



DOVER PUBLIC SCHOOLS

DOVER, NEW JERSEY

NEW STUDENT REGISTRATION

To register a student please make sure to complete the attached forms and provide the following required documents:

1. Birth Certificate (proof of child age)
2. Universal Health Form and Immunization Record (medical records)
3. School Record, Transcript, Report Card or Official Test Score (school records)
4. Transfer Card (If transferring from another school within US)
5. Parent/Guardian Valid Photo ID
6. Two Proofs of Address (Reflecting Current Address)

Options:

- Mortgage Statement
- Residence Lease
- Property Deed
- Contract of Sale
- Tax Bill
- Payment Book
- Sworn Statement of Landlord
- Affidavit
- Valid Driver's License
- Utility Bill (Water, Gas, Electric)
- Bank Statement / Canceled Check
- Voter Registration
- Medical Report
- Benefit Statements

Registration Office Contact us for Appointment	
Jose Cruz (973) 989 2000 Ext. 5023 jcruz@dover-nj.org	Doris Johanna Marulanda (973) 989 2000 Ext. 5024 dmarulanda@dover-nj.org

DOVER SCHOOL DISTRICT
21 Belmont Ave
Dover, NJ 07801

Dover Public Schools District Welcomes You!



STUDENT REGISTRATION FORM/PERMANENT RECORD INFORMATION

Please fill out all forms with clear and legible handwriting. Please use blue or black ink pen.

STUDENT INFORMATION

Grade Entering: _____ Student's Age: _____ Gender: M ___ F ___ Today's Date: _____ / _____ / _____
Month Day Year

Student's Full Name: _____
First Name Middle Name Last Name/Names

Date of Birth: _____ / _____ / _____ Place of Birth: _____
Month Day Year Town State Country

Address: _____
Number Street Apt. Town. State Zip Code

District Dover ___ Mine Hill ___ Victory Gardens ___ Other: _____

Residential Housing Type: Room (shared housing) ___ Apt. Dweller ___ Rent/Lease Home ___ Home Owner ___

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Racial/Ethnic Background: Hispanic ___ White ___ African American ___ American Indian ___ Asian ___ Other ___

Date the Student Entered the USA If Not Born Here: _____ / _____ / _____ Birth Certificate #: _____
Month Day Year

Does the Student Have Siblings in a Dover Public School? YES ___ NO ___ Which School? _____

PARENT/GUARDIAN INFORMATION

Student Lives With: Both Parents ___ Mother ___ Father ___ Legal Guardian ___

Mother's Name: _____ Address: _____
Name Last Name Number Street Apt. Town Zip Code

Cell Phone: _____ Phone 2: _____ E-Mail: _____

Father's Name: _____ Address: _____
Name Last Name Number Street Apt. Town Zip Code

Cell Phone: _____ Phone 2: _____ E-Mail: _____

Legal Guardian: _____ Address: _____
Name Last Name Number Street Apt. Town Zip Code

Cell Phone: _____ Phone 2: _____ E-Mail: _____

COMPLETE ONLY IF THERE IS A CUSTODY ISSUE

Custody Issue: YES ___ NO ___ Legal Guardian: Mother ___ Father ___ Other: _____

Court Order on File: YES ___ NO ___ Court Order Document Number: _____

Custody Status: _____ Custody Start Date: _____ / _____ / _____ Custody End date: _____ / _____ / _____
Month Day Year Month Day Year

EMERGENCY CONTACTS IF YOU CANNOT REACHED

Emergency 1 Name: _____ **Relationship:** _____
Name Last Name With the Student

Address: _____
Number Street Apt. Town. State Zip Code

Cell Phone#: _____ **Phone 2:** _____ **Phone 3:** _____

Emergency 2 Name: _____ **Relationship:** _____
Name Last Name With the Student

Address: _____
Number Street Apt. Town. State Zip Code

Cell Phone#: _____ **Phone 2:** _____ **Phone 3:** _____

Emergency 3 Name: _____ **Relationship:** _____
Name Last Name With the Student

Address: _____
Number Street Apt. Town. State Zip Code

Cell Phone#: _____ **Phone 2:** _____ **Phone 3:** _____

PREVIOUS SCHOOL INFORMATION

Has Student Ever Attended **A DOVER** Public School? YES ___ NO ___ If Yes, School Name: _____

If Student Comes from Another School Outside of Dover, Please Provide the Following Information: Grade: _____

School Name: _____ Last Date Attended School: ___/___/___
Month Day Year

Address: _____ **Phone#:** _____
Number Street Town State Zip Code

Fax #: _____ **E-Mail:** _____

SPECIAL EDUCATION

Regular Education Program: YES ___ NO ___ Special Education Program: YES ___ NO ___

Extra Classes: Speech ___ Math ___ Reading ___ Writing ___ ESL ___ Other: _____

Has the student been involved with the Child Study Team (CST) or has an IEP? YES ___ NO ___

