

Olive Public Schools
2022-2023 School Year

Student Name: (As appears on Birth Certificate) _____
LAST FIRST MIDDLE

Gender: Male Female Date of Birth ____/____/____ Grade: _____

Student Address: _____
Street Number and Name City/State/Zip

Home Telephone Number: _____ County Student Resides In: _____

Ethnicity: (Check One) Hispanic/Latino Not Hispanic/Latino

Race: (Check One) American Indian/Native Alaskan Native Hawaiian/Other Pacific Islander
 Asian White/Caucasian
 Black

Parent/Legal Guardian (#1)

Parent/Legal Guardian (#2)

Legal Name: _____

Legal Name: _____

Relationship to Student: _____

Relationship to Student: _____

Date of Birth: _____ Gender: _____

Date of Birth: _____ Gender: _____

Address: _____

Address: _____

Cell #: _____ Work #: _____

Cell #: _____ Work #: _____

Employer: _____

Employer: _____

Email Address: _____

Email Address: _____

Lives in Household with student: Yes No

Lives in Household with student: Yes No

Are there circumstances about the custody of your child that we should know about, which limit the sharing of records, picking up of your child, etc.? Yes ____ No ____ (It is the parent's/guardian's responsibility to keep the school informed of changes in custody by providing the office current and complete legal documents each year and after any changes).

Do you want to receive text messages and e-mail notifications from school messenger relating to your child?

Text messages - Parent/Guardian #1 Yes No E-mail - Parent/Guardian #1 Yes No

Text messages - Parent/Guardian #2 Yes No E-mail - Parent/Guardian #2 Yes No

In case of an accident illness or medical condition of any kind that requires my child to be picked up from school when parent/legal guardian cannot be located, please call and release my child to one of the following individuals. Emergency contacts must be at least 18 years of age and listed below in order to pick up your child.

Emergency Contact (#3)

Emergency Contact (#4)

Lives in Household with student: Yes No

Lives in Household with student: Yes No

Name: _____

Name: _____

Relationship to student: _____

Relationship to student: _____

Home Phone Number: _____

Home Phone Number: _____

Cell Number: _____

Cell Number: _____

Date: _____

Medical Emergency, Medical Prescription, Over the Counter Medications Authorization Form

Name: _____ Date of Birth: _____ SSN: _____

Emergency Contact: _____ Medical Emergency Phone: _____ Grade: _____

Insurance Company: _____ Phone: _____

Policy Number: _____

Prescriptions student currently takes: _____

Known Medical Conditions: _____

Food or Drug Allergies: _____

Allergies to medication: _____

Medical Prescriptions

Medical prescriptions including inhalers must be kept in the office. Please list the prescription, dose and any instructions.

Over the Counter Medications

List the over the counter medication and the amount that may be given (aspirin, Tylenol, tums etc.)

Completed by parent/guardian: _____

Undersigned parent/legal guardian of _____, minor child, do hereby authorize and consent to allow personnel of school to administer medicines prescribed by my child's doctor or over counter medications. The medicine shall be furnished by the legal guardian and brought to school as needed. *The medication MUST be brought to school in the original container it came with the time to be given and how many times a day the medicine is to be given.*

Undersigned parent/legal guardian of _____, minor child, do hereby authorize and consent to any x-ray examinations, anesthetics, medical or surgical diagnosis, treatment and/or emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff license under the provisions of the Medical Practice Act, and the staff of any acute general hospital holding a current license to operate a hospital from said state. It is understood that this authorization is given in advance of any specific diagnosis, treatment of hospital care being required, but is given to provide authority and consent to render care which the aforementioned physician and the exercise of his best judgment may deem advisable. It is understood that effort will be made to contact the undersigned prior to rendering treatment to the patient, but any of the above treatments will not be withheld if the undersigned cannot be reached.

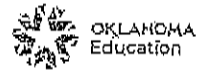
Signature Parent/Legal Guardian

Phone Home

Phone Work

SCHOOL YEAR:

HOME LANGUAGE SURVEY



STUDENT INFORMATION

Student Name: _____ Grade: _____
Last Name First Name Middle Name

Date of Birth: _____ School: _____ Student ID#: _____ Gender: Male Female
MM/DD/YYYY

Is the student of Hispanic or Latino culture or origin? YES NO

Please select one or more of the following races:

- African American/Black
- American Indian/Alaskan Native
- Asian
- Native Hawaiian/Pacific Islander
- Caucasian/White

The purpose of the following questions is to help determine if a student's exposure to a language other than English may make them eligible to receive additional English Learner (EL) supports.

