Heartland Preschool Enrollment Checklist

*Must be completed by parent/guardian and turned in with application. This application will not be considered complete and a delay or denial in acceptance may occur unless this checklist is filled out in its entirety. The only exception is regarding medical/dental records – if those appointments are coming due soon or occurring over summer, please note below.

_____ Completed application

_____ Proof of Residency

_____ Birth Certificate

_____ Custody Papers (if applicable)

_____ Immunization Record

_____ Medical Statement *Date of most recent exam or scheduled exam _____

_____Dental Form *Date of most recent exam or scheduled exam _____

_____Free and Reduced Meal Application-Regardless of whether you have received a Direct Certification Notice

_____Multipurpose Release Form

_____Transportation Form

Physical Examination-every child entering the program must have a physical examination performed each year. Current physical exams are required for acceptance/admission. If your child isn't due for a physical exam soon due to insurance policies, the most recent physical must be submitted with the understanding that an updated form will be required during the year. The exams are valid for 13 months. The physician must complete the Child's Medical Statement (included in this packet) that verifies all required immunizations. No child will be permitted to attend class without a completed child's medical statement. Please discuss the need to the HIB vaccination with your physician. A hemoglobin test is suggested by preschool guidelines. Note: the 5th DPT and 4th polio immunizations do not need to be given before preschool. The Health Department recommends these be given prior to kindergarten entrance.

Dental Examination-a dental exam is needed each year, form to be completed and signed by the dentist

Provide the following documents:

1. **Birth Certificate**-provide a certified copy of the child's birth certificate. This birth certificate is not the one with the footprints. Certified copies can be obtained from the Wayne County Health Department.
2. **Custody Papers**-if there has been a separation, divorce, adoption or guardianship we must have a complete copy of the custody papers.
3. **Proof of Residency**-a mortgage statement, rental agreement, tax bill, current utility bill, etc.

FEE SCHEDULE BASED on ANNUAL INCOME

MONTHLY		$5		$15		$30		$50		$75	
YEARLY		$45		$135		$270		$450		$675	
Household		**1.30**		**1.50**		**1.70**		**1.85**		**2.00**	
2	below	20826	20827	24030	24031	27234	27235	29637	29638	32040	and above
3	below	26208	26209	30240	30241	34272	34273	37296	37297	40320	and above
4	below	31590	31591	36450	36451	41310	41311	44955	44956	48600	and above
5	below	36972	36973	42660	42661	48348	48349	52614	52615	56880	and above
6	below	42354	42355	48870	48871	55386	55387	60273	60274	65160	and above
7	below	47749	47750	55095	55096	62441	62442	67950.5	67951.5	73460	and above
8	below	53157	53158	61335	61336	69513	69514	75646.5	75647.5	81780	and above

Enrollment-Your child will be considered for enrollment in our preschool program after all registration information has been received. If your child does not have a current physical completed, schedule the appointment and write the date of the appointment on the ENROLLMENT CHECKLIST, and turn in the application.

3301-37 of the Administrative Code Preschool Program Rules 1-12, section 08 states:

Child Information (A) The parent shall provide, prior to the date of admission or not later than 30 days after date of admission, and every thirteen months from the date of examination thereafter, a medical statement affirming that the child is in suitable condition for enrollment in the program.

As the parent/legal guardian of _____, I understand that the above documents are required by the Ohio Department of Education (ODE), Ohio Department of Job and Family Services (ODJFS) and Orrville City Schools for enrollment into the program and to maintain an active status within the district. My signature below verifies that all information I have provided is true and correct. I also understand that providing false information would be considered fraud and that information will be turned over to the State of Ohio.

_____ _____

Parent/Legal Guardian Name Date

Heartland Preschool

Registration Form

Office use only:
Student # _____
School _____ Birth Certificate: _____
Social Security Card: _____
Teacher: _____ Immunizations: _____
Custody Paperwork: _____
First day of Attendance: _____ Proof of residency _____

Student Information:

Student Name: _____ / _____
Full First Name (legal) *Full Middle Name (legal)* *Full Last Name (legal)* *Nickname*

Residence Address: _____ / _____
House Number *Street Name* *Apartment No.*

_____
City *State* *Zip Code*

Telephone #'s: _____ ☐ Listed ☐ Unlisted _____
Home Phone # *Parental Cell Phone #*

Mother's Maiden Name: _____ Child's Gender: ☐ Male ☐ Female

Child's Birthdate: _____ **Citizenship:** ☐ US Citizen ☐ Other (please specify _____) Birthplace: _____
Month Day Year *City, State, and Country*

