PRE-KINDERGARTEN & KINDERGARTEN ENROLLMENT & SCREENING FOR 2021-2022 SCHOOL YEAR

The information below is related to upcoming screening and enrollment for Fort Ann Central School District's pre-kindergarten and kindergarten programs. Pre-kindergarten screening appointments are tentatively scheduled for June 28th & June 29th. Kindergarten screening appointments are tentatively scheduled for June 30th & July 1st.

All Children must be residents of the district and meet age guidelines to attend. Children must turn 4 by December 1, 2021 to be eligible for the pre-kindergarten program. Children turning 5 by December 1, 2021 are permitted to enter kindergarten.

Enrollment requirements include original birth certificates, immunization records, recent physical, proof of residency and current custody orders, *(if applicable)*.

Enrollment packets for incoming pre-kindergarten and kindergarten children can be picked up in person at the elementary office, downloaded on our website or can be mailed to you. If this is your *first* child entering the district, please call the elementary office to ensure that you are on the mailing list. (518-639-5594, ext. 52078)

Fort Ann Elementary School

One Catherine Street
Fort Ann, NY 12827

518-639-5594

KINDERGARTEN REGISTRATION

The following information must be completed and submitted:

1. Kindergarten Questionnaire
2. Student Information Sheet
3. Student Racial and Ethnic Identification Form
4. Eligibility Screen for Migrant Education Services
5. Housing Questionnaire along with **two** Proofs of Residency (see list)
6. Kindergarten Pick up Authorization Form
7. Speech and Language Questionnaire
8. Do Not Photograph Form (if applicable)
9. Internet Use Agreement Form
10. Transportation Form
11. Student Health History Form (completed by parent/guardian)
12. Copy of Immunization Record (from doctor)
13. NYS Health Examination Form (to be completed by doctor)*
14. Dental Health Certificate (to be completed by dentist)
15. Physician's Authorization for Admin. of Medication
16. Custody Papers, Orders of Protection, and Guardianship Docs (if applicable)
17. Proof of Identity (birth certificate, baptism certificate, or passport)

*Must be dated within the last 12 months/Can be faxed directly to 518-639-4341

Fort Ann Central Elementary School
Parent Questionnaire
For Kindergarten Screening

Dear Parents:

Please take a few moments to introduce your child to us through this questionnaire. The completed questionnaire is due at the time of your child's screening.

Please read through the form and respond to all items as carefully as you can. You are an important source of information about your child. The information and answers that you provide enable us to better understand the whole child. Information shared on this questionnaire will remain confidential and will only be shared with your child's teacher and specialist teachers. We greatly appreciate your time in completing this form and look forward to working with you and your child.

Child's Full Name: _____ Date of Birth: _____

What name will your child be using in school: _____

Who does your child live with: _____

Does your child have any siblings (inside household or outside): _____

_____

Has your child attended preschool or daycare? _____

If yes, where? _____

Primary language spoken at home: _____

Health

1. Does your child wear glasses? _____
2. Do you suspect your child has a vision or hearing problem? _____
3. Has your child ever had an evaluation for any of the following difficulties: (please circle if applicable)

   Learning **Speech/Language** **Psychological**

   Fine/Gross Motor Skills **Social/Emotional** **Daily Living Skills**

   If your child has had an evaluation for any of the above areas, what is the name and location of the person(s) who administered the evaluation? _____

   What was the outcome of the evaluation(s)? _____

4. Has or does your child receive any of the following:

   Speech/Language Therapy **OT/PT** **Psychological Counseling**

   IEP **504 Plan** **Any Special Education Services**

Child's Name: _____

5. Please circle the skills your child is able to do or demonstrates:

Dress him/herself (zip, button, tie shoes, etc)
Hang up coat
Put shoes on correct feet
Toilet independently
Puts toys/items away when asked
Cleans up a spill
Feeds him/herself independently
Follow a 2-step direction
Blow/wipe nose without being asked
Hold/use crayons or pencils
Hold/use scissors
Initiate/play with children his/her own age
Able to take turns
Able to write his/her name
Write/read/recite the letters of the alphabet
Write/read/recite numbers 1-20
Demonstrates self-control
Actively participate in group activities
Works independently
Knows first and last name
Knows parents first and last names
Cooperates with others
Separates easily from parents

6. Which adjectives would you use to describe your child: (please circle the top 5)

Anxious
Friendly
Shy
Quiet
Boisterous/Loud
Careful
Cooperative
Respectful
Adventurous
Affectionate
Cheerful
Considerate
Enthusiastic
Kind
Outspoken
Stubborn
Talkative
Mischievous
Determined Impulsive
Feisty
Funny
Strong-Willed
Patient
Positive
High-Energy
Honest
Persistent
Sensitive
Fearful

What would you like us to know about your child (strengths, areas of concern, personality, etc)?

_____

_____

FORT ANN CENTRAL SCHOOL DISTRICT

STUDENT INFORMATION SHEET

STUDENT'S FULL NAME:_____
First Middle Last

Date of Birth: _____ Teacher_____ Grade_____

Home Address:_____

Mailing Address:_____

Primary Phone (This number will receive the District's Emergency Notifications):_____

Student Lives With (Circle One): Both Parents Mother Father Other

Parent/Guardian Name:_____ Relationship:_____

Mailing Address:_____

Contact Email:_____

Place of Business:_____

Phone Numbers: Home_____ Cell:_____ Work:_____

Custodial Parent: Yes_____ No_____ Emergency Contact?: Yes_____ No _____

Is this parent active duty military or a veteran?_____

Parent/Guardian Name:_____ Relationship:_____

Mailing Address:_____

Contact Email:_____

Place of Business:_____

Phone Numbers: Home_____ Cell:_____ Work:_____

Custodial Parent: Yes_____ No _____ Emergency Contact?: Yes_____ No_____

Is this parent active duty military or a veteran?:_____

Do you have or have there been any changes to any custodial agreements? (If yes, please provide an updated custody order)_____

_____

Parents/Guardians listed above will be contacted **FIRST** in the event of emergency. Please list **additional emergency contacts** below in the *order* you would like them contacted:

EMERGENCY CONTACT #1

Name:_____

Daytime Location Address:_____Relationship:_____

Daytime Phone:_____Cell:_____

EMERGENCY CONTACT #2

Name:_____

Daytime Location Address:_____Relationship:_____

Daytime Phone:_____Cell:_____

EMERGENCY CONTACT #3

Name:_____

Daytime Location Address::_____Relationship:_____

Daytime Phone:_____Cell:_____

Does your child have any medical conditions, illnesses or allergies? **Yes**_____**No**_____ If **yes**, our School Nurse will contact you for details_____

Does your child have an IEP or 504 Plan, or has he/she been referred for evaluation (Speech, OT, PT, etc)? If yes, please provide a copy of the IEP/504 Plan or provide name of tests, dates and location of any testing:

_____

_____

Other siblings (Both in household or out of household) Date of Birth:

_____ _____

_____ _____

_____ _____

What school district is your child transferring from if any?:_____

_____ _____

Signature of Parent/Guardian Today's Date

Fort Ann Central School District

Student Racial and Ethnic Identification

All students between 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.

English Only

Name of School:

School District Student Identification Number:

Date of Birth (Month/Day/Year):

Student Name;
Last, First, Middle:

Grade Level:

DIRECTIONS TO PARENT/GUARDIAN

PLEASE ANSWER QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1), check (✓) the box that best describes your child.] Check (✓) only ONE box.

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race?

☐ YES, Hispanic

☐ NO, not Hispanic

2. Select one or more races from the following five racial groups [For question (2), check (✓) all groups that apply to your child; check (✓) at least ONE box.]:

☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. E.g. Cherokee, Mohawk, Inuit.

☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **BLACK:** A person having origins in any of the black racial groups of Africa.

☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

3. ☐ Is there a language other than English which is spoken in your home? ☐ YES ☐ NO
If yes, what language? _____

Signature of Parent/Guardian _____ Relationship to Student _____ Date _____

See reverse for important messages to Parents/Guardians
and Confidentiality Procedures and Regulations.

FORT ANN CENTRAL SCHOOL DISTRICT
STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian: THE FORT ANN CENTRAL SCHOOL DISTRICT has adopted a policy that requires the collection and recording of the ethnic identity of students within the district in accordance with the federal categories and definitions. The information will be used:

- Report information to the State and Federal Education Departments.
-Plan educational programs and make sure that they are readily available to all students.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check (✓) in the box for the category or categories which best describe your child. We understand the sensitive nature of this information and wish 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 this 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. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: This form will be filed in the student's permanent record as confidential information.

To the Parent/Guardian: The information that you have provided on this form is confidential. It is protected by the confidentiality regulation cited as follows:

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

Please complete the form on the other side of this page.

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer NY 13350
315-867-2079

Eligibility Screen for Migrant Education Services

*** Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. ***

Has your family moved to a different school district in the last 3 years? YES_____ NO_____

In the last three years, did the parent or guardian of the child enrolling have farm work as a part of job? (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) YES_____ NO_____

If yes, what farm did you work on?_____ Where? _____ When?_____




If you can answer YES to BOTH of the above questions, your family MAY qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.

