Siblings at AV

Name_____ **Gr.**_____
Name_____ **Gr.**_____
Name_____ **Gr.**_____

Allen Village School
EMERGENCY CONTACT INFORMATION

Student Name_____ Grade_____

Address_____ Home Phone_____

Parent/Guardian Info

Mother's Name_____ Home Phone_____

Address_____ Work Phone_____

Email_____ Cell Phone_____

Father's Name_____ Home Phone_____

Address_____ Work Phone_____

Email_____ Cell Phone _____

Emergency Contact Information

Please list below any person who is authorized to pick your child up. Your child will not be allowed to leave with any person not listed below.

Name_____Relationship_____ Phn#_____

Name_____Relationship_____ Phn#_____

Name_____Relationship_____ Phn#_____

Name_____Relationship_____ Phn#_____

Parent Signature_____ **Date**_____

STUDENT HEALTH REGISTRATION FORM

Student Name _____ **Grade** _____ **Sex** _____ **Date of Birth** _____

EMERGENCY CONTACT INFO

Contact #1 Name _____ Relationship_____ Phone # _____

Contact #2 Name _____ Relationship_____ Phone # _____

This questionnaire is designed to aid school staff in anticipating any health concerns that might affect your child's safety or learning.

MEDICAL

Does your child have a Doctor/Nurse Practitioner? Yes ___ No ___
Doctor's/Nurse Practitioner's Name: _____ Phone Number: _____

DENTAL

Does your child have a Dentist? Yes ____ No ____
Dentist Name: _____ Phone Number: _____
Did your child receive a dental exam in the past 12 months? Yes____ No ____ Don't know ____
Describe the condition of your child's teeth. Good ____ Fair ____ Poor ____ Don't know ____
In the past 12 months, did you have problems obtaining dental care for your child? Yes ____ No ____

INSURANCE

Does your child have Insurance? Yes ____No _____What type of coverage does your child have? Medical ____ Dental ____ Both ____
Insurance Carrier: _____ Type of insurance: _____ Policy #: _____ Grp #: _____

MEDICAL HISTORY

Has a physician or health care professional told you that your child has: Yes____ No ____

___ Asthma
___ Diabetes
___ Heart condition
___ Seizure disorder
___ Bone/muscle disease
___ Mental health condition (i.e., depression, anxiety, eating disorder)
___ Bleeding disorder
___ Skin condition
___ADD/ADHD
___ Learning Disability
___ Other _____

Does your child experience any of the following? Yes ____ No ____

___ Nose bleeds
___ Poor appetite
___ Tires easily
___ Frequent earaches
___ Frequent stomach aches
___ Emotional concerns
___ Overweight for age
___ Frequent headaches
___ Underweight for age
___ Physical disability
___ Fainting spells
___ Other _____

Do any of the above condition(s) limit/effect your child at school? Yes ___ No ___ if yes, please explain _____

LIFE THREATENING CONDITIONS

Does your child have any life-threatening health conditions? Yes ___ No ___ Describe: _____

ALLERGIES

Is your child allergic to any of the following? Yes ____ No ____Plants ____ Animals ____ Food ____ Mold ____ Drugs ____ Bees ____ Other ____
Please describe the reaction and treatment for each: _____
_____
Do you plan for your child to receive school prepared lunch? Yes ___ No ___ Will your child require food substitutions? Yes ___ No ___
***The medical statement for students requiring special meals form must be completed to allow food substitutions. ***

MEDICATION

Does your child take any medications? Yes ___ No ___ If yes, name of medication(s) _____
How Often? _____ Purpose _____ Will medication be taken at school? Yes ___ No ___

HEARING/VISION

Do you have any concerns about your child's hearing? Yes ___ No ___
Do you have any concerns about your child's vision? Yes ___ No ___
Does your child wear hearing aids? Yes___ No ___
Does your child wear glasses? Yes ___ No ___

SPEECH/LANGUAGE

Do you have concerns about your child's speech and/or language? Yes ___ No ___
Do others have difficulty understanding your child? Yes ___ No ___ if yes, please explain _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If an authorized emergency contact person or I cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

_____ _____
Parent/Guardian Signature **Date**

Permission Slips

Photo/ Video Release

I authorize the Allen Village School to use and reproduce any and all photographs or video tape, which you have taken of my child for art, advertising, trade or any other lawful purpose whatsoever, without compensation to me. All negatives and positives, together with the prints, shall constitute the school's property solely and completely.