Native Language: _____ _____
Language Spoken by Student *Language Spoken by Child in Home*

Has your child previously attended Preschool? ☐ Yes ☐ No If yes, where? _____

Homeless Status: Please let us know if any of these situations pertain to your family:
☐ Living in Shelter ☐ Unsheltered (living in car, etc.) ☐ Doubled Up (living with another family due to economic hardship, loss of home, or other similar situation)
☐ Living in Hotel/Motel

Names & ages of Brothers and Sisters: _____

Emergency Contact Information:

Mother: _____ Father: _____

Emergency Number Mom: _____ Emergency Phone Dad: _____

Two Emergency contacts (not parents) **are required** and must live within the district. These contacts may pick up my child in case parents can't be reached. My student may be picked up from school by these contacts as long as a written note is provided on the day child is to be released to them. Students will not be released to anyone other than a parent unless a note is provided.

Contact 1: _____
Address: _____
Daytime phone _____ Cell _____
Relationship to child _____

Contact 2: _____
Address: _____
Daytime phone _____ Cell _____
Relationship to Child: _____

Bathroom Statement – I understand that students must be toilet trained and able to use the toilet independently and clean up appropriately.

Signature of Parent/Guardian _____ Date _____

Student's Family Data:

Who has legal custody of this child?
- ☐ Both parents
- ☐ Mother only
- ☐ Father only
- ☐ Foster Care
- ☐ Step Parent
- ☐ Grandparent
- ☐ Other _____

Who is student living with?
- ☐ Both parents
- ☐ Mother
- ☐ Father
- ☐ Step Parent_____
- ☐ Grandparent: _____
- ☐ Guardian: _____
- ☐ Other: _____

Marital Status of parents?
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Never married

Type of Custody:
- ☐ Full Custody
- ☐ Shared/Joint Custody
- ☐ Grandparent Legislation

A complete set of custody and/or guardianship papers must be on file with the school.

Name of Father/Legal Guardian:		Name of Mother/ Legal Guardian	
Address if different than student's address		Address if different than student's address	
Father's Employer		Mother's Employer	
Daytime Phone #		Daytime Phone #	
Cell Phone #		Cell Phone #	
Father's e-mail address:		Mother's E-mail address	

If parents do not live together, should a copy of correspondence be sent to non-residential parent? ☐ Yes ☐ No

Parents or guardians listed above have permission to pick up the child unless otherwise indicated. Notify the school principal immediately if any court orders are in effect restricting noncustodial parents or others from contact with this child. Do not release my child to: _____

I hereby state the information provided on this document is true and current. I am the legal guardian or custodian of this child.

_____

Parent/Guardian Signature Date

Emergency Medical Authorization: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached.
My child has the following allergies or medical condition(s) and may/may not need medication(s) for treatment:

***ALLERGIES**: (specify)_____*EPIPEN Yes or No* ***SEIZURES**:_____ *diastat Yes or No*

***ASTHMA**:_____ *Inhaler Yes or No* *** ADD/ADHD**:_____ *Medication Yes or No* ***DIABETES**:_____ *insulin or oral meds*

***SKIN CONDITIONS** (list):_____ OTHER (specify):_____

Current Medications (list):_____

To ensure the health and safety of my child at school, I authorize the information listed above to be shared with necessary staff members. Yes _____ No _____

****

Part I – To <u>Grant Consent</u>: I hereby give consent for the following medical care providers and local hospital to be called.

Preferred Doctor: _____ Address: _____ Phone _____

Preferred Dentist: _____ Address: _____ Phone _____

Preferred Hospital _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for: (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to any hospital reasonably accessible. The authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian:_____ Date: _____

****

Part II - <u>Refusal to Consent</u>: I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action as they are reasonably able to do so:

_____

Signature of Parent/Guardian: _____ Date: _____

Ethnicity

Student Name: _____ Date of Birth: _____

Because of changing reporting requirements at the Ohio Department of Education, we must gather race/ethnicity information for all our students and new enrollments. Please answer **BOTH** questions:

1. **My child is of Hispanic/Latino Heritage** ? _____ Yes _____ No
   (a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin)

2. Please choose your child's race:

_____ ***Asian*** (Origins of the Far East, Southeast Asia, or Indian subcontinent -- The area includes Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)

_____ ***Black or African American – Non-Hispanic*** (Persons having origins in any of the black racial group in Africa.)