Child's name _____ D.O.B._____Grade_____

Child's name _____ D.O.B._____Grade_____

Child's name _____ D.O.B._____Grade_____

Child's name _____ D.O.B._____Grade_____

Parents/ Guardians

Mother's name _____ Father's Name _____

Home Address _____ Home Phone #_____
(Street Address)

_____ Work or Message # _____
(city, town or village) (Zip)

School District_____ School Building_____

School Contact Person_____ Contact Number _____

Other Useful information (directions, farm names, best time to contact, etc.) _____

_____

_____

To submit this referral please fax to the Herkimer BOCES at (315) 867-2087 or mail to the address above. For more information please call the Migrant Program at (315) 867-2079. Thank you for your assistance.

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer NY 13350
315-867-2079

Cuestionario de Elegibilidad para Servicios de Educación Migrante

*** Servicios del Programa de Educación Migrante son gratuitos y pueden incluir tutoría, ayuda con necesidades de salud, viajes educacionales, programas del verano, actividades de involucrar a los padres, educación para adultos, ayuda de emergencia y referidos a otros servicios como necesario. ***

¿Ha mudado su familia a un distrito escolar diferente en los últimos 3 años? Si____ NO_____

¿En los últimos 3 años ha trabajado un padre o guardián en granja como: lechería, plantando, cosechando frutas o legumbres, el procesamiento o empacar de comida, corta de árboles o cultivo de árboles? Si____NO_____

Si UD dijo que si, ¿en que granja?_____ ¿Donde?_____ ¿Cuándo?_____




Si Usted contestó que Si a ALGUNAS preguntas de arriba, su familia PUEDA calificar para servicios de Educación Migrante. Para estar contactado por una reclutadora del Programa de Educación Migrante, favor de llenar la información de abajo.

Nombre del niño(a) _____ Fecha de Nacimiento_____Grado_____

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado_____

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado_____

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado_____

Padres/ Guardianes

Nombre de la Mamá _____ Nombre del Papá _____

Dirección de la Casa _____ Numero de teléfono en casa_____
(Dirección de la Calle)

_____ # de teléfono del trabajo o de Mensaje_____
(Ciudad o Pueblo) (Código Postal)

Distrito escolar _____ edificio escolar _____

Persona para contactar_____ numero para contactar _____

Otra información Útil (direcciones. nombres de granjas. mejor hora de llamar. etc.) _____

_____

_____

Para someter este referido, favor de mandarlo por fax al Herkimer BOCES a (315) 867-2087 o mandar por correo al dirección de arriba.
Para más información, favor de llamar al Programa Migrante a (315) 867-2079. Gracias.

RESIDENCY QUESTIONNAIRE

Name of LEA: Fort Ann CSD

Name of School: _____

Name of Student: _____
Last First Middle

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

Address: _____ Phone: _____

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

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

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

- ☐ In permanent housing

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

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

_____
Date

If the student is NOT living in permanent housing, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. The district's LEA liaison is required to assist the student in obtaining any necessary documents, including immunization or school records after the student has been enrolled.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

Fort Ann Elementary School

One Catherine Street
Fort Ann, NY 12827

Phone 518-639-5594 Fax 518-639-4341

To enroll your child/children in Fort Ann Central School District, you must provide two proofs of residency:

Preferred:

- Lease Agreement or notarized statement from landlord - must include tenants' names and physical address
- Copy of deed
- Driver's license or NYS Identification card issued by DMV
- State or Government issued identification card with name and address
- Voter Registration card
- Homeowner's Insurance Policy (active) with name and full physical address
- Income Tax Form - most recent year
- School Tax bill - most recent year
- Mortgage Statement*
- Pay Stub* - must include name and full physical address of parent/guardian
- Utility Bill* - National Grid, Local water/sewer, cable
- Notices/Award Letters from DSS, OTDA, SSA*

Accepted only if none of the above are available and with approval of the District:

- Notarized statement from a third party which must include all tenants' names and the full physical address as well as the date tenancy began
- Copy of proof of purchase contract with a letter from an attorney listing the expected closing date/time

*Proof of Residency with * must be within 30 days of receipt by district.

*All above documents must include name of parent/guardian or child's name and the full physical address.

*Call Krista Crosbie, Guidance Secretary, with questions. 518-639-5594

Fort Ann Central School District

1 Catherine Street
Fort Ann, NY 12827
Telephone: (518)639-5594 Fax: (518)639-8911
www.fortannschool.org

PICK UP AUTHORIZATION

Student name_____

Address_____

Parent/guardian_____

Contact number_____

The following list of people has my authorization to pick my child up from school. I understand that these people must show identification each time they pick my child up at the elementary entrance of the building or cafeteria at dismissal time. All others will ***NOT*** be permitted to pick up my child.

	NAME	HOME PHONE	CELL PHONE
1.			
2.			
3.			
4.			
5.			

_____ _____

Signature of parent/guardian Today's date

Copy me
2 Both Sides

SPEECH AND LANGUAGE QUESTIONNAIRE

Student_____

Birth date_____Grade entering_____

Parent/Guardian with whom student lives_____

Siblings and their ages_____

Address_____

Home phone_____Cell_____Work_____

_____ My child is currently receiving speech and language therapy
Agency name_____

_____ My child was but is no longer receiving speech and language therapy.
Agency name_____

_____ My child has never received speech and language therapy.

_____ My child says all speech sounds correctly.

_____ My child does not say all speech sounds correctly

To the best of your knowledge, please list all the speech sounds which your child does not say correctly._____

How well do you understand your child's speech?

Not well at all 1 2 3 4 5 Very Well

How well do you think others understand your child's speech?

Not well at all 1 2 3 4 5 Very Well

Please comment on your child's general communication skills. Include any medical information which may be relevant.

DO NOT PHOTOGRAPH FORM

Dear Parents/Guardians,

We like to promote Fort Ann Central School events and activities through publishing photographs of students on our website, district newsletter, or in other locations. At times, we have also have the opportunity to have photographs of students included in the local newspaper. We would appreciate your permission to publish photographs of your child, should the occasion arise.

Please return this form by 09/18/21 ***ONLY*** if you ***DO NOT*** wish to give permission for your child to be photographed. Thank you.

( ) I **DO NOT** give permission for my child/children to be photographed or have their photo released to the media for educational purposes.

Parent/Guardian Signature:_____

Child's Name:_____

Child's Grade:_____

Date:_____

FORT ANN CENTRAL SCHOOL
ACCEPTABLE USE AGREEMENT: INTRANET/INTERNET
Grades K- 2
Including Summer School
(Renewable In Grades 3, 6 & 9)

As a part of my schoolwork, my school gives me the use of computers and storage space on the server for my work. My behavior and language are to follow the same rules I follow in my class attd in my school. To help myself and others, I agree to the following promises:

1. I will use the computers *only* to do school work, and not for any other reason. I will not store material that is not related to my schoolwork.
2. I will use the Internet *only* with my teacher's permission.
3. I will not give my password to anyone else, and I will not ask for or use anyone else's password.
4. I will not put on the computer my address or telephone number, or any other personal information about myself or anyone else.
5. I will not upload, link, or embed an image of myself or others without my teacher's permission.
6.1 will not play games that a teacher has not approved.
7.1 will be polite and considerate when I use the computer; I will not use it to annoy, be mean to, frighten, threaten, tease, bully, or poke fun at anyone; I will not use swear words or any other rude language.
8. I will not try to see, send, or upload anything that says and/or shows bad or mean things about anyone's race,religion or gender.
9. I will not damage the computer or anyone else's work.
10. I will not take credit for other people's work.
11. If I have or see a problem, I will not try to fix it myself but I will tell the teacher.
12. I will not block or interfere with school or school system communications.
13. My teacher may look at my work to be sure that I am following these rules, and if I am not, there will be consequences which may include not being able to use the computer.
14. I know that the conduct that is forbidden in school is also forbidden when I use computers outside of school if it interferes with other students' education, and if I break the rules there will consequences in school.

Print Student's Name: _____ **Grade:** _____
Student's Signature: _____ **Date:** _____

Parents: *I have read and discussed with my child the Acceptable Use Agreement, and I give permission for his or her use of the resources. /understand that computer access is conditional upon adherence to the agreement. Although students are supervised using computers, a11d their use is electronically monitored, I am aware of the possibility that my child may gain access to materials that school officials and I may consider inappropriate or not of educational value.*

Print Parent's Name: _____
Parent's Signature: _____ **Date:** _____

***STUDENTS MAY NOT USE COMPUTERS UNLESS**
THIS AGREEMENT IS SIGNED AND RETURNED TO THE TEACHER.

20/21 FORT ANN CENTRAL SCHOOL
TRANSPORTATION INFORMATION FORM

FORT ANN SCHOOL DISTRICT TRANSPORTATION POLICY

1. Students who are in Kindergarten **MUST** be met by their parent/guardian, if a parent/guardian is not there to meet their child, they will be taken back to school.
2. Transportation information forms must be completed every school year, even if the information is the same as the previous year.
3. Transportation information forms should be completed any time there is a change in your child's bus route.
4. If this form is not returned, we will schedule your child's bus route from our most current **HOME** address.
   NOTE: REQUEST FORMS MUST BE FILLED OUT PRIOR TO CHANGE. PLEASE ALLOW FOR 3 TO 5 DAYS FOR PROCESSING.

