

Ms. Erin E. Woods  
Superintendent of Schools  
(315) 562-8130  
Fax: (315) 562-2477

Mrs. Amy Sykes  
7-12 Principal  
(315) 562-8131  
Fax: (315) 562-2477

Ms. Lura Hughes  
PK-6 Principal  
(315) 562-8132  
Fax: (315) 562-2477

**EDWARDS-KNOX CENTRAL SCHOOL DISTRICT**

2512 COUNTY ROUTE 24  
HERMON, NEW YORK 13652

BUS GARAGE: (315) 562-8133  
MAIN OFFICE FAX: (315) 562-2477  
[www.ekcsk12.org](http://www.ekcsk12.org)

**BOARD OF EDUCATION**

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February 2023

Dear Parent/Guardian:

Thank you for expressing interest for your son/daughter to attend our full-day Universal Prekindergarten program. Enclosed you will find a Prekindergarten Registration Form for the 2023-2024 school year and an information sheet regarding our Universal Prekindergarten program.

We ask that you return the registration packet to us **by Monday, March 13, 2023**. Applications will be accepted after that date, but there is a possibility that the 36 slots will be filled; and you may jeopardize securing a spot for your child. **APPLICATIONS ARE FILLED ON A FIRST COME FIRST SERVED BASIS ON WHEN WE RECEIVE THE COMPLETED APPLICATION, CHILD BIRTH CERTIFICATE AND IMMUNIZATION RECORD, AND THE REQUIRED PARENTAL DOCUMENTATION (PHOTO I.D. AND PROOF OF RESIDENCY IN THE E-K SCHOOL DISTRICT).**

In mid-summer, families of registered Prekindergarten students will receive mailed notification of your child's classroom teacher. Any additional information that we have at that time will be shared as well. Prior to the start of school in September, there will be an opportunity for a Prekindergarten meet and greet.

Please do not hesitate to call our office or to contact Amanda Oemcke or Shannon Saxton at (315) 562-8132 if you have further questions.

Sincerely,



Lura K. Hughes  
Elementary Principal

LKH/ss

Enclosures

UNIVERSAL PREKINDERGARTEN  
2023-2024 School Year

Any child in the Edwards-Knox Central School District who is or will be four years old on or before December 1, 2023, is eligible to attend the Edwards-Knox Universal Prekindergarten program.

The program consists of a full-day session running from 7:55 a.m. to 2:55 p.m. daily.

Children will be involved in basic readiness skills such as cutting and pasting; recognizing colors, numbers, shapes, and letters; printing names; fine motor skills; large motor skills; and personal care skills such as zipping, tying, and taking care of personal belongings, as well as a social-emotional program (Second Step).

If you have a child who is eligible and who wishes to attend the Prekindergarten program, please call Cynthia VanBrocklin in the Elementary Office at (315) 562-8132, Ext. 25533, to request an application be sent to you.

If you have any questions, you may call (315) 562-8132, Ext. 25533, and speak with Cynthia VanBrocklin in the Elementary Office; or ask for Amanda Oemcke or Shannon Saxton.

**2023-2024 SCHOOL YEAR  
PREKINDERGARTEN REGISTRATION FORM**

**ITEMS REQUIRED TO BE SUBMITTED WITH THIS REGISTRATION PACKET:**

***\*A COPY OF PARENT/GUARDIAN PHOTO I.D.***

***\*PROOF OF RESIDENCY IN THE E-K SCHOOL DISTRICT (I.E. A PIECE OF MAIL, COPY OF LEASE OR RENTAL AGREEMENT)***

***\*CHILD'S BIRTH CERTIFICATE***

***\*CHILD'S IMMUNIZATION***

***IT IS ALSO RECOMMENDED THAT A DENTAL CERTIFICATE BE PROVIDED IF ONE IS AVAILABLE.***

Student Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ M\_\_\_\_ F\_\_\_\_

Mother's Name \_\_\_\_\_

911 Address \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Name \_\_\_\_\_

911 Address \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Student lives with: \_\_\_\_ both, \_\_\_\_ mother, \_\_\_\_ father, \_\_\_\_\_ other

\*\*\*\*\*

**PLEASE COMPLETE ALL OF THE FOLLOWING:**

1. Please list other pre-school children in your family.

(1) child's name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

(2) child's name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

(3) child's name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Does your child have any special needs or supports in the area of toileting?

\_\_\_\_ Yes \_\_\_\_ No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

3. Is child taking any medication: ☐ Yes ☐ No If yes, please list: \_\_\_\_\_

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4. Have you suspected your child may have defective eyesight? \_\_\_\_\_

If yes, has he/she ever been seen by an optometrist or an eye specialist? \_\_\_\_\_

If yes, what was the date, results of the examination, and recommendation, if any: \_\_\_\_\_

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5. Have you ever suspected that he/she may have defective hearing? \_\_\_\_\_

If yes, has he/she ever been examined? \_\_\_\_\_

If yes, what were the results of the examination, and recommendations, if any: \_\_\_\_\_

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6. Has your child had any other screenings or evaluations?