1. What is the dominant language most often spoken by the student? _____
2. What is the language routinely spoken in the home, regardless of the language spoken by the student? _____
3. What language was first learned by the student? _____
4. Does the parent/guardian need interpretation services? YES NO If YES, in what language? _____
5. Does the parent/guardian need translated materials? YES NO If YES, in what language? _____
6. What was the date the student first enrolled in a school in the United States? _____
MM/YYYY

Date (MM/DD/YYYY)

Parent or Guardian Signature

TEACHER USE ONLY

The response of a language other than English to any or all of questions #1, #2, and #3 above should prompt local review of the student's potential EL identification and assessment history in the state Accountability Reporting application. If no previous EL history is present, the student must be administered a state-approved screening tool to determine their EL status.

If this HLS will be used for the purposes of Non-EL Bilingual qualification, please indicate one of the following:

A language other than English is indicated TWO OR MORE TIMES in questions #1, #2, and #3 above. The student is considered "more often" and has previously demonstrated English language proficiency on the PKST* or WIDA assessment:

Assessment Name	Year Assessed	Score

A language other than English is indicated ONE TIME in questions #1, #2, and #3 above. The student is considered "less often" and has demonstrated English language proficiency on the PKST* or WIDA assessment. The student's PKST* or WIDA assessment score and additional qualifying score is noted on the attached "Less Often" Non-EL Bilingual Qualification Form.

*A PKST score is valid only for a student's pre-K year(s). Regardless of the PKST score earned, a student administered the PKST must be administered the WIDA K Screener at the outset of kindergarten. To qualify a student as Non-EL Bilingual beyond their pre-K year, a student must either demonstrate initial proficiency on the WIDA K Screener or subsequently on the K ACCESS or ACCESS assessment.

CORPORAL PUNISHMENT AUTHORIZATION

I do I do not give my permission for corporal punishment as a means of disciplinary action for my child _____.

Parent/Legal Guardian Signature _____ Date _____

PHOTOGRAPHY RELEASE PERMISSION

During the school year, students may be photographed or videotaped by the district personnel and/or media while they are in the classrooms or participating in school activities, under the supervision of school personnel. Please sign the form below to indicate if the Olive School District has the right to release your child's photo, _____, for publication.

Yes No Parent Signature _____ Date _____

COMPUTER USAGE

For use of Olive Public School computers by a student to occur, this agreement must be signed by the parent/guardian and the student. I understand that the use of Olive School District computers is for educational purposes only. Violations of school policy regarding computer use will be suspension from school, financial restitution for damaged or destroyed hardware of software to include technical expenses to restore the original operational status of the computer. I understand that the School District has taken precautions to eliminate access to controversial materials; however I also recognize that it is impossible for the district to restrict access to all controversial materials.

Please check one:

Yes, I give permission for my child to access the internet and to use the Olive Public Schools computers for educational purposes.

No, I do not give permission for my child to access the internet and to use the Olive Public Schools computers for educational purposes.

Student's Signature

Date

Parent/Guardian Signature

Date

Olive Public Schools
Chromebook Checkout

I understand that the Chromebook is Olive Public Schools Property.

I understand that I am financially responsible for any damages that occurs to the Chromebook while it is in my possession. The Chromebook will be checked out electronically and tied to the student information system account.

I understand that use of the Chromebook, including websites and documents can be monitored.

I, the parent or legal guardian agree to pay for any damages to the chrome book checked out in our name.

By digitally signing for this document, you are accepting all terms.

U.S. DEPARTMENT OF EDUCATION
OFFICE OF INDIAN EDUCATION
WASHINGTON, DC 20202
TITLE VII STUDENT ELIGIBILITY CERTIFICATION
Elementary and Secondary Education Act, Title VII, Part A, Subpart 1

Parents: Please return this completed form to your child's school. In order to apply for a formula grant under the Indian Education Program, your child's school must determine the number of Indian children enrolled. Any child who meets the following definition may be counted for this purpose. You are not required to complete or submit this form to the school. However, if you choose not to submit a form, the school cannot count your child for funding under the program. This form will become part of your child's school record and will not need to be completed every year. This form will be maintained at the school and information on the form will not be released without your written approval.

Definition: Indian means any individual who is (1) a member (as defined by the Indian tribe or band) of an Indian tribe or band, including those Indian tribe or bands terminated since 1940, and those recognized by the State in which the tribe or band reside; or (2) a descendent in the first or second degree (parent or grandparent) as described in (1); or (3) considered by the Secretary of the Interior to be an Indian for any purpose; or (4) an Eskimo or Aleut or other Alaska Native; or (5) a member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

NAME OF CHILD _____ Date of Birth _____
(As shown on school enrollment records)

School Name _____ Grade _____

NAME OF TRIBE, BAND OR GROUP _____

Tribe, Band or Group is: (check one)
 Federally Recognized, Including Alaska Native State Recognized Terminated Organized Indian Group Meeting #5 of the Definition Above

Name of individual with tribal membership: _____

Individual named is (check one): Child Child's Parent Child's Grandparent

Proof of membership, as defined by tribe, band, or group is:
A. Membership or enrollment number (if readily available) _____ OR
Other (explain) _____