Today's Date _____ Effective Date _____

Student's Name _____ Grade _____

Parent/Guardian Name _____

Primary Home Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Please put a check if your child is a walker, parent drop off _____AM or parent pick up _____PM

AM Alternate Child Care Provider: _____

Address _____

Sitter Home Phone _____ Sitter Cell Phone _____

Please **circle** which days your child(ren) will be PICKED UP at daycare:

MON TUES WED THURS FRI

PM Alternate Child Provider: _____

Address _____

Sitter Home Phone _____ Sitter Cell Phone _____

Please **circle** which days your child(ren) will be DROPPED OFF at daycare:

MON TUES WED THURS FRI

Parent/Guardian Signature _____

FORT ANN CENTRAL SCHOOL DISTRICT

STUDENT HEALTH HISTORY

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

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

CHECK ALL THAT APPLY TO YOUR CHILD:

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

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

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

☐No ☐Yes:_____

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

_____

Parent/Guardian Signature:_____ Date:_____

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: ☐ M ☐ F DOB:

School: Grade: Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached

☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached

☐ Yes, indicate type ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached

☐ Yes, indicate type ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

☐ Yes, indicate type ☐ Type 1 ☐ Type 2 ☐ HgbA1c results: _____ Date Drawn: _____

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
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	

Lead Level Required Grades Pre- K & K **Date**

☐ Test Done ☐ Lead Elevated ≥10 µg/dL

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ Other:

☐ **System Review and Exam Entirely Normal**

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

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

☐ 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/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	**Negative** ☐	**Positive** ☐	**Referral** ☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **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:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

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

List medications taken at home:

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature: **Date:**

Provider Name: *(please print)* Stamp:

Provider Address:

Phone:

Fax:

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

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. 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 dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist 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: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

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

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam 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 name and address (please print or stamp)

Dentist'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 ¼ 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):_____

III. 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.

New York State Center for School Health
Supporting Student Success Through Health and Education

X NYS Required X NYC Required X NYS Optional X NYC Optional

NYS and NYC Screening & Health Exam Requirements

	New Entrant	Pre K or K*	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grade 6	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
HEARING SCREENING:														
Pure Tone	X	X	X		X		X		X				X	
SCOLIOSIS SCREENING														
Boys											X			
Girls							X		X					
VISION SCREENING														
Color Perception	X													
	X													
Fusion		X	X											
Near Vision	X	X	X		X		X		X				X	
	X	X	X		X		X							
Distance Acuity	X	X	X		X		X		X				X	
	X	X	X		X		X							
Hyperopia	X													

*Determine if your Kindergarten or Pre K students are your district's new entrants.

Health Examination Overview

	New Entrant	Pre K or K	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grade 6	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
Health Examination**	X	X	X		X		X		X		X		X	
	X													
Dental Certificate	X	X	X		X		X		X		X		X	

**Health Examinations may be either a Health Appraisal (health exam performed by the School Medical Director) or Health Certificate (health exam performed by the student's primary medicalprovider). They must be dated no more than 12 months prior to the start of the school year in which they are required, or the date of entrance to the school for new entrants.

This sample resource was created by the New York State Center for School Health and is located at www.schoolhealthny.com in the Laws | Guidelines | Memos - Effective July 2018 (revised 2/2018)

7513F.1

FORT ANN CENTRAL SCHOOL DISTRICT
SELF-MEDICATION RELEASE FORM

Date: _____

Student's Name: _____

has been instructed in the proper use of the following medication procedures: _____

_____

_____

_____

We (Physician's signature) _____ and

(Parent or Person in Parental Relation's signature) _____

request that (Student's name) _____ be permitted to

carry the medication on his/her person or to keep same in his/her locker or physical education locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use. He/she understands the importance of immediately notifying the teacher or school registered professional nurse of the use of an anaphylactic medication.

Note: This form must be completed *in addition* to the routine District medication form for those students who request permission to carry their own medication on campus or keep this medication in a school or physical education locker.

2020-21 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** If the 4th dose was received at 4 years or older or **3 doses** If 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]		**Not applicable**	**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** If the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses** or **2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years**		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]		**Not applicable**	**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses or 1 dose** If the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grade 6: 10 years; minimum age for grades 7 through 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2020-2021, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grade 6; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 7 through 12.
   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. Only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grade 7: 10 years; minimum age for grades 8 through 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. PCV is not required for children 5 years or older.
   f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

FORT ANN CENTRAL SCHOOL DISTRICT
PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

1) To be completed by the parent or guardian:

I request that my child, _____ DOB _____
GRADE _____ receive the medication as prescribed below by our physician.

The medication is to be personally delivered by me (parent or guardian) in the original labeled pharmacy container stating the specific name of the medication and dispensing orders.

Signature (Parent/Guardian): _____

Telephone: Home _____ Work _____ Date _____

2) To be completed by physician

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

Name of Student: _____ DOB: _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____
*Order may extend to a summer school session if needed [ ] Yes [ ] No

Possible Side Effects and Adverse Reactions (if any): _____

PLEASE CHECK ONE:

[ ] I deem this child to be **self-directed** and understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.

[ ] I deem this child to be **non-self-directed** and understand that administration of oral topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

Plan reviewed with parent(s)/guardian(s):

Parent Signature: _____ Date: _____

*Parent/Guardian must submit written request to School Nurse prior to summer session.

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FORT ANN CENTRAL SCHOOL DISTRICT
SELF-MEDICATION RELEASE FORM

Date: _____

Student's Name: _____

has been instructed in the proper use of the following medication procedures: _____
_____
_____
_____

We (Physician's signature) _____ and

(Parent or Person in Parental Relation's signature) _____

Request that **(Student's name)** _____ be permitted to

carry the medication on his/her person or to keep same in his/her locker or physical education locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use. He/she understands the importance of immediately notifying the teacher or school registered professional nurse of the use of an anaphylactic medication.

Note: This form must be completed *in addition* to the routine District medication form for those students who request permission to carry their own medication on campus or keep this medication in a school or physical education locker.

PARENT/GUARDIAN CONSENT TO RELEASE ELIGIBILITY INFORMATION FOR FREE AND REDUCED PRICE MEALS OR FREE MILK

Date August 1, 2020

Dear Parent/Guardian:

If your child is eligible for free and reduced price meals or free milk, he/she also may be eligible for other benefits. To receive these benefits, you must provide written consent to permit school officials to give your name, address, and an indication that your household is eligible for free and reduced price meals or free milk, to representatives of certain programs. **Failure to sign a consent statement that will allow disclosure of this information will not affect your child's eligibility or participation in the school meals or milk programs.**

Some of the programs that may request names and eligibility information to be used to provide benefits, and for which parent/guardian consent is required, include: federal health insurance programs such as Medicaid or Children's Health Insurance program (CHIP), other federal programs, State programs, local health and education programs and other local activities. For example, the disclosure of children's eligibility for free and reduced price meals or free milk to determine eligibility for free text books, free band instruments, holiday baskets, school supplies, etc., or reduced fees for summer school or driver education programs, would require written consent by the child's parent/guardian.

If you wish to provide consent to release information contained in your child's free and reduced price meal application, to receive other benefits, please complete the attached consent statement.

Please call Mrs. Krista Crosbie at (518)639-5594 ext. 52101 if you have questions.

Sincerely,

Enclosure (consent statement)

Nondiscrimination Statement:
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.

This institution is an equal opportunity provider.

Letter to Parents for School Meal Programs

Dear Parent/Guardian:

Children need healthy meals to learn. Fort Ann Central School offers healthy meals every school day. Breakfast costs **$1.25**; lunch costs **$2.65**. Your children may qualify for free meals or for reduced price meals. Beginning July 1, 2019, students in New York State that are approved for reduced price meals will receive breakfast and lunch meals and snacks served through the Afterschool Snack Program at no charge.

1. DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD? No. Complete the application to apply for free or reduced price meals. *Use one Free and Reduced Price School Meals Application for all students in your household.* We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: Krista Crosbie, 1 Catherine Str., Fort Ann, NY 12827, (518)639-5594 ext. 52101.
2. WHO CAN GET FREE MEALS? All children in households receiving benefits from **SNAP, the Food Distribution Program on Indian Reservations** or **TANF**, can get free meals regardless of your income. Categorical eligibility for free meal benefits is extended to all children in a household when the application lists an Assistance Program's case number for any household member. Also, your children can get free meals if your household's gross income is within the free limits on the Federal Income Eligibility Guidelines. Households with children who are categorically eligible through an Other Source Categorically Eligible designation, as defined by law, may be eligible for free benefits and should contact the SFA for assistance in receiving benefits.
3. CAN FOSTER CHILDREN GET FREE MEALS? Yes, foster children that are under the legal responsibility of a foster care agency or court, are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Foster children may also be included as a member of the foster family if the foster family chooses to also apply for benefits for other children. Including children in foster care as household members may help other children in the household qualify for benefits. If non-foster children in a foster family are not eligible for free or reduced price meal benefits, an eligible foster child will still receive free benefits.
4. CAN HOMELESS, RUNAWAY, AND MIGRANT CHILDREN GET FREE MEALS? Yes, children who meet the definition of homeless, runaway, or migrant qualify for free meals. If you haven't been told your children will get free meals, please call or e-mail **[school, homeless liaison or migrant coordinator information]** to see if they qualify.
5. WHO CAN GET REDUCED PRICE MEALS? Your children may be approved as reduced price eligible if your household income is within the reduced-price limits on the Federal Eligibility Income Chart, shown on this letter. Beginning July 1, 2019, students in New York State that are approved for reduced price meals will receive breakfast and lunch meals and snacks served through the Afterschool Snack Program at no charge.
6. SHOULD I FILL OUT AN APPLICATION IF I RECEIVED A LETTER THIS SCHOOL YEAR SAYING MY CHILDREN ARE APPROVED FOR FREE MEALS? Please read the letter you got carefully and follow the instructions. Call the school at (518)639-5594 ext. 52101 if you have questions.
7. MY CHILD'S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT ANOTHER ONE? Yes. Your child's application is only good for that school year and for up to the first 30 operating days of this school year. You must send in a new application unless the school told you that your child is eligible for the new school year.
8. I GET WIC. CAN MY CHILD(REN) GET FREE MEALS? Children in households participating in WIC may be eligible for free or reduced price meals. Please fill out a FREE/REDUCED PRICE MEAL application.
9. WILL THE INFORMATION I GIVE BE CHECKED? Yes and we may also ask you to send written proof.
10. IF I DON'T QUALIFY NOW, MAY I APPLY LATER? Yes, you may apply at any time during the school year. For example, children with a parent or guardian who becomes unemployed may become eligible for free and reduced price meals if the household income drops below the income limit.
11. WHAT IF I DISAGREE WITH THE SCHOOL'S DECISION ABOUT MY APPLICATION? You should talk to school officials. You also may ask for a hearing by calling or writing to: Mr. Justin Hoskins, 1 Catherine St., Fort Ann, NY 12827; (518)639-5594 ext. 52060; jhoskins@fortannschool.org.
12. MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN? Yes. You or your child(ren) do not have to be U.S. citizens to qualify for free or reduced price meals.
13. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD? You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro-rated share of expenses), do not include them.
14. WHAT IF MY INCOME IS NOT ALWAYS THE SAME? List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only made $900, put down that you made $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.
15. WE ARE IN THE MILITARY. DO WE INCLUDE OUR HOUSING ALLOWANCE AS INCOME? If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.
16. MY SPOUSE IS DEPLOYED TO A COMBAT ZONE. IS HER COMBAT PAY COUNTED AS INCOME? No, if the combat pay is received in addition to her basic pay because of her deployment and it wasn't received before she was deployed, combat pay is not counted as income. Contact your school for more information.
17. MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR? To find out how to apply for **SNAP** or other assistance benefits, contact your local assistance office or call **1-800-342-3009**.

