Enrollment Forms Check List

Name of child: ________________________________________

_____ Hillsdale College Authorization Agreement and Release
_____ Immunization Check List (see included state guidelines)
_____ Medication Policy (if applicable)
_____ Military Information
_____ Student Handbook Agreement
_____ Authorization for Student Pick Up
_____ Permission for Walking Field Trips
_____ Student Records Transfer Form
_____ Free & Reduced Lunch Form
AUTHORIZATION AGREEMENT AND RELEASE
(Charter School Student)

Hillsdale College, a Michigan nonprofit corporation, is a liberal arts college dedicated to academic excellence and institutional independence. Hillsdale College through its Barney Charter School Initiative provides assistance to selected charter schools such as [NAME OF CHARTER SCHOOL] (“School”) to teach students in the best classical and civic traditions. Hillsdale College and its collaborators may conduct oral interviews, photograph or film, collect documents and other tangible and electronic objects, host events, create educational materials and news articles, and create workproduct and merchandise (such as books and video) for sale or distribution (collectively, “Materials”). Some of these Materials may include images or other recordings of the individual named below (“Student”).

By signing this Authorization Agreement and Release (“Agreement”), Student agrees to allow Hillsdale College to use the Materials in connection with its nonprofit mission (the “Mission”), including, without limitation, preparation of a brochure to be used in fund-raising for the Barney Charter School Initiative.

- Hillsdale College may record Student’s statements, image, voice, comments, and actions (“Likeness”).
- Hillsdale College may use the recordings and Materials and in any lawful manner relating to its Mission. The recordings may become a permanent part of Hillsdale College’s collections and will be made available to educate students or to encourage donors to give to Hillsdale College. The Materials are the property of Hillsdale College and Student waives any claim to rights in the Materials.
- This permission is for all media now known or later developed, worldwide, royalty-free, and in perpetuity. It is for the benefit of Hillsdale College, its licensees, successors, and assigns.
- Student releases Hillsdale College from any liability (and agrees not to sue Hillsdale College) for its use of Student’s Likeness as described in this Agreement or otherwise permitted by law.
- Student is over the age of eighteen (18). If Student is not 18 years of age, the undersigned is the parent or legal guardian of the Student and the parent or legal guardian represents that he/she has the legal authority to sign this Agreement on behalf of the Student.
- School consents to (and releases Hillsdale College from any liability from) Hillsdale College’s visit to the School, Hillsdale College’s collection of Materials at the School, and Hillsdale College’s use of the Materials as provided in this Agreement.
- This Agreement is governed by the laws of the State of Michigan. It is the entire agreement between Student and Hillsdale College.
- School has not been promised anything in exchange for this Agreement.

AGREED AND ACCEPTED this ______ day of ____________, 2014:

____[Name]_________ Charter School

__________________________
Signature

__________________________
Signature Student / Signature Parent

__________________________
Printed Name, Title

__________________________
Street Address

33 E. College St., Hillsdale, MI 49242 | Phone: (517) 437-7341 | Fax: (517) 437-3923
AUTHORIZATION AGREEMENT AND RELEASE
(Charter School Student)

Telephone; Email
# Immunization Check List

Note: This form is to help parents/guardians determine whether there are any additional immunizations their child(ren) need. Several documents follow with information from the state of Indiana outlining immunization requirements and the process for those who wish to seek an exemption.

Name of Child: ________________________________________  Grade:______________

<table>
<thead>
<tr>
<th>K &amp; Grade 1</th>
<th>Grades 2 to 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____3 Hep B</td>
<td>_____3 Hep B</td>
</tr>
<tr>
<td>_____5 DTaP</td>
<td>_____5 DTaP</td>
</tr>
<tr>
<td>_____4 Polio</td>
<td>_____4 Polio</td>
</tr>
<tr>
<td>_____2 MMR</td>
<td>_____2 MMR</td>
</tr>
<tr>
<td>_____2 Varicella</td>
<td>_____2 Varicella</td>
</tr>
<tr>
<td>_____2 Hep A (Hepatitis A)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grades 6 to 11</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____3 Hep B</td>
<td>_____3 Hep B</td>
</tr>
<tr>
<td>_____5 DTaP</td>
<td>_____5 DTaP</td>
</tr>
<tr>
<td>_____4 Polio</td>
<td>_____4 Polio</td>
</tr>
<tr>
<td>_____2 MMR</td>
<td>_____2 MMR</td>
</tr>
<tr>
<td>_____2 Varicella</td>
<td>_____2 Varicella</td>
</tr>
<tr>
<td>_____1 Tdap (Tetanus &amp; Pertussis)</td>
<td>_____1 Tdap</td>
</tr>
<tr>
<td>_____1 MCV4 (Meningococcal conjugate)</td>
<td>_____2 MCV4</td>
</tr>
</tbody>
</table>
SEA 461 – Immunization Law

SEA 461 made many revisions and updates to the Immunization Law (IC 20-34-4). Below is a description of what the law now requires.