Name and address of organization maintaining membership data for the tribe, band or group:

I verify that the information provided above is accurate:

PARENT'S SIGNATURE _____ DATE _____

Mailing Address _____ Telephone _____

Notice: Public Reporting Burden Notice on Reverse Side

Emergency Contact (#5)

Lives In Household with student: Yes No

Name: _____

Relationship to student: _____

Home Phone Number: _____

Cell Number: _____

Emergency Contact (#6)

Lives In Household with student: Yes No

Name: _____

Relationship to student: _____

Home Phone Number: _____

Cell Number: _____

School Information for Previous Year (2019-2020) - Name of Public/Private/Home School -

Has your child been previously evaluated for or received services in:

- Special Education
- Speech
- Gifted/Talented
- 504 Plan
- ELL

TRANSPORTATION - Circle most frequently used:

Bus Rider AM PM Car Rider AM PM Walker AM PM

ROUTE NAME: _____

HEALTH INFORMATION -

List any current medical conditions, injury, illness, disease surgery.

Does your child have a food, insect, drug, or Latex allergy? _____ If yes, please list _____

Is your child prescribed an Epi-Pen? _____

Does your child have Asthma? _____

Does your child have Diabetes? _____ Type 1 Type 2

Does your child have a seizure disorder? _____ Medication prescribed? _____ If yes, please list _____

Does your child routinely take medication? _____ If yes, please list _____

Does your child wear glasses? _____

AS A PARENT/GUARDIAN OF THE ABOVE, I VERIFY THAT THE INFORMATION ON THIS ENROLLMENT FORM IS CURRENT, AND THAT I WILL IMMEDIATELY INFORM THE SCHOOL OF ANY CHANGES IN THIS INFORMATION. I AUTHORIZE ANY SCHOOL PERSONNEL TO TAKE REASONABLE EMERGENCY MEASURES, INCLUDING CALLING 911, ON BEHALF OF MY CHILD.

I verify all information provided is accurate to the best of my knowledge:

Parent/Guardian #1 Signature

Date

Parent/Guardian #2 Signature

Date

2022-2023 Household Application for Free and Reduced Price School Meals

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

Apply online:

STEP 1 List All Household Members who are Infants, Children, and Adolescents (including grade 12) in your household (including those with additional names) on this application (use of copy).

Child's First Name	MI	Child's Last Name	DOB	School Name	Grade	Student? Yes No	Foster Child	Homeless, Migrant, Runaway

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, TANF, or PAFIP?

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: _____

STEP 3 Report Income for All Household Members (5th Edition) (You answered Yes to STEP 2)

Write only one case number in this space.

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

Child Income: \$ _____

How often?
 Weekly Monthly Quarterly Annually

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 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 Member (First and Last)	Earnings from Work	Public Assistance/ Child Support/Alimony	Pension/Retirement/ All Other Income	How often?
	\$ _____	\$ _____	\$ _____	Weekly <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Annually <input type="radio"/>
	\$ _____	\$ _____	\$ _____	Weekly <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Annually <input type="radio"/>
	\$ _____	\$ _____	\$ _____	Weekly <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Annually <input type="radio"/>
	\$ _____	\$ _____	\$ _____	Weekly <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Annually <input type="radio"/>
	\$ _____	\$ _____	\$ _____	Weekly <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Annually <input type="radio"/>

Total Household Members (Children and Adults): _____

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: _____

Check if no SSN:

STEP 4 Contact Information and adult signature. Mail Completed Form To:

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.

Street Address (if available): _____ Apt # _____ City _____ State _____ Zip _____

Printed name of adult signing the form: _____ Signature of adult: _____

Daytime Phone and Email (optional): _____ Today's date: _____

INSTRUCTIONS Sources of Income

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	- A child is blind or disabled and receives Social Security benefits
- Disability Payments	- A parent is disabled, retired, or deceased, and their child receives Social Security benefits
- Survivor's Benefits	- A friend or extended family member regularly gives a child spending money
- Income from person outside the household	- A child receives regular income from a private pension fund, annuity, or trust
- Income from any other source	

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

OPTIONAL Children's Race and Ethnicity Identifiers

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, this institution is prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at <https://www.usda.gov/sites/default/files/documents/USDA-AOASCR%20P-Complaint-Form-0508-0002-508-11-28-17-Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9982, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or fax: (833) 256-1665 or (202) 690-7442; or email: program.intake@usda.gov

This institution is an equal opportunity provider

Do not fill out For School Use Only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24 Monthly x 12

Total Income

From other?	Weekly	Bi-Weekly	2x Month	Monthly	Household Size
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Eligibility:

Free	Reduced	Disqual
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Categorical Eligibility

Determining Official's Signature

Confirming Official's Signature

Verifying Official's Signature

Date