2020-2021 INCOME ELIGIBILITY GUIDELINES
FOR FREE AND REDUCED PRICE MEALS OR FREE MILK

REDUCED PRICE ELIGIBILITY INCOME CHART

Total Family Size	Annual	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$ 23,606	$ 1,968	$ 984	$ 908	$ 454
2	$ 31,894	$ 2,658	$ 1,329	$ 1,227	$ 614
3	$ 40,182	$ 3,349	$ 1,675	$ 1,546	$ 773
4	$ 48,470	$ 4,040	$ 2,020	$ 1,865	$ 933
5	$ 56,758	$ 4,730	$ 2,365	$ 2,183	$ 1,092
6	$ 65,046	$ 5,421	$ 2,711	$ 2,502	$ 1,251
7	$ 73,334	$ 6,112	$ 3,056	$ 2,821	$ 1,411
8	$ 81,622	$ 6,802	$ 3,401	$ 3,140	$ 1,570
*Each Add'l person add	$ 8,288	$ 691	$ 346	$ 319	$ 160

w to Apply. To get free or reduced price meals for your children carefully complete one application following the instructions for your household and return it he designated office listed on the application. If you now receive SNAP, Temporary Assistance to Needy Families (TANF) for any children or participate in Food Distribution Program on Indian Reservations (FDPIR), the application must include the children's names, the household SNAP, TANF or FDPIR case nber and the signature of an adult household member. All children should be listed on the same application. If you do not list a SNAP, TANF or FDPIR case nber for any household member, the application must include the names of everyone in the household, the amount of income each household member, and v often it is received and where it comes from. It must include the signature of an adult household member and the last four digits of that adult's social security nber or check the box if the adult does not have a social security number. **An application for free and reduced price benefits cannot be approved unless nplete eligibility information is submitted, as indicated on the application and in the instructions.** Contact your local Department of Social Services your SNAP or TANF case number or complete the income portion of the application. No application is necessary if the household was notified by the SFA ir children have been directly certified. If the household is not sure if their children have been directly certified, the household should contact the school.

oorting Changes. The benefits that you are approved for at the time of application are effective for the entire school year and up to 30 operating days into the v school year (or until a new eligibility determination is made, whichever comes first). You no longer need to report changes for an increase in income or :rease in household size, or if you no longer receive SNAP.

ome Exclusions. The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred such care under the Child Care Development (Block Grant) Fund should not be considered as income for this program.

duced Price Eligible Students. **Beginning July 1, 2019, students in New York State that are approved for reduced price meals will receive breakfast d lunch meals and snacks served through the Afterschool Snack Program at no charge.**

he operation of child feeding programs, no child will be discriminated against because of race, sex, color, national origin, age or disability

al Service to Children With Disabilities: Federal regulations require schools and institutions to serve meals at no extra charge to children with a disability ch may restrict their diet. A student with a disability is defined in 7CFR Part 15b.3 of Federal regulations, as one who has a physical or mental impairment ch substantially limits one or more major life activities of such individual, a record of such an impairment or being regarded as having such an impairment. jor life activities include but are not limited to: functions such as caring for one's self, performing manual tasks, seeing, hearing, eating, sleeping, walking nding, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. You must request meal modifications n the school and provide the school with medical statement from a State licensed healthcare professional. If you believe your child needs substitutions :ause of a disability, please get in touch with us for further information, as there is specific information that the medical statement must contain.

nfidentiality. The United States Department of Agriculture has approved the release of students names and eligibility status, without parent/guardian consent, persons directly connected with the administration or enforcement of federal education programs such as Title I and the National Assessment of Educational gress (NAEP), which are United States Department of Education programs used to determine areas such as the allocation of funds to schools, to evaluate ioeconomic status of the school's attendance area, and to assess educational progress. Information may also be released to State health or State education grams administered by the State agency or local education agency, provided the State or local education agency administers the program, and federal State ocal nutrition programs similar to the National School Lunch Program. Additionally, all information contained in the free and reduced price application may released to persons directly connected with the administration or enforcement of programs authorized under the National School Lunch Act (NSLA) or Child rition Act (CNA) including the National School Lunch and School Breakfast Programs, the Special Milk Program, the Child and Adult Care Food Program, mmer Food Service Program and the Special Supplemental Nutrition Program for Women Infants and Children (WIC); the Comptroller General of the United tes for audit purposes, and federal, State or local law enforcement officials investigating alleged violation of the programs under the NSLA or CNA.

application: You may apply for benefits any time during the school year. Also, if you are not eligible now, but during the school year become unemployed, 're a decrease in household income, or an increase in family size you may request and complete an application at that time.

The disclosure of eligibility information not specifically authorized by the NSLA requires a written consent statement from the parent/guardian. We will let you know when your application is approved or denied.

Sincerely

Mrs Krista Crosbie

Nondiscrimination Statement. This explains what to do if you believe you have been treated unfairly.

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, S.W.
Washington, D.C. 20250-9410;

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

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

This institution is an equal opportunity provider.

MEAL SERVICES TO CHILDREN WITH DISABILITIES

Dear Parent/Guardian:

The National School Lunch Program (NSLP) and School Breakfast Program (SBP) aim to provide all participating children, regardless of background, with the nutritious meals they need to be healthy. This includes ensuring children with disabilities have an equal opportunity to participate in and benefit from the NSLP and SBP.

Federal regulations require schools and institutions to serve meals at no extra charge to those children whose disability restricts their diet in such a way that they cannot fully participate in the food service program without some modification to the foods offered or the scheduled menu. If you believe your child needs substitutions because of a disability, please get in touch with us for further information. You must request meal modifications from the school and provide the school with a medical statement from a State licensed healthcare professional. This medical statement must contain but is not limited to the following:

- Information about the child's physical or mental impairment that is sufficient to allow the school to understand how it restricts the child's diet,
- An explanation of what must be done to accommodate the child's special dietary need,
- The food or foods to be omitted and recommended alternatives, in the case of a modified meal

If you have questions regarding the need for meal modifications, contact Mrs. Krista Crosbie at (518)639-5594. Ext. 52101 for further information.

Nondiscrimination Statement:
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.

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Date Withdrew_____ F___R____D____

2020-2021 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call (518)639-5594 ext. 52101, if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **Fort Ann Central School**
1 Catherine Street
Fort Ann, NY 12827

. List all children in your household who attend school.

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

. SNAP/TANF/FDPIR Benefits:
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.**

lame: _____ CASE #: _____

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

ll Household Members (including yourself and all children that have income).
ist 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 ıcome, 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 lank, you are certifying (promising) that there is no income to report.

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

otal Household Members (Children and Adults) ☐☐

***Last Four Digits of Social Security Number:** XXX-XX- _ _ _ _ I do not have a SS# ☐

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

. Signature: An adult household member must sign this application before it can be approved.
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 ill 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 ederal laws, and my children may lose meal benefits.
ignature: _____ Date: _____
mail Address: _____
ome Phone: _____ Work Phone: _____ Home Address: _____

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

thnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
ace (Check one or more) : ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

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

☐ SNAP TANF Foster

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 Mrs. Krista Crosbie, Fort Ann Central School.
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. (518)639-5594 ext. 52101. 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.

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(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

This institution is an equal opportunity provider.

CONSENT TO RELEASE FREE OR REDUCED PRICE ELIGIBILITY INFORMATION

School officials may release information that shows that my child/children are eligible for free or reduced price meals or free milk to the following programs. I understand that the information will only be provided to the program(s) checked.