_____ ***American Indian/Alaskan Native*** (Persons having origins in any of the original peoples of North and South America – including Central America – and who maintain tribal affiliation or community attachment.)

_____ ***Native Hawaiian or Other Pacific Islander*** (Persons having origins in any of the original peoples of Hawaii, Guam, Soma or other Pacific Islands.)

_____ ***White -Non-Hispanic*** (People who have origins in any of the original peoples of Europe, North Africa, or the Middle East.)

_____ ***Hispanic*** – (Persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin regardless of race.) **(MUST CHOOSE one of the following categories also – use definitions above.)**

_____ Asian
_____ Black or African American
_____ American Indian/Alaskan Native
_____ Native Hawaiian or Other Pacific Islander
_____ White

_____ ***Multi-Racial:*** **(Choose all that apply – use definitions above)**

_____ Asian
_____ Black or African American
_____ American Indian/Alaskan Native
_____ Native Hawaiian or Other Pacific Islander
_____ White

Parental Signature: _____ Date: _____

Home Language Survey

Complete this home language survey at the student's initial enrollment in school. This form must be signed and dated by the parent or guardian. It must be kept in the student's file. This form will be used only for determining whether the student needs English Learner services and will not be used for immigration matters or reported to immigration authorities.

Student's Last Name: ----------

Student's First Name: ---------- Date of Birth _____

ENGLISH

1. Is a language other than English spoken in your home? ☐ No ☐ Yes _____ (specify language)
2. Does your child communicate in a language other than English? ☐ No ☐ Yes _____ (specify language)
3. Which language did your child learn first? _____ (specify language)
4. In which language do you prefer to receive information from the school? _____ (specify language)
5. What is your relationship to the child? ☐ Father ☐ Mother ☐ Guardian ☐ Other (specify) _____

Parent Signature : _____ **Date:** _____

ESPAÑOL (SPANISH)

1. ¿Se habla otro idioma que no sea el inglés en su casa? ☐ No ☐ Sí _____ (especifique idioma)
2. ¿Habla el estudiante un idioma que no sea el inglés? ☐ No ☐ Sí _____ (especifique idioma)
3. ¿Cuál fué el primer idioma que aprendió su hijo/a? _____ (especifique idioma)
4. ¿En que idioma prefiere recibir comunicaciones de la escuela? _____ (especifique idioma)
5. ¿Cuál es su relación con el estudiante? ☐ Padre ☐ Madre ☐ Guardián ☐ Otro (especifique) _____

Parent Signature : _____ **Date:** _____

Ohio Department of Education
Office of Early Learning and School Readiness
Child Medical Statement

Section I- Child Medical Information

Revised 2/23/17

Child's Name (Print or type)	Date of Birth

Immunizations			Exempt for Immunizations		
Complete for Age	O Yes	O No	Religious Conviction	O Yes	O No
In Process	O Yes	O No	Health	O Yes	O No
			Reason of Conscience	O Yes	O No

List any limitations or health conditions for this child including allergies, daily medication, dietary restrictions:

_____

_____

Recommended Immunizations (enter month, day , year)						
Vaccines	DOSE 1	DOSE 2	DOSE 3	DOSE 3	DOSE 4	DOSE 5
Diphtheria, Tetanus, Pertussis (DTP)						
Hepatitis B						
Haemophilus Influenza type b (HIB)						
Measles, Mumps, Rubella (MMR)						
Inactivated Polio						
Varicella (Chicken pox)						
Influenza						
Pneumococcal Conjugate (PCV)						
Rotavirus						
Hepatitis A						
Other						
The immunizations above are recommended by the Centers of Disease Control and Prevention and the Ohio Department of Health						

Recommended Assessments/ Screenings

Vision O Yes O No Date _____ Hearing O Yes O No Date _____

Dental O Yes O No Date _____ Lead O Yes O No Date _____

BMI O Yes O No Date _____ Other _____

Section II- Child Medical Statement Verification

Physician / Clinic / Hospital Name _____

Provider Address _____

Provider Phone number _____

Check box of examining medical professional

☐ Physician ☐ Physician's Assistant ☐ Advanced Practice Nurse

The child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional _____

Programs funded through Ohio Dept. of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that their families are informed of the importance of health screenings and the resources to obtain them.