If yes, please explain: _____

KINDERGARTEN REGISTRATION ONLY: Did the Child Attend Pre-School? YES ___ NO ___

If Yes, Pre-School Name: _____ How Long Did the Student Attend? _____

Address: _____ **Phone:** _____
Number Street Town State Zip Code

I, Undersigned, Do Hereby Authorize Officials of Dover Public Schools to Contact Directly the Person(s) Named on This Form and Do Authorize the Named Physicians to Render Such Treatments as May Be Deemed Necessary in An Emergency, For the Health of Said Child. In The Event That Physician, Other Person Named on This Form, Or Parent(s) / Guardian(s) Cannot Be Contacted, the School Officials Are Hereby Authorized to take Whatever Action is deemed Necessary in Their Judgment, For the Health of Aforesaid Child. I Will Not Hold the School District Financially Responsible for the Emergency Care and/or Transportation for Said Child.

Signature of Parent(s)/Guardian(s): _____ **Relationship to Student:** _____

DOVER PUBLIC SCHOOLS

Step 1: Home Language Survey (Parent/Family Version)

Purpose: The home language survey is used solely to offer appropriate educational services ([U.S. ED EL Toolkit](#), Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of residence.

Student Information:

Student Name: _____ Date of Birth (YYYYMMDD): _____

Current Address: _____

Survey Questions:

1.) List all languages used in the student's home.

2.) Was the first language used by the student a language other than English?

_____ No _____ Yes

3.) Does the student speak or understand a language other than English?

_____ No _____ Yes

4.) When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English **most of the time**?

_____ No _____ Yes

5.) When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English **most of the time**?

_____ No _____ Yes

Dover Public School District
Student Residence Questionnaire

Student's Name : _____ Date of Birth _____

Person completing the form:

- Father /Mother/Guardian Unaccompanied Student (Not living with father/mother/guardian)
 Student Other

Name: _____

Email Address: _____

Answer these questions about the student's residency. The information that you are giving us is confidential and is protected by The Family Educational Rights and Privacy Act. We use this information to decide which schools students should attend. We also use this information to ensure that the rights of a child, an unaccompanied young person, are in compliance with the McKinney-Vento Homeless Assistance Act.

- 1.The student's address is a temporary address? Yes No
 2.The student lives in this address due to the loss of a home or financial difficulties? Yes No

If the answer to any of the above questions is yes, complete the following:

Where does the student identified above live? (Check one answer)

- In a hotel or motel due to loss of home or financial difficulties.
- In a Homeless Shelter, temporary shelter, or is abandoned in a hospital.
- Shares residency with another family.
- In a car, parking lot, mobile home parking lot, mobile home, camper, street, public space, a house with below standard living conditions, an abandoned building.
- A train or bus station.
- Moves from one place to another (uses the hospitality of acquaintances).
- In a public or private space that is not equipped as a regular place where you can sleep.
- Other : _____

Last school that the student attended:

School _____ District _____
 City _____ State _____

Name of the father/mother/tutor or person responsible for the educational decisions:

Name _____ Signature _____
 Name _____ Signature _____

Address: _____

City: _____ Signature _____

Home Phone Number _____ Work Phone Number _____

Cellular Phone _____ Email Address _____

OR

Student (If is an unaccompanied student or homeless):

Name _____ Signature _____

Address: _____

Email address _____ Telephone Number _____

If the child or unaccompanied student DOES NOT live in a permanent residence, he/she DOES NOT require proof of residency or any other documents which normally are requested for registration (health information, school records, etc.) The child or unaccompanied young person must register immediately at their original school, the school that other students attend and that they are in, the area where they currently live, in or another school that they can attend according to their convenience.

OFFICE USE ONLY			
Date completed:	Eligible: <input type="checkbox"/> yes <input type="checkbox"/> no	District Representative:	Comments:



Parent Occupational Survey

In order to better serve your child, our school district wants to identify students who may qualify to receive additional educational services, such as tutoring, school supplies, free or reduced-price lunch, summer camps, and other services. **The information provided below will be kept confidential.** Please answer the following questions and return this form to your child's school.

Today's Date	Parent/Guardian First & Last Name
Student First Name	Student Last Name
School Name	Student Grade

1. Have you or an immediate family member performed any of the jobs listed below temporarily or seasonally, in any part of the United States, in the past three years?

- No
- Yes. **Check all that apply and list the total number of months worked:**



Agriculture/Field Work (planting, picking, sorting crops; soil preparation; irrigation; fumigation)

Total Months Worked: _____



Processing & Packaging (fruit, vegetables, chicken, eggs, pork, beef)

Total Months Worked: _____



Dairy/Cattle Raising (feeding, milking, rounding up)

Total Months Worked: _____



Nursery/Greenhouse (planting, potting, pruning, watering, harvesting)

Total Months Worked: _____



Forestry (soil preparation, planting, cutting trees; landscaping not included)

Total Months Worked: _____



Commercial Fishing & Processing (catching, sorting, packing, transporting)

Total Months Worked: _____

2. In the past three years, has your family moved to another state, city, school district, and/or county?

- No
- Yes. **How long have you resided in your current address?**
- _____ Years _____ Months _____ Weeks

If you answered "Yes" to questions 1 and 2, please complete the information below.