(Check the box next to the program area(s) you wish to release information to)

- ☐ Federal health programs such as Medicaid or Children's Health Insurance Program (CHIP).
- ☐ State or federal programs such as the Youth Summer Work program or the Educational Talent Search Program.
- ☐ Local health and education programs and other local programs that provide benefits such as free textbooks or school supplies, free band instruments, or reduced fees for summer school or driver education.
- ☐ Community programs such as holiday baskets, summer arts and playground programs.

I understand that I will be releasing information that will show that my child/children are eligible for free and reduced price meals or free milk. I give consent to release my confidential information for the above named uses.

Child/Children:

_____

_____

_____

I certify that I am the child's parent/guardian for whom the application was made.

Signature of Parent/Guardian: _____

Print Name: _____

Address: _____

Phone Number: _____

Date: _____

Nondiscrimination Statement:

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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.

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FREE AND REDUCED PRICE MEAL APPLICATION FACT SHEET

When filling out the application form, please pay careful attention to these helpful hints.

SNAP/TANF/FDPIR case number: This must be the complete valid case number supplied to you by the agency including all numbers and letters, for example, E123456, or whatever combination is used in your county. Refer to a letter you received from your local Department of Social Services for your case number or contact them for your number.

Foster Child: A child who is living with a family but who is under the legal care of the welfare agency or court may be listed on your family application. List the child's "personal use" income. This includes only those funds provided by the agency which are identified for the personal use of the child, such as personal spending allowances, money received by his/her family, or from a job. Funds provided for housing, food and care, medical, and therapeutic needs are not considered income to the foster child. Write "0" if the child has no personal use income.

Household: A group of related or non-related people who are living in one house and share income and expenses.

Adult Family Members: All related and non-related people who are 21 years of age and older living in your house.

Financially Independent: A person is financially independent and a separate economic unit/household when his or her earnings and expenses are not shared by the family/household. Separate economic units in the same residence are characterized by prorating expenses and by economic independence from one another.

Current Gross Income: Money earned or received at the present time by each member of your household before deductions. Examples of deductions are federal tax, State tax, and Social Security deductions. If you have more than one job, you must list the income from all jobs. If you receive income from more than one source (wage, alimony, child support, etc.), you must list the income from all sources. Only farmers, self-employed workers, migrant workers, and other seasonal employees may use their income for the past 12 months reported from their 1040 Tax Forms.

Examples of gross income are:

- Wages, salaries, tips, commissions, or income from self-employment
- Net farm income – gross sales minus expenses only – not losses
- Pensions, annuities, or other retirement income including Social Security retirement benefits
- Unemployment compensation
- Welfare payments (does not include value of SNAP)
- Public Assistance payments
- Adoption assistance
- Supplemental Security Income (SSI) or Social Security Survivor's Benefits
- Alimony or child support payments
- Disability benefits, including workman's compensation
- Veteran's subsistence benefits
- Interest or dividend income
- Cash withdrawn from savings, investments, trusts, and other resources which would be available to pay for a child's meals
- Other cash income

Income Exclusions: 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 Development (Block Grant) Fund should not be considered as income for this program.

If you have any questions or need help in filling out the application form, please contact:

Name: Mrs. Krista Crosbie Title: Reviewing Official

Telephone Number: (518)639-5594 ext. 52101

Fort Ann Elementary School

One Catherine Street
Fort Ann, NY 12827
518-639-5594 Fax (518) 639-4341
www.fortannschool.org

PRE-KINDERGARTEN REGISTRATION

The following information must be completed and submitted:

1. Pre-Kindergarten Questionnaire
2. Student Information Sheet
3. Proof of identity (birth certificate, baptism certificate, or passport)
4. Student Racial and Ethnic Identification Form
5. Residency questionnaire
6. Two Proofs of Residency (*see list*)
7. Pre-Kindergarten Pick up Authorization Form
8. Speech and Language Questionnaire
9. Do not Photograph Form (*if applicable*)
10. Student Health History Form (completed by parent/guardian)
11. Copy of Immunization Record
12. NYS Health Examination Form (to be completed by doctor within 1yr)
13. Dental Health Certificate (*optional*))
14. Self medication release form (*if applicable*)
15. Proof of Identity (birth certificate, baptism certificate, or passport)
16. Free or reduced school lunch form (*if applicable*)
17. Custody Papers, Orders of Protection, & Guardianship Documents (*if applicable*)

Fort Ann Central School

Pre-Kindergarten Questionnaire

Family Information

Child's Full Name: _____ Date of Birth: _____

Mother's Name: _____ Email: _____

Mother's Address: _____ Best Number to Reach Mom: _____

Father's Name: _____ Email: _____

Father's Address: _____ Best Number to Reach Dad: _____

Siblings (please include birthdate/grade/teacher as applies)

_____

_____

Social & Health History

Has your child attended school and/or daycare? _____

If yes, where: _____

Does your child have any health or social concerns? Allergies? _____

_____

Does your child use the toilet/get dressed independently?	Yes	Not yet	Sometimes
Does your child use crayons/pencils/scissors?	Yes	Not yet	Sometimes
How often do you read with your child?	Daily	Weekly	Monthly
Does your child play well/share with other children?	Yes	No	Sometimes

Is there anything else you wish to share about your child? _____

_____

_____

Thank you!

I know you feel like you have answered these questions a thousand times but I like to have a copy to keep in the classroom. I am looking forward to a great year! ~Mrs. Hull, Pre-K Teacher

FORT ANN CENTRAL SCHOOL DISTRICT

STUDENT INFORMATION SHEET

STUDENT'S FULL NAME:_____
First Middle Last

Date of Birth: _____Teacher_____Grade_____

Home Address:_____

Mailing Address:_____

Primary Phone (This number will receive the District's Emergency Notifications):_____

Student Lives With (Circle One): Both Parents Mother Father Other

Parent/Guardian Name:_____Relationship:_____

Mailing Address:_____

Contact Email:_____

Place of Business:_____

Phone Numbers: Home_____Cell:_____Work:_____

Custodial Parent: Yes_____No_____ Emergency Contact?: Yes_____ No _____

Is this parent active duty military or a veteran?_____

Parent/Guardian Name:_____Relationship:_____

Mailing Address:_____

Contact Email:_____

Place of Business:_____

Phone Numbers: Home_____Cell:_____Work:_____

Custodial Parent: Yes_____ No _____ Emergency Contact?: Yes_____ No_____

Is this parent active duty military or a veteran?:_____

Do you have or have there been any changes to any custodial agreements? (If yes, please provide an updated custody order)_____

_____

Parents/Guardians listed above will be contacted **FIRST** in the event of emergency. Please list **additional emergency contacts** below in the *order* you would like them contacted:

EMERGENCY CONTACT #1

Name:_____

Daytime Location Address:_____Relationship:_____

Daytime Phone:_____Cell:_____

EMERGENCY CONTACT #2

Name:_____

Daytime Location Address:_____Relationship:_____

Daytime Phone:_____Cell:_____

EMERGENCY CONTACT #3

Name:_____

Daytime Location Address::_____Relationship:_____

Daytime Phone:_____Cell:_____

Does your child have any medical conditions, illnesses or allergies? **Yes**_____**No**_____ If **yes**, our School Nurse will contact you for details_____

Does your child have an IEP or 504 Plan, or has he/she been referred for evaluation (Speech, OT, PT, etc)? If yes, please provide a copy of the IEP/504 Plan or provide name of tests, dates and location of any testing:

_____

_____

Other siblings (Both in household or out of household) Date of Birth:

_____ _____

_____ _____

_____ _____

What school district is your child transferring from if any?:_____

_____ _____

Signature of Parent/Guardian Today's Date

Fort Ann Central School District

Student Racial and Ethnic Identification

The Fort Ann Central School District has adopted a policy that requires the collection and recording of the ethnic identity of students within the district in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and Federal Education Departments.
- Plan educational programs and make sure they are available to all students.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze the differences in academic performance, attendance, and completion of school.

We need your help in order to accomplish the above tasks. Please review the Racial/Ethnic definitions on the reverse side of this form. Place a ✓ in the box that best describes your child. *We understand the sensitive nature of this information and wish to assure you it will be kept secure and confidential in accordance with all State and Federal privacy laws and regulations.*

If the information requested is not provided on this 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. Thank you for your cooperation.

Confidentiality Procedures and Regulations

To School Staff: This form will be filed in the student's permanent record as confidential information.

To the Parent/Guardian: The information you have provided on this form is confidential. It is protected by the confidentiality regulation cited as follows:

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to students records and unauthorized release of any student record information identifiable by either student name or student identification number.

Please complete the questions on the next page.

All students between 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.

Fort Ann Central School District

Student Racial and Ethnic Identification

Name of School: Fort Ann Elementary School	**Student Identification Number** (school staff to fill in):

Student Name (Last, First, Middle):

Date of Birth (Month/Day/Year):	**Grade Level:**

1. **Is this student Hispanic, Latino, or or Spanish origin?**
   Please check only ONE box.

   Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture of origin, regardless of race.

   ☐ YES - Hispanic ☐ NO - Not Hispanic

2. **Select one or more races from the following five racial groups.**
   Check ALL groups that apply to your child. Please check at least one box.

   ☐ **American Indian or Alaska Native** - A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation of community recognition. E.g. Cherokee, Mohawk, Inuit.

   ☐ **Asian** - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Phillipine Islands, Thailand, and Vietnam.