Immunizations for Child Care, Head Start and Pre-School Attendance:

Please follow the following link to the ACIP Easy-to-read Immunization Schedule for Infants and Children[1],[2]

http://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf

Ohio Revised Code 5104.014, Division B:
Each child's[3] caretaker parent shall provide to the center, home, or in-home aide a medical statement, as described in division (D) of this section, indicating that the child has been immunized against or is in the process[4] of being immunized against all of the following diseases:

1. **Chicken pox;**	6. **Influenza;**	11. **Poliomyelitis;**
2. **Diphtheria;**	7. **Measles;**	12. **Rotavirus;**
3. **Haemophilus influenzae type b;**	8. **Mumps;**	13. **Rubella;**
4. **Hepatitis A;**	9. **Pertussis;**	14. **Tetanus.**
5. **Hepatitis B;**	10. **Pneumococcal disease;**	

Ohio Revised Code 5104.014, Division C:
A child is not required to be immunized against a disease specified in **Division (B)** of this section if any of the following is the case:

1. Immunization against the disease is medically contraindicated for the child;
2. The child's parent or guardian has declined to have the child immunized against the disease for reasons of conscience, including religious convictions;
3. Immunization against the disease is not medically appropriate for the child's age.

In the case of influenza, a child is not required to be immunized against the disease if the seasonal vaccine is not available.

Ohio Revised Code 5104.014, Division D:
The medical statement shall include all of the following information:

1. The dates that a child received immunizations against each of the diseases specified in division (B) of this section;
2. Whether a child is subject to any of the exceptions specified in division (C) of this section.
3. The medical statement shall include a component where a parent or guardian may indicate that the parent or guardian has declined to have the child immunized.

Follow the link below to the Ohio Department of Jobs and Family Services' Child Medical Statement:

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=01305

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[1] Vaccine doses are only considered **valid** if administered according to the most recent version of the *Recommended Immunization Schedules for Persons Aged 0 Through 18 Years* or the *Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind*, as published by the Advisory Committee on Immunization Practices.

[2] Vaccine doses administered **≤ 4 days** before the minimum interval or age are **valid** (grace period). Doses administered **≥ 5 days earlier** than the minimum interval or age are **not valid** doses and should be repeated as age-appropriate. **If MMR and Varicella are not given on the same day, the doses must be separated by at least 28 days with no grace period.**

[3] **"Child" includes both of the following**: 1)An infant, toddler, or preschool age child; and 2) A school-age child who is not enrolled in a public or nonpublic school but is enrolled in a child day-care center, type A family day-care home, or licensed type B family day-care home or receives child care from a certified in-home aide.

[4] **"In the process of being immunized"** means having received at least the first dose of an immunization sequence and complying with the immunization intervals or catch-up schedule prescribed by the director of health (in accordance with the ACIP catch-up schedule).

OHIO DEPARTMENT OF EDUCATION
DIVISION OF EARLY CHILDHOOD EDUCATION
DENTAL FORM

Name of Child	___Male___Female
Date of Birth	
Child's current age	
Parent(s)/Guardian Name	

1. Is the child now receiving any of the following? If "yes", include length of time receiving fluoride.
   - Topical fluoride application _____No _____Unknown _____Yes
   - Fluoridated water _____No _____Unknown _____Yes
   - Fluoride supplement diet _____No _____Unknown _____Yes
     _____Tablets _____Liquid
2. Does the child have any of the following? If "yes", provide details.
   - Allergies _____Yes _____No
   - Asthma _____Yes _____No
   - Bleeding _____Yes _____No
   - Diabetes _____Yes _____No
   - Epilepsy _____Yes _____No
   - Heart/Vascular disease _____Yes _____No
   - Liver disease _____Yes _____No
   - Rheumatic fever _____Yes _____No
   - Sickle cell disease _____Yes _____No
   - Other (Please list) _____Yes _____No
3. Does the child have any trouble with teeth, gums or mouth? _____Yes _____No
   If so, what kind?_____
4. Child has previously seen a dentist? _____Yes _____No
   Dentist Name_____ Date of last visit_____
5. Child is under a physician's care? _____Yes _____No
   Physician Name_____
6. Child is receiving medication? _____Yes _____No
7. Date of dental examination_____

Dentist Name (Print)			
Dentist Name (Signature)			
Complete Address			
Phone Number			
License No.		Tax ID No.	

PLEASE COMPLETE THE BACK OF THIS FORM IF TREATMENT IS NECESSARY

ORAL CONDITIONS BEFORE TREATMENT:
Missing O Decayed O Filled O

Priority Group: _____Needs Attention Immediately
_____Needs Attention Soon
_____Needs Routine Care

Dental Needs:_____Treatment (restoration, pulp therapy, extraction)
_____Cleaning_____Fluoride_____No Problem
_____Other:_____

Tooth#/ Letter	Surfaces	Description of Work	Treatment Approved	Date Services Performed	ADA Procedure #	Actual Charges

Approximate number of visits: _____ Approximate cost: _____
This is an accurate determination of services required.