Section 1
- each school shall keep an immunization record of the school's students
- whenever a student transfers to another school, the transferring school may furnish the immunization record to the new school
- a high school may furnish a copy of the student's immunization record to a state educational institution

Section 2
- every child residing in Indiana who is enrolled in an accredited school shall be immunized as determined by the ISDH
- ISDH may expand the list of required immunizations as needed in the interest of public health
- before November 30 of each year, ISDH shall publish a two year calendar - the requirements for the upcoming year and the planned requirements for the subsequent year
- the time frame for the calendar does not apply in the event of an emergency as determined by the state health commissioner
- ISDH shall adopt rules regarding the required immunizations, the child's age for administering each vaccine, the number of doses required, and the documentation of proof of immunity

Section 3
- each school shall notify each parent of a student who enrolls of the immunization requirements and that immunization is required for the student's continued enrollment, attendance, or residence at the school unless - the parent provides documentation of immunity, a medical exemption or a religious objection
- schools shall provide parents of 6th grade students with information prescribed by the ISDH regarding the HPV vaccine
- lists the information the ISDH must include regarding the HPV infection
- ISDH shall provide the IDOE with immunization educational materials, the IDOE shall provide these materials to schools for sharing with parents, and schools may post these materials on the school's web site
Section 4
- the parent of any student who has not received the required immunizations shall present the student to a health care provider authorized to administer the immunizations
- the health care provider who administers the required immunizations shall enter the immunization information into CHIRP

Section 5
- each school shall require the parent of a student who has enrolled in the school to furnish, not later than the first day of school, proof of the student's immunization status either as a written document from the health care provider or documentation from CHIRP
- the statement must include the student's date of birth and the date of each immunization
- a student may not be permitted to attend school beyond the first day of school without furnishing the immunization record unless the school gives the student a waiver or the local health department or a health care provider determines that the student's immunization schedule has been delayed due to extreme circumstances
- the waiver may not exceed 20 school days and if an extreme circumstance exists, the parent shall furnish a written statement and a schedule, approved by a health care provider who is authorized to administer immunizations or the local health department, for the completion of the remainder of the immunizations
- allows the ISDH to take action against a school for failure to enforce this section
- neither a religious objection or medical exception relieves the parent of the responsibility to report their child's immunization status to the school
- allows the ISDH to adopt rules for this section

Section 5.5
- this section was repealed and no longer exists as of July 2015
- this was the section that required schools to collect HPV information from parents of 6th grade girls

Section 6
- allows the ISDH to collect immunization data using CHIRP
- requires school corporations to ensure that all applicable immunization data is entered into CHIRP by the first Friday in February
- allows the ISDH and the local health department to validate immunization reports by on site reviews of non-identifying immunization data if a substantial threat to the health and safety of a student or the school community exists
- allows the ISDH to adopt rules for this section

Additional Guidance:

Q: Where can I find additional information regarding the Immunization Law?
A: More information can be found on the CHIRP website.

Q: Who should I contact if I have additional questions?
A: Please contact Jolene Bracale, Program Coordinator for Student Health Services, at jbracale@doe.in.gov.
## School Immunization Requirements

### 3 to 5 years old
- 3 Hep B (Hepatitis B)
- 4 DTaP (Diphtheria, Tetanus & Pertussis)
- 3 Polio (Inactivated Polio)
- 1 MMR (Measles, Mumps, Rubella)
- 1 Varicella

### K – 2nd Grade
- 3 Hep B
- 5 DTaP
- 4 Polio
- 2 MMR
- 2 Varicella
- 2 Hep A (Hepatitis A)

### Grades 3 to 5
- 3 Hep B
- 5 DTaP
- 4 Polio
- 2 MMR
- 2 Varicella

### Grades 6 to 11
- 3 Hep B
- 5 DTaP
- 4 Polio
- 2 MMR
- 2 Varicella
- 1 Tdap (Tetanus & Pertussis)
- 1 MCV4 (Meningococcal conjugate)