I hereby waive the right that I may have, to inspect and/or approve the finished product that may be used in conjunction therewith, or the use to which it may be applied.

_____ _____

Parent/Guardian Signature **Date**

_____

Student Name

Permission to Participate in Field Trips

The undersigned parent or guardian of _____ hereby consents to his/her participation in the following activities: educational field trips with Allen Village School. It is understood that an Allen Village School sponsor or teacher can, under reasonable and limited conditions, alter plans of this activity. However, such alterations shall involve activities or arrangements in the same general category described above. It is also understood that in the event the parent or guardian has any questions regarding the plans or believes the description to be inadequate, he or she shall contact the trip sponsor to obtain additional information.

The undersigned does hereby consent to the above named student participating in the field trip or activity identified, including transportation to and from the activity, if applicable, and for and in consideration of the special activity referred to, the undersigned hereby covenants and agrees on his/her own behalf of the student named above, not to sue the school, it's officers, agents, servants, and/ or employees, for any amount in excess of the insurance coverage as aforesaid. Nothing herein is intended to or shall be construed to release any insurance company or any third party from any obligation to pay under any liability insurance or other benefits.

_____ _____

Parent/Guardian Signature **Date**

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

Date Received by LEA (LEA use only) ____________

STEP 1 List ALL Household Members who are infants, children, and students up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper)

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Read **How to Apply for Free and Reduced Price School Meals** for more information.

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

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR? Circle one: Yes / No

If you answered NO > Complete STEP 3. **If you answered YES** > Write a case number here then go to STEP 4 (Do not complete STEP 3) **Case Number:** __ __ __ __ __ __ __ __ __ __ Write only one case number in this spac

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here?

Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with the All Adult Household Members section.

A. Child Income

Sometimes children in the household earn income. Please include the TOTAL gross income earned by all children listed in STEP 1 here.

Child income	How often? Weekly	Bi-Weekly	2x Month	Monthly
$	◯	◯	◯	◯

B. All Adult Household Members (including yourself)

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 gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance/ Child Support/Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/Retirement/ All Other Income	How often? Weekly	Bi-Weekly	2x Month	Monthly
	$	◯	◯	◯	◯	$	◯	◯	◯	◯	$	◯	◯	◯	◯
	$	◯	◯	◯	◯	$	◯	◯	◯	◯	$	◯	◯	◯	◯
	$	◯	◯	◯	◯	$	◯	◯	◯	◯	$	◯	◯	◯	◯

Total Household Members (Children and Adults) ☐☐

Last four digit of Social Security Number (SSN) of primary wage earner or other adult household member. X X X X X ☐☐☐☐ **Check if no SSN** ☐

STEP 4 Contact information and adult signature

Mail Completed Form To: Allen Village School, 706 W. 42nd St. Kansas City, MO 64111

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

Street Address (if available) ____ Apt # ____ City ____ State ____ Zip ____ Daytime Phone and Email (optional) ____

Printed name of adult completing the form ____ Signature of adult completing the form ____ Today's date ____

DO NOT FILL OUT THIS SECTION. THIS IS FOR SCHOOL USE ONLY.

ANNUAL INCOME CONVERSION: WEEKLY X 52, EVERY 2 WEEKS X 26, TWICE A MONTH X 24, MONTHLY X 12 (USE ONLY IF MULTIPLE FREQUENCY)

❑Food Stamps/Temporary Assistance Household size:__________ Total income:__________ Per: ❑Week ❑Every 2 Weeks ❑Twice a Month ❑Month ❑Year

Eligibility: ❑Free ❑Reduced ❑Denied Reason:__________ Date withdrawn:__________

Determining Official's Signature: Date Approved/Denied:

INSTRUCTIONS Sources of Income

Sources of Income for Children	
Sources of Child Income	**Example(s)**
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability Payments - Survivor's Benefits	- A child is blind or disabled and receives Social Security benefits - A Parent is disabled, retired, or deceased, and their child receives Social Security benefits
- Income from person outside the household	- A friend or extended family member regularly gives a child spending money
- Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults		
Earnings from Work	**Public Assistance/ Alimony/Child Support**	**Pensions / Retirement / All Other Income**
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private pensions or disability benefits - Regular income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household

OPTIONAL Children's Racial and Ethnic Identities

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

Ethnicity (check one): ❑ 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 Islander ❑ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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.