Dentist Signature_____Date_____

All planned treatment (_____IS _____IS NOT) complete. If not, explain here:

The following services were provided. Explanation of each included with this report.
_____Routine recall visits
_____Dietary problem(s)
_____Harmful oral habit
_____Special home emphasis, oral hygiene
_____Developmental problem(s)
_____Needs fluoride supplement

I certify that I have completed the service(s) listed on this page and the services as Marked. Itemized charges do not exceed my usual and customary fees.

Dentist Signature_____ Date_____

This is an OPTIONAL SUPPLEMENTAL FORM provided by the Ohio Department of Education that may be used to comply with the Head Start Performance Standards regarding dental examination and data (45 CFR 1304.3-3,4,5). PROGRAMS MAY OR MAY NOT CHOOSE TO USE THIS FORM. The annual dental exam by a dentist is an oral diagnostic procedure which should include radiographs (x-rays) only if the dentist determines that they are absolutely necessary. This should be completed within 90 days of the child's entrance into the program. Developmental dental history should be part of health screening completed within 45 days of entrance.

ORRVILLE CITY SCHOOLS

FREQUENTLY ASKED QUESTIONS ABOUT FREE AND REDUCED PRICE SCHOOL MEALS

Dear Parent/Guardian:
Children need healthy meals to learn. Orrville City Schools offers healthy meals every school day. Children may buy lunch for $2.25 for elementary/$2.50 for middle & high school and breakfast for $1.00 for elementary/$1.25 for middle & high school students. **Your children may qualify for free meals or for reduced price meals.** Reduced price is **$.30** for breakfast and **$.40** for lunch. This packet includes an application for free or reduced price meal benefits, and a set of detailed instructions. Below are some common questions and answers to help you with the application process.

1. WHO CAN GET FREE OR REDUCED PRICE MEALS?
   - All children in households receiving benefits from supplemental nutrition assistance program (SNAP) or Ohio Works First (OWF) are eligible for free meals.
   - **Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals.**
   - **Children participating in their school's Head Start program are eligible for free meals.**
   - Children who meet the definition of homeless, runaway, or migrant are eligible for free meals.
   - Children may receive free or reduced price meals if your household's income is within the limits on the Federal Income Eligibility Guidelines. Your children may qualify for free or reduced price meals if your household income falls at or below the limits on this chart.

FEDERAL ELIGIBILITY INCOME CHART For School Year 2016-2017			
Household size	Yearly	Monthly	Weekly
1	$21,978	$1,832	$423
2	29,637	2,470	570
3	37,296	3,108	718
4	44,955	3,747	865
5	52,614	4,385	1,012
6	60,273	5,023	1,160
7	67,951	5,663	1,307
8	75,647	6,304	1,455
Each additional person:	7,696	642	148

2. HOW DO I KNOW IF MY CHILDREN QUALIFY AS HOMELESS, MIGRANT, OR RUNAWAY? Do the members of your household lack a permanent address? Are you staying together in a shelter, hotel, or other temporary housing arrangement? Does your family relocate on a seasonal basis? Are any children living with you who have chosen to leave their prior family or household? If you believe children in your household meet these descriptions and haven't been told your children will get free meals, please call or e-mail **Brett Lanz @ 330.682.4816/orvl_blanz@tccsa.net.**

3. DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD? No. *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: Marlene Steiner, Coordinator of Applications, @ 815 N. Ella St. or your child's school office.**

4. SHOULD I FILL OUT AN APPLICATION IF I RECEIVED A LETTER THIS SCHOOL YEAR SAYING MY CHILDREN ARE ALREADY APPROVED FOR FREE MEALS? **NO**, but please read the letter you got carefully and follow the instructions. **You will need to complete the waiver form.** If any children in your household were missing from your eligibility notification, contact **Marlene Steiner @ 330.682.9761** immediately.

5. MY CHILD'S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT A NEW ONE? Yes. Your child's application is only good for that school year and for the first few 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. If you do not send in a new application that is approved by the school or you have not been notified that your child is eligible for free meals, your child will be charged the full price for meals.

6. I GET WIC. CAN MY CHILDREN GET FREE MEALS? Children in households participating in WIC may be eligible for free or reduced price meals. Please send in an application.

