TO (School/District Name):
ADDRESS:

STEP 1 List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

Child's First Name	MI	Child's Last Name	Grade	Foster Child	Migrant	Runaway	Homeless
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

Check all that apply

If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.

STEP 2 Do any household members (including you) participate in: SNAP, TANF, or FDPIR?

○ **NO** → Go to STEP 3. ○ **YES** → Write case number here and proceed to STEP 4.

CASE NUMBER (NOT EBT NUMBER):

Write only one case number in this space.

STEP 3 List ALL household members and income for each member (before taxes and deductions)

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.)
List all Adult Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Annual	Public Assistance, Child Support, Alimony	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Pensions, Retirement, Social Security, SSI, VA Benefits, All Other	How often received? Weekly	Every 2 Weeks	2x Month	Monthly
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Numbers of Social Security Number of Primary Wage Earner or other Adult Household Member (If Applicable)

Check if no Social Security Number ☐

Please see application's back for list of income sources.

B. Child Income
Sometimes children in the household earn or receive income.
Include the TOTAL income (before taxes and deductions) received by ALL children listed in STEP 1 here.

Child Income	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Annual
$	○	○	○	○	○

STEP 4 Contact information and adult signature. **RETURN COMPLETED FORM TO YOUR CHILD'S SCHOOL:** Insert school address here

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (confirm) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Mailing Address (if available) | City | State | Zip | Phone (optional) | Email (optional)

Return completed form to your child's school.

SOURCES AND EXAMPLES OF INCOME

For additional information on income, please refer to the instructions that accompany this application.

Sources of Income			Examples of Income for Children
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**	
• Salary, wages, cash bonuses, tips, commissions • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers' compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security/Disability (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household	• A child has a regular full or part-time job where they earn a salary or wages • A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits • A friend or extended family member regularly gives a child spending money • A child receives regular income from a private pension fund, annuity, or trust

OPTIONAL

Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Return this completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights.

DO NOT FILL OUT

For school use only.

Annual Income Conversion: Weekly × 52, Every 2 Weeks × 26, Twice a Month × 24, Monthly × 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income

How often?

Weekly	Every 2 Weeks	2x Month	Monthly	Annual
○	○	○	○	○

Household size

Categorical Eligibility ☐

Eligibility

Free	Reduced	Denied
○	○	○

Determining Official's Signature | Date | Confirming Official's Signature | Date | Verifying Official's Signature | Date

Use of Information Statement

The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met.

Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, 'Check if no Social Security Number.' Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number. Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

The contact information below is solely to file a complaint of discrimination

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: **https://www.usda.gov/sites/default/files/documents/ad-3027.pdf,** from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

*MAIL: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: program.intake@usda.gov

***Do not mail applications to this address, only complaints of discrimination.**

Return completed form to your child's school.

This institution is an equal opportunity provider.