   ☐ **Native Hawaiian or Other Pacific Islander** - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   ☐ **Black** - A person having origins in any of the black racial groups of Africa

   ☐ **White** - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East

3. **Is there a language other than English which is spoken in your home?**

   ☐ YES. The language is _____.

   ☐ NO. The only language spoken at home is English.

Signature of Parent/Guardian:	**Relationship to student:**	**Date:**

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer, NY 13350
315-867-2079

Eligibility Screen for Migrant Education Services

*** Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. ***

Has your family moved to a different school district in the last 3 years? YES_____ NO_____

In the last three years, has the parent or guardian of the child enrolling done farm work as a paid job? (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) YES_____ NO_____

If yes, what farm did you work on?_____ Where?_____ When?_____




If you can answer YES to [illegible] of the above questions, your family MAY qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.

Child's name _____ D.O.B._____ Grade_____

Child's name _____ D.O.B._____ Grade_____

Child's name _____ D.O.B._____ Grade_____

Child's name _____ D.O.B._____ Grade_____

Parents/ Guardians

Mother's name _____ Father's Name _____

Home Address _____ Home Phone #_____
(Street Address)

_____ Work or Message #_____
(city, town or village) (Zip)

School District_____ School Building_____

School Contact Person_____ Contact Number _____

Other Useful information (directions, farm names, best time to contact, etc.) _____

_____

_____

To submit this referral please fax to the Herkimer BOCES at (315) 867-2087 or mail to the address above. For more information please call the Migrant Program at (315) 867-2079. Thank you for your assistance.

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer NY 13350
315-867-2079

Cuestionario de Elegibilidad para Servicios de Educación Migrante

*** Servicios del Programa de Educación Migrante son gratuitos y pueden incluir tutoría, ayuda con necesidades de salud, viajes educacionales, programas del verano, actividades de involucrar a los padres, educación para adultos, ayuda de emergencia y referidos a otros servicios como necesario. ***

¿Ha mudado su familia a un distrito escolar diferente en los últimos 3 años? Sí_____ NO_____

¿En los últimos 3 años ha trabajado un padre o guardián en granja como: lechería, plantando, cosechando frutas o legumbres, el procesamiento o empacar de comida, corta de árboles o cultivo de árboles? Sí_____NO_____

Si UD dijo que si, ¿en que granja?_____ ¿Donde?_____ ¿Cuándo?_____




Si Usted contestó que Sí a algunas preguntas de arriba, su familia puede calificar para servicios de Educación Migrante. Para estar contactado por una reclutadora del Programa de Educación Migrante, favor de llenar la información de abajo.

Nombre del niño(a) _____ Fecha de Nacimiento_____Grado_____

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado_____

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado_____

Nombre del niño(a) _____ Fecha de Nacimiento _____Grado_____

Padres/ Guardianes

Nombre de la Mamá _____ Nombre del Papá _____

Dirección de la Casa _____ Numero de teléfono en casa_____
(Dirección de la Calle)

_____ # de teléfono del trabajo o de Mensaje_____
(Ciudad o Pueblo) (Código Postal)

Distrito escolar _____ edificio escolar _____

Persona para contactar_____ numero para contactar_____

Otra información Útil (direcciones, nombres de granjas, mejor hora de llamar, etc.) _____

_____

_____

Para someter este referido, favor de mandarlo por fax al Herkimer BOCES a (315) 867-2087 o mandar por correo al dirección de arriba.
Para más información, favor de llamar al Programa Migrante a (315) 867-2079. Gracias.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

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

Address: _____ Phone: _____

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

Where is the student currently living? (*Please check <u>one</u> box*)

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

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

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

_____
Date

If <u>**ANY box other than "In Permanent Housing" is checked,**</u> then the student/family should be immediately referred to the MV Liaison. In such cases, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled**.

<u>**After**</u> the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

<u>**NOTE TO SCHOOLS/LEAS:**</u> If the student is <u>**NOT**</u> living in permanent housing, please ensure that a DESIGNATION FORM is completed.

CUESTIONARIO DE VIVIENDA

Nombre del Distrito Escolar: _____

Nombre de la Escuela: _____

Nombre del Estudiante: _____
Apellido Primer Nombre Segundo Nombre

Género: ☐ Hombre ☐ Mujer Fecha de Nacimiento: ____ / ____ / ____ Grado: _____ ID#: _____
Mes Dia Año (jardín de infantes – 12) (opcional)

Dirección: _____ Teléfono: _____

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.

¿Donde está el estudiante viviendo actualmente? (*Por favor marque una caja.*)

- ☐ En un refugio
- ☐ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- ☐ En un hotel/motel
- ☐ En un carro, parque, autobús, tren, o camping
- ☐ Otra vivienda temporal (Por favor describa):

  _____

- ☐ En un hogar permanente
- ☐

_____ _____

Nombre de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

Firma de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

_____

Fecha

Si CUALQUIER caja que no sea "En un hogar permanente" está marcada, **no se requieren prueba de domicilio** u otros documentos normalmente requeridos para inscripción **y el estudiante debe ser matriculado inmediatamente.** Después de que el estudiante sea matriculado, el distrito o la escuela debe pedir los documentos escolares, incluyendo los documentos de inmunización, al distrito o la escuela anterior. El enlace del distrito debe ayudar al estudiante conseguir cualquier otro documento necesario o inmunización.

ATENCIÓN ESCUELAS Y DISTRITOS: Si el estudiante **NO** vive en un hogar permanente, favor de asegúrese que una Formulario de Designación sea completado.

Fort Ann Central School District

One Catherine Street
Fort Ann, NY 12827
Telephone: (518)639-5594 Fax: (518)639-4341

PERMISSION TO PICK UP

Student Name_____Grade_____

Address_____

Parent/Guardian_____

Contact #_____

The following list of people has my authorization to pick my child up from school. I understand that these people must show identification each time they pick my child up at the elementary entrance of the building or cafeteria at dismissal time or earlier if an appointment is scheduled. All others will ***NOT*** be permitted to pick up my child.

	NAME	RELATIONSHIP	CONTACT #
1			
2			
3			
4			
5			

_____ _____

Signature of Parent/Guardian Today's Date

More lines on back

SPEECH AND LANGUAGE QUESTIONNAIRE

Student_____

Birth date_____ Grade entering _____

Parent(s) with whom student lives _____

Siblings and their ages _____

Address _____

Home phone _____ Work phone _____

_____ My child is currently receiving speech and language therapy.

Agency name _____

_____ My child was but is no longer receiving speech and language therapy.

Agency name _____

_____ My child has never received speech and language therapy.

_____ My child says all speech sounds correctly.

_____ My child does not say all speech sounds correctly.

To the best of your knowledge, please list all of the speech sounds which your child does not say correctly. _____

How well do you understand your child's speech?

Not well at all 1 2 3 4 5 Very Well

How well do you think others understand your child's speech?

Not well at all 1 2 3 4 5 Very Well

Please comment on your child's general communication skills. Include any medical information which may be relevant.

THANK YOU FOR YOUR TIME.

DO NOT PHOTOGRAPH FORM

Dear Parents/Guardians,

We like to promote Fort Ann Central School events and activities through publishing photographs of students on our website, district newsletter, or in other locations. At times, we have also have the opportunity to have photographs of students included in the local newspaper. We would appreciate your permission to publish photographs of your child, should the occasion arise.

Please return this form by 09/18/21 ***ONLY*** if you ***DO NOT*** wish to give permission for your child to be photographed. Thank you.

( ) I **DO NOT** give permission for my child/children to be photographed or have their photo released to the media for educational purposes.

Parent/Guardian Signature:_____

Child's Name:_____

Child's Grade:_____

Date:_____

FORT ANN CENTRAL SCHOOL DISTRICT

STUDENT HEALTH HISTORY
2021-2022

Student Name:	**Gender:** M ▫ F ▫
Date of Birth:	**Age:**
Parent/Guardian: (person completing form)	**Grade:**

Has your child ever:	YES	NO	If yes, please explain and include date
Had an ongoing medical condition	▫	▫	
Seen a medical specialist	▫	▫	
Had surgery/been hospitalized	▫	▫	
Had a bone or muscle injury	▫	▫	
Passed out or fainted	▫	▫	
Had a concussion or head injury	▫	▫	
Had a seizure	▫	▫	
Worn glasses or contact lenses	▫	▫	
Used hearing aids	▫	▫	
Had braces, spacers or other orthodontics	▫	▫	

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD

- ▫ ADHD/ADD
- ▫ Asthma
- ▫ Ear Tubes
- ▫ Heart Conditions
- ▫ Seizures
- ▫ Single Organ (▫ kidney, ▫ testicle)
- ▫ Anaphylaxis
- ▫ Autism
- ▫ Eating disorder
- ▫ OCD/ODD
- ▫ Skin Conditions
- ▫ Other: _____
- ▫ Anxiety/Depression
- ▫ Diabetes
- ▫ Headaches/Migraines
- ▫ Scoliosis

Please indicate:	YES	NO	Please specify:	
Allergies	▫	▫	Specify:	Severity: ▫ mild ▫ severe
Medication at Home	▫	▫	Name:	Dose:
Mediation at School	▫	▫	Name:	Dose:
Dietary Concerns	▫	▫	▫ Gluten Free ▫ Lactose Free	Other: _____

Any additional health concerns: _____

_____

Parent/Guardian Signature: _____ Date: _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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

STUDENT INFORMATION

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

HEALTH HISTORY

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

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

BMI_____kg/m2

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	

Lead Level Required Grades Pre- K & K **Date**

☐ Test Done ☐ Lead Elevated ≥5 µg/dL

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

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:				DOB:
SCREENINGS				
Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative** ☐	**Positive** ☐	**Referral** ☐ Yes ☐ No	**Not Done** ☐

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

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

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

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

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

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

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

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

New York State Center for School Health

Supporting Student Success Through Health and Education

X NYS Required X NYC Required X NYS Optional X NYC Optional

NYS and NYC Screening & Health Exam Requirements

	New Entrant	Pre K or K*	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grade 6	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
HEARING SCREENING:														
Pure Tone	X	X	X		X		X		X				X	
SCOLIOSIS SCREENING														
Boys											X			
Girls							X		X					
VISION SCREENING														
Color Perception	X													
	X													
Fusion		X	X											
Near Vision	X	X	X		X		X		X				X	
	X	X	X		X		X							
Distance Acuity	X	X	X		X		X		X				X	
	X	X	X		X		X							
Hyperopia	X													

*Determine if your Kindergarten or Pre K students are your district's new entrants.