Home Street Address	Apt #
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City

State

Zip Code

Telephone Number

Best Day of Week & Time of Day to Call

For School Use Only: Please send survey with two **YES** responses to your district migrant liaison.

Student State ID:

Enrollment Date:

District ID:

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Dover Public Schools
21 Belmont Ave Dover, NJ 07801

HEALTH INFORMATION FORM: COMPLETE THE INFORMATION BELOW. If new to the Dover Public School District, please provide your child's health, medical, and immunization records and school entrance physical to the school nurse.

Student Name - please write name as it appears on the student's birth certificate.

Last Name:	First Name:	Middle Initial:
Date of Birth: (month/day/year) ____/____/____	Gender ____ M ____ F	Grade Level:

Is the student currently on medication? ____Y ____N	If yes, list any medications and condition:
Does the student have any allergies? ____Y ____N Has there been an allergic reaction in the past year? ____Y ____N	If yes, list any allergies: Date of last allergic reaction:
Has the student ever been hospitalized? ____Y ____N	If yes, list hospital, date, and condition:
Does the student have any chronic illness? (example: Diabetes, Asthma, seizures) ____Y ____N	If yes, explain
Have there been any updates to the student's immunizations/tetanus? ____Y ____N	If yes, list date and type of immunization:
Does the student have (check all that apply): ____ Braces ____ Glasses ____ Contact lenses	
Any other medical information you would like the school to be aware of ? ____Y ____N	If yes, explain:
Does this student have any health insurance including NJ Family Care? Medicaid, Medicare, private or other? ____ No, my child does not have health insurance. You may release my name and address to the NJ Family Care Program to contact me about health insurance ____ Yes, my child has health insurance.	Written consent required pursuant to 20 U.S.C 1232 g(b)(1) and 34 C.F.R. 99.30 (b). NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

Primary Doctor Name:	Phone:	Date of last exam:
Dentist Name:	Phone:	Date of last exam:
Eye Doctor Name:	Phone:	Date of last exam:

I, the undersigned, hereby give permission for my child to receive the following medical attention as part of the school health program in Dover Public Schools for the duration that my child is enrolled in the Dover Public School District: receive first aid; receive blood pressure, height and weight, vision and hearing screenings by the school nurse; and receive a scoliosis screening examination by the school nurse if my child is ages 10 to 18.

I also hereby authorize officials of the Dover Public School District to contact directly the person(s) named on the Parent/Guardian Emergency Contact form and do authorize the School Nurse to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this form, or parents/guardians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the aforesaid child, including transporting the child to the hospital. I will not hold the school district financially responsible for the emergency care and/or transportation for the said child.

Parent/Guardian Name (Print): _____

Signature: _____ Date: ____/____/____

For school use only: Received by (name/date): _____

Entered in Genesis by(name/date): _____

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)			
Child's Name (Last)	(First)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number () -	Work Telephone/Cell Phone Number () -	
Parent/Guardian Name	Home Telephone Number () -	Work Telephone/Cell Phone Number () -	
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.			
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination:		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Abnormalities Noted:		Weight (must be taken within 30 days for WIC)	
		Height (must be taken within 30 days for WIC)	
		Head Circumference (if <2 Years)	
		Blood Pressure (if ≥3 Years)	

IMMUNIZATIONS	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Application #:

2023-2024 Application for Free and Reduced Price School Meals

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

APPLY ONLINE: payschoolscentral.com
RETURN TO (School/District Name): Dover Public Schools
ADDRESS: 21 Belmont Ave. Dove, NJ07801

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.

MI	Child's First Name	Child's Last Name	[press space bar to advance]	School Name (Abbr.)	Grade	Foster Child	Migrant Worker	Runaway	Homeless
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check all that apply

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

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

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			Public Assistance, Child Support, Allmonny			Pensions, Retirement, Social Security, VA Benefits, All Other			
	Weekly	2xMonth	Monthly	Annual	Weekly	2xMonth	Monthly	Weekly	2xMonth	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)

Child Income \$

How often received? Weekly 2xMonth Monthly Annual

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.

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 <ul style="list-style-type: none"> Salary, wages, cash bonuses, tips, commissions Net income from self-employment (farm or business) If you are in the U.S. Military: <ul style="list-style-type: none"> Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) Allowances for off-base housing, food, and clothing 	Public Assistance/Alimony/Child Support <ul style="list-style-type: none"> Unemployment benefits Workers' compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits 	<ul style="list-style-type: none"> 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
Pensions/Retirement/All other sources of income <ul style="list-style-type: none"> 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 		

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)

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

Not Hispanic or Latino

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 x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income

How often? Weekly Every 2 Weeks 2xMonth Monthly Annual

Household size

Federal Income Eligibility Free Reduced Denied Yes No No

If Federal Denied: Eligible for NJIE? Yes No

Categorical Eligibility

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.