7. WILL THE INFORMATION I GIVE BE CHECKED? Yes. We may also ask you to send written proof of the household income you report.

8. 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.

9. 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: **Marlene Steiner, 815 N. Ella St., Orrville, OH 44667 or call 330.682.9761.**

10. MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN? Yes. You, your children, or other household members do not have to be U.S. citizens to apply for free or reduced price meals.

11. 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.

12. WHAT IF SOME HOUSEHOLD MEMBERS HAVE NO INCOME TO REPORT? Household members may not receive some types of income we ask you to report on the application, or may not receive income at all. Whenever this happens, please write a 0 in the field. However, if any income fields are left empty or blank, those will also be counted as zeroes. Please be careful when leaving income fields blank, as we will assume you meant to do so.

13. WE ARE IN THE MILITARY. DO WE REPORT OUR INCOME DIFFERENTLY? Your basic pay and cash bonuses must be reported as income. If you get any cash value allowances for off-base housing, food, or clothing, it must also be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income. Any additional combat pay resulting from deployment is also excluded from income.

14. WHAT IF THERE ISN'T ENOUGH SPACE ON THE APPLICATION FOR MY FAMILY? List any additional household members on a separate piece of paper, and attach it to your application. Contact **Marlene Steiner, 815 N. Ella St., or 330.682.9761 or to receive a second application.**

15. MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR? To find out how to apply for Ohio SNAP or other assistance benefits, contact your local assistance office or call 877-852-0010.

If you have other questions or need help, call **330.682.9761.**

Sincerely,

Marlene D. Steiner
Coordinator of Application

Healthy Start & Healthy Families

Does your child qualify for the School Meals Program? If so, your family may qualify for free health coverage!



Healthy Start & Healthy Families

Healthy Start offers free health care coverage for kids (birth to age 19) and pregnant women.

Healthy Families offers free health care coverage for the entire family - parents AND kids.

Healthy Start & Healthy Families Covers:

Doctor Visits
Hospital Care
Immunizations
Substance Abuse
Prescriptions
Vision Services
Dental Care
Mental Health

And Much More!

For more information or an application, call:

1-800-324-8680 (a free call!)

TDD 1-800-292-3572

Monday - Friday 7 am to 8 pm
Saturday - Sunday 12 pm to 5 pm

Healthy Start

Your family's size and income determines if you and your family are eligible for Healthy Start or Healthy Families. Healthy Start & Healthy Families are Medicaid Programs administered by The Ohio Department of Job & Family Services.

INSTRUCTIONS FOR APPLYING

A HOUSEHOLD MEMBER IS ANY CHILD OR ADULT LIVING WITH YOU

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) OR OHIO WORKS FIRST (OWF), FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the school name and school grade level for each child.
Part 2: List the 10-digit case number for any household member (including adults) receiving SNAP or OWF benefits.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose to.

IF NO ONE IN YOUR HOUSEHOLD GETS SNAP OR OWF BENEFITS AND IF ANY CHILD IN YOUR HOUSEHOLD IS HOMELESS, A MIGRANT OR RUNAWAY, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the school name and school grade level for each child.
Part 2: Skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call Brett Lanz- 330.682.4816
Part 4: Complete only if a child in your household isn't eligible under Part 3. See Instruction for All Other Households.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary if you didn't need to fill in part 4.
Part 6: Answer this question if you choose to.

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:

If all children in the household are foster children:

Part 1: List all foster children and the school name and school grade level for each child. Check the box indicating the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose to.

If some of the children in the household are foster children:

Part 1: List all household members and the name of school and school grade level for each child. For any person, including children, with no income, you must check the "No Income" box. Check the box if the child is a foster child.
Part 2: If the household does not have a SNAP or OWF 10-digit case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Brett Lanz-330.682.4816. If not, skip this part.
Part 4: Follow these instructions to report total household income from this month or last month.

- **Box 1–Name:** List all household members with income.
- **Box 2 –Gross Income and How Often It Was Received:** For each household member, list each type of income received for the month. Check the box to tell us how often the person receives the income—weekly, every other week, twice a month, or monthly. For earnings, be sure to list the **gross income**, not the take-home pay. Gross income is the amount earned *before* taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. For other income, list the amount and check the box to tell us how often each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits. Under *All Other Income*, list Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from SNAP, FDPIR, WIC, Federal education benefits and foster payments received by the family from the placing agency. For ONLY the self-employed, under *Earnings from Work*, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 5: Adult household member must sign the form and list the last four digits of their Social Security Number (or mark the box if s/he doesn't have one).
Part 6: Answer this question, if you choose.