### Grade 12
- 3 Hep B
- 5 DTaP
- 4 Polio
- 2 MMR
- 2 Varicella
- 1 Tdap
- 2 MCV4

### Hep B
The minimum age for the 3rd dose of Hepatitis B is 24 weeks of age.

### DTaP
Four doses of DTaP/DTP/DT are acceptable if 4th dose was administered on or after child’s 4th birthday.

### Polio
Three doses of Polio are acceptable for all grade levels if the third dose was given on or after the 4th birthday and at least 6 months after the previous dose with only one type of vaccine used (all OPV or all IPV). For students in grades kindergarten through 6th grade the final dose must be administered on or after the 4th birthday, and be administered at least 6 months after the previous dose.

### Live Vaccines (MMR, Varicella & LAIV)
Live vaccines that are not administered on the same day must be administered a minimum of 28 days apart. The second dose should be repeated if the doses are separated by less than 28 days.

### Varicella
Physician documentation of disease history, including month and year, is proof of immunity for children entering preschool through 8th grade. Parental report of disease history is acceptable for grades 9-12.

### Tdap
There is no minimum interval from the last Td dose.

### MCV4
Individuals who receive dose 1 on or after their 16th birthday only need 1 dose of MCV4.

### Hep A
The minimum interval between 1st and 2nd dose of Hepatitis A is 6 calendar months

For children who have delayed immunizations, please refer to the 2016 CDC “Catch-up Immunization Schedule” to determine adequately immunizing doses. All minimum intervals and ages for each vaccination as specified per 2016 CDC guidelines must be met for a dose to be valid. A copy of these guidelines can be found at [http://www.cdc.gov/vaccines/schedules/](http://www.cdc.gov/vaccines/schedules/)
VACCINE MEDICAL EXEMPTION
State Form 54648 (4-11)
Indiana State Department of Health, Immunization Division

INSTRUCTIONS:
1. This form for any child in grades K – 12 who is unable to receive a vaccine required for school entry due to a medical contraindication.
2. Complete and sign form. Submitted to school as proof of exemption from required immunization.

Patient Name ____________________________________________________ Date of Birth (month/day/year) ________________
Parent/Guardian Name _____________________________________________ Relationship _____________________________
Street Address _______________________________________________________________________________________________
City _______________________________________ ZIP Code __________ Telephone Number _________________________

General Contraindications to All Vaccines (Vaccine should not be given.)
Severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component

☐ Hepatitis B (Hep B) ☐ Inactivated poliovirus (IPV) ☐ Meningococcal, conjugate (MCV4)
☐ Diphtheria, tetanus, pertussis (DTaP, Tdap) ☐ Measles, mumps, rubella (MMR) or Meningococcal, polysaccharide (MPSV4)
☐ Tetanus, diphtheria (DT, Td) ☐ Varicella (Var)

Which vaccine or vaccine component caused reaction? _______________________________________________________________

Type of Clinical Reaction & Date (month, day year) _______________________________________________________________

Vaccine Specific Contraindications (Vaccine should not be given.)

DTaP or Tdap
☐ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within seven (7) days of administration of previous dose of DTP or DTaP

☐ Pregnancy
☐ Estimated Date of Confinement (EDC): _______________________________ (month, day year)

MMR
☐ Known severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long term immunosuppressive therapy; or patients with HIV infection who are severely immunocompromised)

Varicella
☐ Pregnancy
☐ Estimated Date of Confinement (EDC): _______________________________ (month, day year)

☐ Substantial suppression of cellular immunity

Vaccine Specific Precautions (Vaccine may be given or held depending on clinical situation.)