Health Examination Overview

	New Entrant	Pre K or K	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grade 6	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
Health Examination**	X	X	X		X		X		X		X		X	
	X													
Dental Certificate	X	X	X		X		X		X		X		X	

**Health Examinations may be either a Health Appraisal (health exam performed by the School Medical Director) or Health Certificate (health exam performed by the student's primary medicalprovider). They must be dated no more than 12 months prior to the start of the school year in which they are required, or the date of entrance to the school for new entrants.

This sample resource was created by the New York State Center for School Health and is located at www.schoolhealthny.com in the Laws|Guidelines|Memos - Effective July 2018 (revised 2/2018)

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. 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 dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist 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: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

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

I. The Dental Health condition of _____ **on** _____ **(date of exam) The date of the exam 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 name and address (please print or stamp)

Dentist'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):_____

III. 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.

7513F.1

FORT ANN CENTRAL SCHOOL DISTRICT
SELF-MEDICATION RELEASE FORM

Date: _____

Student's Name: _____

has been instructed in the proper use of the following medication procedures: _____

_____

_____

_____

We (Physician's signature) _____ and

(Parent or Person in Parental Relation's signature) _____

request that **(Student's name)** _____ be permitted to carry the medication on his/her person or to keep same in his/her locker or physical education locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use. He/she understands the importance of immediately notifying the teacher or school registered professional nurse of the use of an anaphylactic medication.

Note: This form must be completed *in addition* to the routine District medication form for those students who request permission to carry their own medication on campus or keep this medication in a school or physical education locker.

PARENT/GUARDIAN CONSENT TO RELEASE ELIGIBILITY INFORMATION FOR FREE AND REDUCED PRICE MEALS OR FREE MILK

Date August 1, 2020

Dear Parent/Guardian:

If your child is eligible for free and reduced price meals or free milk, he/she also may be eligible for other benefits. To receive these benefits, you must provide written consent to permit school officials to give your name, address, and an indication that your household is eligible for free and reduced price meals or free milk, to representatives of certain programs. **Failure to sign a consent statement that will allow disclosure of this information will not affect your child's eligibility or participation in the school meals or milk programs.**

Some of the programs that may request names and eligibility information to be used to provide benefits, and for which parent/guardian consent is required, include: federal health insurance programs such as Medicaid or Children's Health Insurance program (CHIP), other federal programs, State programs, local health and education programs and other local activities. For example, the disclosure of children's eligibility for free and reduced price meals or free milk to determine eligibility for free text books, free band instruments, holiday baskets, school supplies, etc., or reduced fees for summer school or driver education programs, would require written consent by the child's parent/guardian.

If you wish to provide consent to release information contained in your child's free and reduced price meal application, to receive other benefits, please complete the attached consent statement.

Please call Mrs. Krista Crosbie at (518)639-5594 ext. 52101 if you have questions.

Sincerely,

Enclosure (consent statement)

Nondiscrimination Statement:
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.

This institution is an equal opportunity provider.

Letter to Parents for School Meal Programs

Dear Parent/Guardian:

Children need healthy meals to learn. Fort Ann Central School offers healthy meals every school day. Breakfast costs **$1.25**; lunch costs **$2.65**. Your children may qualify for free meals or for reduced price meals. Beginning July 1, 2019, students in New York State that are approved for reduced price meals will receive breakfast and lunch meals and snacks served through the Afterschool Snack Program at no charge.

1. DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD? No. Complete the application to apply for free or reduced price meals. *Use one Free and Reduced Price School Meals Application for all students in your household.* We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: Krista Crosbie, 1 Catherine Str., Fort Ann, NY 12827, (518)639-5594 ext. 52101.
2. WHO CAN GET FREE MEALS? All children in households receiving benefits from **SNAP, the Food Distribution Program on Indian Reservations** or **TANF**, can get free meals regardless of your income. Categorical eligibility for free meal benefits is extended to all children in a household when the application lists an Assistance Program's case number for any household member. Also, your children can get free meals if your household's gross income is within the free limits on the Federal Income Eligibility Guidelines. Households with children who are categorically eligible through an Other Source Categorically Eligible designation, as defined by law, may be eligible for free benefits and should contact the SFA for assistance in receiving benefits.
3. CAN FOSTER CHILDREN GET FREE MEALS? Yes, foster children that are under the legal responsibility of a foster care agency or court, are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Foster children may also be included as a member of the foster family if the foster family chooses to also apply for benefits for other children. Including children in foster care as household members may help other children in the household qualify for benefits. If non-foster children in a foster family are not eligible for free or reduced price meal benefits, an eligible foster child will still receive free benefits.
4. CAN HOMELESS, RUNAWAY, AND MIGRANT CHILDREN GET FREE MEALS? Yes, children who meet the definition of homeless, runaway, or migrant qualify for free meals. If you haven't been told your children will get free meals, please call or e-mail **[school, homeless liaison or migrant coordinator information]** to see if they qualify.
5. WHO CAN GET REDUCED PRICE MEALS? Your children may be approved as reduced price eligible if your household income is within the reduced-price limits on the Federal Eligibility Income Chart, shown on this letter. Beginning July 1, 2019, students in New York State that are approved for reduced price meals will receive breakfast and lunch meals and snacks served through the Afterschool Snack Program at no charge.
6. SHOULD I FILL OUT AN APPLICATION IF I RECEIVED A LETTER THIS SCHOOL YEAR SAYING MY CHILDREN ARE APPROVED FOR FREE MEALS? Please read the letter you got carefully and follow the instructions. Call the school at (518)639-5594 ext. 52101 if you have questions.
7. MY CHILD'S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT ANOTHER ONE? Yes. Your child's application is only good for that school year and for up to the first 30 operating days of this school year. You must send in a new application unless the school told you that your child is eligible for the new school year.
8. I GET WIC. CAN MY CHILD(REN) GET FREE MEALS? Children in households participating in WIC may be eligible for free or reduced price meals. Please fill out a FREE/REDUCED PRICE MEAL application.
9. WILL THE INFORMATION I GIVE BE CHECKED? Yes and we may also ask you to send written proof.
10. IF I DON'T QUALIFY NOW, MAY I APPLY LATER? Yes, you may apply at any time during the school year. For example, children with a parent or guardian who becomes unemployed may become eligible for free and reduced price meals if the household income drops below the income limit.
11. WHAT IF I DISAGREE WITH THE SCHOOL'S DECISION ABOUT MY APPLICATION? You should talk to school officials. You also may ask for a hearing by calling or writing to: Mr. Justin Hoskins, 1 Catherine St., Fort Ann, NY 12827; (518)639-5594 ext. 52060; jhoskins@fortannschool.org.
12. MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN? Yes. You or your child(ren) do not have to be U.S. citizens to qualify for free or reduced price meals.
13. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD? You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro-rated share of expenses), do not include them.
14. WHAT IF MY INCOME IS NOT ALWAYS THE SAME? List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only made $900, put down that you made $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.
15. WE ARE IN THE MILITARY. DO WE INCLUDE OUR HOUSING ALLOWANCE AS INCOME? If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.
16. MY SPOUSE IS DEPLOYED TO A COMBAT ZONE. IS HER COMBAT PAY COUNTED AS INCOME? No, if the combat pay is received in addition to her basic pay because of her deployment and it wasn't received before she was deployed, combat pay is not counted as income. Contact your school for more information.
17. MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR? To find out how to apply for **SNAP** or other assistance benefits, contact your local assistance office or call **1-800-342-3009**.