ALL OTHER HOUSEHOLDS, INCLUDING WIC HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the school name and school grade level for each child. For any person, including children, with no income, you must check the "No Income Box".
Part 2: If the household does not have a SNAP or OWF 10-digit case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Brett Lanz @ 330.682.4816. If not, skip this part.
Part 4: Follow these instructions to report total household income from this month or last month.

- **Box 1–Name:** List all household members with income.
- **Box 2 –Gross Income and How Often It Was Received:** For each household member, list each type of income received for the month. Check the box to tell us how often the person receives the income—weekly, every other week, twice a month, or monthly. For earnings, be sure to list the **gross income**, not the take-home pay. Gross income is the amount earned *before* taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. For other income, list the amount and check the box to tell us how often each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits. Under *All Other Income*, list Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from SNAP, FDPIR, WIC, Federal education benefits and foster payments received by the family from the placing agency. For ONLY the self-employed, under *Earnings from Work*, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 5: An adult household member must sign the form and list the last four digits of his or her Social Security Number (or mark the box if s/he doesn't have one).
Part 6: Answer this question if you choose to.

Your children may qualify for free or reduced price meals if your household income falls at or below the limits on this chart:

INCOME ELIGIBILITY GUIDELINES			
Household size	Yearly	Monthly	Weekly
1	$21,978	$1,832	$423
2	29,637	2,470	570
3	37,296	3,108	718
4	44,955	3,747	865
5	52,614	4,385	1,012
6	60,273	5,023	1,160
7	67,951	5,663	1,307
8	75,647	6,304	1,455
Each additional person:	7,696	642	148

Privacy Act Statement: This explains how we will use the information you give us.
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), Ohio Works First (OWF) case number or other 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.

Orrville City Schools is an equal opportunity provider and employer.

2016-2017 FREE AND REDUCED PRICE SCHOOL MEALS FAMILY APPLICATION

PLEASE Do NOT turn in a paper application if you have received a DIRECT CERTIFICATION notice for this school this year

Part 1. ALL HOUSEHOLD MEMBERS

Names of all household members (First, Middle Initial, Last)	Name of school and school grade level for each child/or indicate "NA" if child is not in school. School	Grade	Check if a foster child (legal responsibility of welfare agency or court). *If all children listed below are foster children, skip to Part 5 to sign this form.	Check if No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Part 2. BENEFITS: If any member of your household receives SNAP or OWF benefits, provide the name and 10-digit case number for the person who receives benefits and **skip to Part 5**. If no one receives these benefits, **skip to Part 3.** 0

NAME: ______________________ 10-DIGIT CASE NUMBER: ______________________

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Brett Lanz @ 330.682.4816

Homeless ☐ Migrant ☐ Runaway ☐

Part 4. TOTAL HOUSEHOLD GROSS INCOME (before deductions). List all income on the same line as the person who receives it. Check the box for how often it is received. Record each income only once.

1. NAME (List all household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED															
	Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, Social Security, SSI, VA benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All Other Income (include frequency, such as "weekly" "monthly" "quarterly" "annually")
(Example) Jane Smith	$200	☒	☐	☐	☐	$150	☐	☒	☐	☐	$0	☐	☐	☐	☐	$50 / quarterly
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /______
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /______
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /______
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /______
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /______

Part 5. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that deliberate misrepresentation of the information may cause my children to lose meal benefits and I may be subject to prosecution under State and Federal statutes.

Sign here: X______________________ Print name:______________________ Date: __________

Address:______________________________________ Phone Number:______________________

Last four digits of your Social Security Number: ___ ___ ___ ___ ☐ I do not have a Social Security Number

Part 6. Children's ethnic and racial identities (optional)

Choose one ethnicity:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Choose one or more (regardless of ethnicity):
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ White
- ☐ Native Hawaiian or other Pacific Islander

Don't fill out this part. 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

Total Income: __________ Per:☐Week, ☐Every 2 Weeks, ☐Twice A Month, ☐Month, ☐Year Household size: ______

Categorical Eligibility: ___ Date Withdrawn: _______ Eligibility: Free___ Reduced___ Denied___ Reason: ______________

Determining/Approval Official's Signature: ______________________________ Date: __________

Confirming Official's Signature: ______________________________ Date: __________

Follow-up Official's Signature: ______________________________ Date: __________

If selected for Verification, Data Verification Notice Sent:_______ Response Date: _______ 2nd Notice Sent:_______ Results Sent:_______

Verification Result: No Change _____ Free to Reduced Price _____ Free to Paid _____ Reduced Price to Free _____ Reduced Price to Paid _____

HEARTLAND PRESCHOOL
MULTI-PURPOSE RELEASE FORM

STUDENT: _____ DATE: _____

PRESCHOOL HANDBOOK

I will read/review the Preschool Handbook and agree to follow the policies and procedures of Heartland Preschool. The handbook will be given after registration is complete.