DTaP or Tdap
☐ Guillain-Barre syndrome (GBS) within six (6) weeks after a previous dose of tetanus-containing vaccine
☐ History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least ten (10) years have elapsed since the previous dose
☐ Progressive or unstable neurologic disorder, uncontrolled seizures or progressive encephalopathy: defer vaccination with DTaP or Tdap until a treatment regimen has been established and the condition has stabilized

DTaP
☐ Temperature of ≥105°F (≥40.5°C) within forty-eight (48) hours after vaccination with a previous dose of DTP/DTaP
☐ Collapse and shock-like state (i.e.: hypotonic hyporesponsive episode) within forty-eight (48) hours after previous dose of DTP/DTaP
☐ Seizure or convulsion within three (3) days after receiving a previous dose of DTP/DTaP
☐ Persistent, inconsolable crying lasting three (3) or more hours within forty-eight (48) hours after a previous dose of DTP/DTaP

MMR
☐ Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product)
☐ History of thrombocytopenia or thrombocytopenic purpura

Varicella
☐ Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product)
☐ Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) twenty-four (24) hours before vaccination; if possible, delay resumption of these antiviral drugs for fourteen (14) days after vaccination

Other Medical Contraindication (Must list vaccine(s) and contraindications individually – continue on back if necessary.)

Vaccine Specific Contraindication

Please indicate the duration of the medical exemption, and if and when vaccine can be safely administered. (Exemption can last for a maximum of one (1) year, and a new form must be completed annually if medical exemption still applies.)
☐ Medical exemption is permanent, and will apply for one (1) year from today’s date.
☐ Medical exemption is temporary (<1 year), and resolution is anticipated by _____/_____/_____
☐ Medical exemption is pregnancy, and Estimated Date of Confinement (EDC) is _____/_____/_____

Physician Name ____________________________________________________ Physician License Number ______________________
Office Address _____________________________________________________ Telephone ______________________________
Physician Signature _________________________________________________ Date (month, day year) ______________________
MEDICATIONS AT SCHOOL: PARENT INSTRUCTION GUIDE

NOTE: The Parent/Guardian MUST supply and deliver ALL medication.

IMPORTANT MEDICATION INFORMATION

To safeguard the transportation of medication to and from school, all prescriptions and over the counter medications must be brought into the school office by a parent or guardian. Students are not permitted to carry any medication without a physician's statement in writing. Any unused medication unclaimed by the parent by the last student day of school will be destroyed.

Dear Parent/Guardian:

Our staff is willing to give your children medications when needed. We are bound by Indiana state law to follow certain regulations regarding medication. We must follow these procedures:

Medication for Chronic Disease or Medical Condition
A student with a chronic disease or medical condition may possess and self-administer medication for the chronic disease or medical condition if the following conditions are met:

1. The student’s parent has filed an authorization with the student’s school leader for the student to possess and self-administer the medication. The authorization must include the following in a written statement by the student’s doctor that:
   a. The student has an acute or chronic disease or medical condition for which the physician has prescribed medication;
   b. The student has been instructed in how to self-administer the medication; and
   c. The nature of the disease or medical condition requires emergency administration of the medication.

The parent’s authorization and doctor’s order must be filed with the student’s principal or designee annually.

A school may not send home with a student medication that is possessed by a school for administration during school hours or at school functions. Medication that is possessed by a school for administration during school hours or at school functions for a student in grades kindergarten through grade 8 may be released only to:

1. The student’s parents; or
2. An individual who is:
   a. At least eighteen (18) years of age; and
   b. Designated in writing by the student’s parent to receive the medication.

Prescription Medication (Ordered by the doctor)
1. Medication must be in the original container, labeled with student’s name / date / medication / dosage / time;
2. A written order from the doctor stating specific instructions.
3. Signed permission form from the parent / guardian.
Non-Prescription Medication (example: Tylenol, cold tablets, cough syrup)

1. Medication must be in the original container; and
2. Signed permission form from parent/guardian explaining when the medication is to be given and the amount your child is to receive.

Please call the school if you have any questions.

Authorization to Dispense Medication (Prescription Medication)

PART ONE – TO BE COMPLETED BY A PHYSICIAN

The personnel at Seven Oaks Classical School are hereby notified that ____________________________,
a student at SOCS, is under my care and that said school personnel are hereby requested to give the said student
medication as listed below, in accordance with the directions listed below. The undersigned physician further
acknowledges that the legal custodian of said student has been informed as to the need for said medication and the
directions for its use.