2020-2021 INCOME ELIGIBILITY GUIDELINES
FOR FREE AND REDUCED PRICE MEALS OR FREE MILK

REDUCED PRICE ELIGIBILITY INCOME CHART

Total Family Size	Annual	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$ 23,606	$ 1,968	$ 984	$ 908	$ 454
2	$ 31,894	$ 2,658	$ 1,329	$ 1,227	$ 614
3	$ 40,182	$ 3,349	$ 1,675	$ 1,546	$ 773
4	$ 48,470	$ 4,040	$ 2,020	$ 1,865	$ 933
5	$ 56,758	$ 4,730	$ 2,365	$ 2,183	$ 1,092
6	$ 65,046	$ 5,421	$ 2,711	$ 2,502	$ 1,251
7	$ 73,334	$ 6,112	$ 3,056	$ 2,821	$ 1,411
8	$ 81,622	$ 6,802	$ 3,401	$ 3,140	$ 1,570
*Each Add'l person add	$ 8,288	$ 691	$ 346	$ 319	$ 160

w to Apply: To get free or reduced price meals for your children carefully complete one application following the instructions for your household and return it he designated office listed on the application. If you now receive SNAP, Temporary Assistance to Needy Families (TANF) for any children or participate in Food Distribution Program on Indian Reservations (FDPIR), the application must include the children's names, the household SNAP, TANF or FDPIR case nber and the signature of an adult household member. All children should be listed on the same application. If you do not list a SNAP, TANF or FDPIR case nber for any household member, the application must include the names of everyone in the household, the amount of income each household member, and v often it is received and where it comes from. It must include the signature of an adult household member and the last four digits of that adult's social security nber or check the box if the adult does not have a social security number. **An application for free and reduced price benefits cannot be approved unless nplete eligibility information is submitted, as indicated on the application and in the instructions.** Contact your local Department of Social Services your SNAP or TANF case number or complete the income portion of the application. No application is necessary if the household was notified by the SFA ir children have been directly certified. If the household is not sure if their children have been directly certified, the household should contact the school.

porting Changes: The benefits that you are approved for at the time of application are effective for the entire school year and up to 30 operating days into the v school year (or until a new eligibility determination is made, whichever comes first). You no longer need to report changes for an increase in income or crease in household size, or if you no longer receive SNAP.

ome Exclusions: The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred such care under the Child Care Development (Block Grant) Fund should not be considered as income for this program.

duced Price Eligible Students: **Beginning July 1, 2019, students in New York State that are approved for reduced price meals will receive breakfast d lunch meals and snacks served through the Afterschool Snack Program at no charge.**

he operation of child feeding programs, no child will be discriminated against because of race, sex, color, national origin, age or disability.

al Service to Children With Disabilities: Federal regulations require schools and institutions to serve meals at no extra charge to children with a disability ch may restrict their diet. A student with a disability is defined in 7CFR Part 15b.3 of Federal regulations, as one who has a physical or mental impairment ch substantially limits one or more major life activities of such individual, a record of such an impairment or being regarded as having such an impairment. jor life activities include but are not limited to: functions such as caring for one's self, performing manual tasks, seeing, hearing, eating, sleeping, walking, nding, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. You must request meal modifications n the school and provide the school with medical statement from a State licensed healthcare professional. If you believe your child needs substitutions cause of a disability, please get in touch with us for further information, as there is specific information that the medical statement must contain.

nfidentiality: The United States Department of Agriculture has approved the release of students names and eligibility status, without parent/guardian consent, persons directly connected with the administration or enforcement of federal education programs such as Title I and the National Assessment of Educational gress (NAEP), which are United States Department of Education programs used to determine areas such as the allocation of funds to schools, to evaluate cioeconomic status of the school's attendance area, and to assess educational progress. Information may also be released to State health or State education grams administered by the State agency or local education agency, provided the State or local education agency administers the program, and federal State ocal nutrition programs similar to the National School Lunch Program. Additionally, all information contained in the free and reduced price application may released to persons directly connected with the administration or enforcement of programs authorized under the National School Lunch Act (NSLA) or Child trition Act (CNA), including the National School Lunch and School Breakfast Programs, the Special Milk Program, the Child and Adult Care Food Program, mmer Food Service Program and the Special Supplemental Nutrition Program for Women Infants and Children (WIC); the Comptroller General of the United ites for audit purposes, and federal, State or local law enforcement officials investigating alleged violation of the programs under the NSLA or CNA.

application: You may apply for benefits any time during the school year. Also, if you are not eligible now, but during the school year become unemployed, ve a decrease in household income, or an increase in family size you may request and complete an application at that time.

The disclosure of eligibility information not specifically authorized by the NSLA requires a written consent statement from the parent/guardian. We will let you know when your application is approved or denied.

Sincerely,

Mrs. Krista Crosbie

Nondiscrimination Statement: This explains what to do if you believe you have been treated unfairly.

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.

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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, S.W.
Washington, D.C. 20250-9410;

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

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

This institution is an equal opportunity provider.

MEAL SERVICES TO CHILDREN WITH DISABILITIES

Dear Parent/Guardian:

The National School Lunch Program (NSLP) and School Breakfast Program (SBP) aim to provide all participating children, regardless of background, with the nutritious meals they need to be healthy. This includes ensuring children with disabilities have an equal opportunity to participate in and benefit from the NSLP and SBP.

Federal regulations require schools and institutions to serve meals at no extra charge to those children whose disability restricts their diet in such a way that they cannot fully participate in the food service program without some modification to the foods offered or the scheduled menu. If you believe your child needs substitutions because of a disability, please get in touch with us for further information. You must request meal modifications from the school and provide the school with a medical statement from a State licensed healthcare professional. This medical statement must contain but is not limited to the following:

- Information about the child's physical or mental impairment that is sufficient to allow the school to understand how it restricts the child's diet,
- An explanation of what must be done to accommodate the child's special dietary need,
- The food or foods to be omitted and recommended alternatives, in the case of a modified meal

If you have questions regarding the need for meal modifications, contact Mrs. Krista Crosbie at (518)639-5594. Ext. 52101 for further information.

Nondiscrimination Statement:
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(1) mail: U.S. Department of Agriculture
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Washington, D.C. 20250-9410;

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

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

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Date Withdrew_____ F___R___D___

2020-2021 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call (518)639-5594 ext. 52101, if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **Fort Ann Central School**
1 Catherine Street
Fort Ann, NY 12827

List all children in your household who attend school.

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

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 #: _____

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

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

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

Total Household Members (Children and Adults) ☐☐

***Last Four Digits of Social Security Number:** XXX-XX-__ __ __ __ I do not have a SS# ☐

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

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: _____
Mail Address: _____
Home Phone: _____ Work Phone: _____ Home Address: _____

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

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Race (Check one or more): ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

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

☐ SNAP TANF Foster

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 Mrs. Krista Crosbie, Fort Ann Central School.
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. (518)639-5594 ext. 52101. 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.

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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

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CONSENT TO RELEASE FREE OR REDUCED PRICE ELIGIBILITY INFORMATION

School officials may release information that shows that my child/children are eligible for free or reduced price meals or free milk to the following programs. I understand that the information will only be provided to the program(s) checked.

(Check the box next to the program area(s) you wish to release information to)

- ☐ Federal health programs such as Medicaid or Children's Health Insurance Program (CHIP).
- ☐ State or federal programs such as the Youth Summer Work program or the Educational Talent Search Program.
- ☐ Local health and education programs and other local programs that provide benefits such as free textbooks or school supplies, free band instruments, or reduced fees for summer school or driver education.
- ☐ Community programs such as holiday baskets, summer arts and playground programs.

I understand that I will be releasing information that will show that my child/children are eligible for free and reduced price meals or free milk. I give consent to release my confidential information for the above named uses.

Child/Children:

_____

_____

_____

I certify that I am the child's parent/guardian for whom the application was made.

Signature of Parent/Guardian: _____

Print Name: _____

Address: _____

Phone Number: _____

Date: _____

Nondiscrimination Statement:

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(1) mail: U.S. Department of Agriculture
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(2) fax: (202) 690-7442; or

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

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FREE AND REDUCED PRICE MEAL APPLICATION FACT SHEET

When filling out the application form, please pay careful attention to these helpful hints.

SNAP/TANF/FDPIR case number: This must be the complete valid case number supplied to you by the agency including all numbers and letters, for example, E123456, or whatever combination is used in your county. Refer to a letter you received from your local Department of Social Services for your case number or contact them for your number.

Foster Child: A child who is living with a family but who is under the legal care of the welfare agency or court may be listed on your family application. List the child's "personal use" income. This includes only those funds provided by the agency which are identified for the personal use of the child, such as personal spending allowances, money received by his/her family, or from a job. Funds provided for housing, food and care, medical, and therapeutic needs are not considered income to the foster child. Write "0" if the child has no personal use income.

Household: A group of related or non-related people who are living in one house and share income and expenses.

Adult Family Members: All related and non-related people who are 21 years of age and older living in your house.

Financially Independent: A person is financially independent and a separate economic unit/household when his or her earnings and expenses are not shared by the family/household. Separate economic units in the same residence are characterized by prorating expenses and by economic independence from one another.

Current Gross Income: Money earned or received at the present time by each member of your household before deductions. Examples of deductions are federal tax, State tax, and Social Security deductions. If you have more than one job, you must list the income from all jobs. If you receive income from more than one source (wage, alimony, child support, etc.), you must list the income from all sources. Only farmers, self-employed workers, migrant workers, and other seasonal employees may use their income for the past 12 months reported from their 1040 Tax Forms.

Examples of gross income are:

- Wages, salaries, tips, commissions, or income from self-employment
- Net farm income – gross sales minus expenses only – not losses
- Pensions, annuities, or other retirement income including Social Security retirement benefits
- Unemployment compensation
- Welfare payments (does not include value of SNAP)
- Public Assistance payments
- Adoption assistance
- Supplemental Security Income (SSI) or Social Security Survivor's Benefits
- Alimony or child support payments
- Disability benefits, including workman's compensation
- Veteran's subsistence benefits
- Interest or dividend income
- Cash withdrawn from savings, investments, trusts, and other resources which would be available to pay for a child's meals
- Other cash income

Income Exclusions: 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 Development (Block Grant) Fund should not be considered as income for this program.

If you have any questions or need help in filling out the application form, please contact:

Name: Mrs. Krista Crosbie Title: Reviewing Official

Telephone Number: (518)639-5594 ext. 52101