Parent/Guardian Signature: _____

EMERGENCY DISMISSAL

On rare occasions, we have early dismissal due to hazardous conditions. School buses will run their usual routes. Please indicate which dismissal action is preferred:

_____ My child is to remain at school until I personally pick him/her up
_____ My child is to go home with the stated authorized person _____

Parent/Guardian /Signature _____

FIELD TRIP PERMIT

I want my child to be able to go on field trips this year with his or her class. She/he has my permission to go whenever the teachers and administration think it advisable. My approval for such trips remains effective for the entire school year, even though I understand that parents will be reminded prior to the field trip.

Parent/Guardian Signature: _____

PERMISSION TO PUBLISH

Heartland Preschool has my permission to use my child's name, picture, and/or original work for school-related activities that may be published in OrrViews, The Daily Record, Akron Beacon Journal, or the school's website.

Parent/Guardian Signature: _____

File: EDE

ACCEPTABLE USE AND INTERNET SAFETY POLICY

Student's Name (print!): _____ Student's Grade: _____

STUDENT'S AGREEMENT

Every student, regardless of age, must read and sign below:

I have read, understand and agree to abide by the terms of the foregoing Acceptable Use and Internet Safety Policy. Should I commit any violation or in any way misuse my access to the School District's computer network and the Internet, I understand and agree that my access privilege may be revoked and School disciplinary action may be taken against me.

_____ _____

Student name (PRINT CLEARLY) Home Phone

_____ _____

Student signature (first and last name) Date

_____

Address

User (place an "X" in the correct blank): I am age 18 or older _____ I am under age 18 _____

If I am signing this Policy when I am under 18, I understand that when I turn 18, this Policy will continue to be in full force and effect and agree to abide by this Policy.

PARENT'S OR GUARDIAN'S AGREEMENT

To be read and signed by parents or guardians of students who are under 18:

As the parent or legal guardian of the above student, I have read, understand and agree that my child or ward shall comply with the terms of the School District's Acceptable Use and Internet Safety Policy for the student's access to the School District's computer network and the Internet. I understand that access is being provided to the students for educational purposes only. However, I also understand that it is impossible for the School to restrict access to all offensive and controversial materials and understand my child's or ward's responsibility for abiding by the Policy. I am therefore signing this Policy and agree to indemnify and hold harmless the School, the School District and the Data Acquisition Site that provides the opportunity to the School district for computer network and Internet access against all claims, damages, losses and costs, of whatever kind, that may result from my child's or ward's use of his or her access to such networks or his or her violation of the foregoing Policy. Further, I accept full responsibility for supervision of my child's or ward's use of his or her access account if and when such access is not in the School setting. I hereby give permission for my child or ward to use the building-approved account to access the School District's computer network and the Internet.

_____ _____

Parent or Guardian name(s) (PRINT CLEARLY) Home Phone

_____ _____

Parent or Guardian signature(s) Date

_____

Address

ADOPTED: *September 21, 2001*
REVISED: *July 1, 2009*
LEGAL REFS: *Children's Internet Protection Act of 2000 (P.L. 106-554, HR 4577)*
Communications Act of 1934, as amended (47 USC 254[h],[1])
Elementary and Secondary Education Act of 1965, as amended (20 USC 6801 et seq., Part F)

Preschool Daily Transportation Authorization

Child's Name_____

_____ will be picked up by a parent/guardian

_____ will be picked up by _____ (This person **must** be one of the names listed as emergency contacts on the registration form.)

_____ will ride bus # _____ to this address _____.

Please provide the name and address if it is different from home.

_____

I understand that an adult must walk my student to the bus and an adult must meet the bus when unloading at home. If an adult is not at the bus door to meet my student, the student will be returned to school or the bus garage.

Parent signature_____ Date_____

If changes are needed, please send a note with your child to their teacher. **Emergency changes to your student's daily procedure must be called in to the office by 2:30 PM. We will not accept changes after this time.