Diagnosis for which medication is given: ____________________________________________

Name of medication: ___________________________________________________________

Dosage: ___________________________ Form: ___________________________ Time to be given: ___________________________

If medication is to be given “when needed,” describe indications:

____________________________________________________________________________________

____________________________________________________________________________________

How soon can it be repeated? ________________________________________________

Is child authorized to carry “when needed” medications on his or her person? Yes_________ No_________

List significant side effects:

____________________________________________________________________________________

Length of time this medication is recommended: _________________________________

Other information:

____________________________________________________________________________________

Signature of Primary Care Provider: ________________________________________________

Date: ___________________________ Phone Number: ___________________________
PART TWO – TO BE COMPLETED BY PARENT OR GUARDIAN

I, as legal custodian of ________________________ request and direct the camp personnel of Seven Oaks Classical School to give said child medication as listed below:

Name of medication:
__________________________________________________________________________________

Dosage: ___________________________ Form: __________________ Time to be given: _________________________

If medication is to be given “when needed,” describe indications:
__________________________________________________________________________________

__________________________________________________________________________________

How soon can it be repeated? ___________________________ 

Length of time this medication is to be given: ___________________________

Signature of Parent or Guardian: ____________________________________________ Date: ________________

Authorization to Dispense Medication (Non-Prescription Medication)

TO BE COMPLETED BY PARENT OR GUARDIAN

I, as legal custodian of ________________________ request and direct the camp personnel of Seven Oaks Classical School to give said child medication as listed below:

Name of medication:
__________________________________________________________________________________

Dosage: ___________________________ Form: __________________ Time to be given: _________________________

If medication is to be given “when needed,” describe indications:
__________________________________________________________________________________

__________________________________________________________________________________

How soon can it be repeated? ___________________________ 

Length of time this medication is to be given: ___________________________

Signature of Parent or Guardian: ____________________________________________ Date: ________________
Military Information

Name of Child: __________________________________________

Please check one:

_____ Parent is not in any branch of the military.

_____ Parent is in the Armed Forces of the United States who is on active duty.

_____ Parent is in the reserve component of a branch of the armed forces of the United States.

_____ Parent is in the National Guard.

Name of Parent/Guardian: __________________________________

Signature of Parent/Guardian: ________________________________

Date: __________________________
Student Handbook Agreement

The Seven Oaks Classical School Student Handbook can be found at sevenoaksclassical.org, under the tab labeled “Parents.” Or you may stop by the office for a printed version.

I, parent/guardian of _____________________________________________, have read the Student Handbook and agree to its terms.

Signature of parent/guardian: _______________________________________________________

Date: __________________________
Authorization for Student Pick Up

Child(ren)'s Name(s)

______________________________________   ____________________________________
______________________________________   ____________________________________
______________________________________   ____________________________________

Please complete all that apply:

1. The following individuals are authorized to pick up my child(ren).

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. My child may walk home immediately after school
   ____ whenever he/she wishes
   ____ only when I send a note each time
   ____ only when I call the office each time

3. My child may ride a bike immediately after school
   ____ whenever he/she wishes
   ____ only when I send a note each time
   ____ only when I call the office each time

Parent Signature: ____________________________________________ Date: ________________
Parent Printed Name: __________________________________________
Permission for Walking Field Trips

I/We, as parent(s) or guardian(s), grant permission to the staff of Seven Oaks Classical School to take my child with his/her class on walking field trips on the grounds of the school property and nearby property. I understand that all due care and caution will be taken by the school staff. I additionally understand that this permission will be good for the entire school year unless I withdraw permission in writing and send notice directly to the school office. I will hold the SOCS Board, its staff and its volunteers harmless in case of accident or injury.

I/We agree to indemnify and hold harmless Seven Oaks Classical School, Inc., its agents, employees, administrators, assigns and Board members from any and all liability incurred by a student injured while on a walking trip unless such injury is caused by, or is attributable to, the negligence of an agent or employee of Seven Oaks Classical School, Inc.

Student’s Name: __________________________________________________________

Grade: ______________

Parent Signature: _________________________________________________________

Parent Printed Name: _____________________________________________________

Date: ___________________
Student Records Transfer Form

Previous School Information

Name of previous school: ________________________________________________________________

School Corporation of legal residence: ________________________________

Transfer of Student Records

According to the Federal Regulations – Family Rights and Privacy Act (Buckley Amendment, Sec 93.34), it is no longer necessary to obtain written consent to release records between schools. I understand, as a parent/guardian, I am entitled to a copy of my child’s records upon request. My signature indicates that I, as parent/guardian, having read the before stated, am informed of this policy.

Parent/guardian signature: ___________________________ Date: ____________

Parent/guardian printed name: __________________________________________
**Seven Oaks Classical School**
**2016-2017 Household Application for Free and Reduced Price School Meals**
Complete one application per household. Please use a pen (not a pencil).

**STEP 1** List ALL infants, children, and students up to grade 12 who are members of your household (if more spaces are required for additional names, attach another sheet of paper).

<table>
<thead>
<tr>
<th>Child’s First Name</th>
<th>MI</th>
<th>Child’s Last Name</th>
<th>Student?</th>
<th>Only Student: Name of School Building</th>
<th>Only Student: Birthdate</th>
<th>Only Student: Grade</th>
<th>Only Student: Living with parent or caretaker relative?</th>
<th>Foster Homeless, Migrant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

**STEP 2** Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP (Food Stamp) or TANF?

If **NO** > Go to STEP 3.
If **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 space.

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

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all children in household listed in STEP 1 here.

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

**STEP 4** Contact information and adult signature

1. 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 false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

<table>
<thead>
<tr>
<th>Street Address (if available)</th>
<th>Apt #</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Daytime Phone and Email (optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Printed name of adult completing the form | Signature of adult completing the form | Today’s date |
Other Benefits – This section does not need to be completed to receive free or reduced price meal benefits.

Do you want to receive Textbook Assistance?
☐ Yes  If yes, sign to the right  
☐ No

I certify that I am the parent/guardian of the child(ren) for whom application is being made. My signature below authorizes the release of information on this application for textbook assistance. I give up my right of confidentiality for this purpose only. This application information will be shared with the Indiana Family and Social Services Administration pursuant to I.C. 20-33-5-2 and I.C. 12-14-28-2, solely for purposes of complying with 45 C.F.R. Parts 260 and 266.

Signature of adult completing the form ____________  Today’s date ____________

This application information may be shared with the Family and Social Services Administration for the purpose of identifying children who may qualify for free or low-cost health insurance under Medicaid or Hoosier Healthwise. If you want the application information shared for this purpose, please sign below. I certify I am the parent/guardian of the child(ren) for whom application is being made. I authorize the release of information for this purpose.

Signature of adult completing the form ____________  Today’s date ____________

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.

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:

mail:  U.S. Department of Agriculture  Office of the Assistant Secretary for Civil Rights  1400 Independence Avenue, SW  Washington, D.C. 20250-9410  fax:  (202) 690-7442; or  email:  program.intake@usda.gov.

This institution is an equal opportunity provider.

FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE

INCOME CONVERSION TO YEARLY:

WEEKLY X 52  EVERY 2 WEEKS X 26  TWICE A MONTH X 24  MONTHLY X 12

ELIGIBILITY DETERMINATION

Income Eligibility: Total Household Size: _______  Total Income$: _______  per: ☐ Weekly  ☐ Every 2 Weeks  ☐ Monthly  ☐ Twice a Month  ☐ Yearly

OR Categorical Eligibility:  ☐ Food Stamps/TANF  ☐ Migrant  ☐ Homeless  ☐ Runaway  ☐ Foster

Eligibility Determination:  ☐ Approved Free  ☐ Approved Reduced Price  ☐ Denied

Reason for Denial:  ☐ Income Too High  ☐ Incomplete Application  ☐ Other  ☐

Type of Eligibility Notification Provided (if denied, notification must be written):  ☐ Verbal  ☐ Written  Date: ____________  Date Withdrawn: ____________

Signature of Determining Official:__________

VERIFICATION

Confirmation Review Official:__________  Application Direct Verified? Yes  ☐ No  ☐

Date Verification Notice Sent: ____________

Date Response Due from Households: ____________

Date Second Notice Sent (or N/A): ____________

Approval Based On:  ☐ Food Stamps / TANF Case Number  ☐ Household Size and Income  ☐ Other _______

Verification Results:  ☐ No Change  ☐ Free to Reduced  ☐ Free to Paid  ☐ Reduced to Free  ☐ Reduced to Paid

Reason for Change:  ☐ Income: _______  ☐ Household Size: _______  ☐ Change in Food Stamps / TANF  ☐ Other: _______

Date Notice of Change Sent: ____________

Date Change Made: ____________

Request for Appeal: ____________

Date Hearing Requested: ____________

Hearing Decision: ____________

Verifying Official’s Signature: ____________  Date: ____________