☐ Yes ☐ Date \_\_\_\_\_ ☐ No

If yes, what were the results: \_\_\_\_\_

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7. Has your child been hospitalized at all since birth? ☐ Yes ☐ No

If yes, what was the reason? \_\_\_\_\_

8. Any other illnesses or injuries? \_\_\_\_\_

9. Has your child ever seen a dentist? ☐ Yes ☐ No

10. Does your child have any allergies? ☐ Yes ☐ No If yes, please list: \_\_\_\_\_

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11. Can he/she remember a short message or a telephone number? ☐ Yes ☐ No

Additional Comments: \_\_\_\_\_

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12. Are there any medical/emotional needs or issues that should be shared with your child's teacher(s)?

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Are you interested in volunteering in the Prekindergarten program?

☐ Yes ☐ No

*I understand that all reports and testing results will be treated confidentially.*



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ENROLLMENT OFFICE**

2512 County Route 24  
Hermon, NY 13652

Phone: (315) 562-8130  
Fax: (315) 562-2477 (Pre-K-6)  
Fax: (315) 562-8137 (7-12)

**FOR OFFICE USE ONLY:**

Student ID#: \_\_\_\_\_

Grade: \_\_\_\_\_

Teacher/Homeroom: \_\_\_\_\_

**EMERGENCY INFORMATION SHEET – 2023-2024**

**Student Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle:** \_\_\_\_\_

Gender: ☐ M ☐ F Date of Birth: \_\_\_\_\_ Bus #/Driver: \_\_\_\_\_

Resident 911 Address: \_\_\_\_\_

Resident Mailing Address: \_\_\_\_\_

Language Spoken at Home: ☐ English ☐ Other (specify): \_\_\_\_\_

**Is there a current custody arrangement?** ☐ Yes ☐ No *If yes, paperwork must be provided. If changes occur at ANY time during the school year, updated documentation is required.*

**Father:** \_\_\_\_\_ Legal Guardian: ☐ Yes ☐ No Receives Mail: ☐ Yes ☐ No

Lives in household: ☐ Yes ☐ No If no, address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Mother:** \_\_\_\_\_ Legal Guardian: ☐ Yes ☐ No Receives Mail: ☐ Yes ☐ No

Lives in household: ☐ Yes ☐ No If no, address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Other Legal Guardian IF NOT FATHER/MOTHER:** \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Sibling(s) living in same household:**

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Name: \_\_\_\_\_ Grade: \_\_\_\_\_

**Emergency Contact Information** (people to contact if parent not available AND to whom we may release your child to):

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Phone No: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Phone No: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Phone No: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Phone No: \_\_\_\_\_

If there is an **early dismissal**, child should be sent to: \_\_\_\_\_

Address: \_\_\_\_\_

**Medication and/or special medical needs to share with staff:** \_\_\_\_\_

**Permission to (please check):** ☐ Provide Treatment ☐ Call Ambulance ☐ Call Doctor

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**HOUSING QUESTIONNAIRE**

Student Name: \_\_\_\_\_ Gender: ☐M ☐F Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

During the time the student resides at the current location, who is responsible for:

(a) Receiving and responding to academic and other reports concerning the student?

\_\_\_\_\_

(b) Making decisions regarding the student's education?

\_\_\_\_\_

(c) Releasing records for the student?

\_\_\_\_\_

(d) Providing other necessary consents for the student?

\_\_\_\_\_

The answers you give below will assist the district in determining what services you or your child may be able to receive under the McKinney-Vento Act 42 U.S.C. 11435. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they do not have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

☐ In permanent housing

Answer question

2 if not in

permanent housing

☐ In a shelter

☐ With another family or other person because of loss of housing or as a result of economic hardship sometimes referred to as "doubled-up")

☐ In a hotel/motel

☐ In a car, park, bus, train, or campsite

☐ Other temporary living situation (please describe): \_\_\_\_\_

2. Last permanently housed location: \_\_\_\_\_

Presenting a false record or falsifying records is an offense under Section 37.10 Penal Code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3d).

**I certify that all the information I provided is true and accurate. I understand that:**

**\*if I provide false information to the Edwards-Knox Central School District, I may be committing the crime of Perjury in the Third Degree (a Class A Misdemeanor);**

**\*if I provide false information to the Edwards-Knox Central School District with the intent to defraud the Edwards-Knox Central School District, I may be committing the crime of Perjury in the Second Degree (a Class E Felony); and**

**\*I may be prosecuted on criminal charges for such false information.**

\_\_\_\_\_  
Printed Name of Parent, Guardian, or  
Student (for unaccompanied homeless youth)

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

\_\_\_\_\_  
Date



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**STUDENT RACIAL AND ETHNIC IDENTIFICATION LETTER**

To Parents/Guardians:

In accordance with federal categories and definitions, the Edwards-Knox Central School District is required to collect and record ethnic identity of students in the district. The information will be used to:

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

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions. Put a check (✓) in the box for the category or categories which best describe your child. The Edwards-Knox Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

**CONFIDENTIALITY PROCEDURES AND REGULATIONS**

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

**To the Parent/Guardian:** the information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below:

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



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**STUDENT RACIAL AND ETHNIC IDENTIFICATION LETTER**

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

**PLEASE ANSWER BOTH QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND.**

**1. Is your child Hispanic, Latino, or of Spanish origin?** (Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.) Check (✓) the one box that best describes your child:

- ☐ YES: Hispanic.
- ☐ NO: Not Hispanic.

**2. Select one or more races from the following five racial groups. Check (✓) at least one box but choose all groups that apply to your child:**

- ☐ **AMERICAN INDIAN OR ALASKA NATIVE:** a person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition (i.e. Cherokee, Mohawk, Inuit).
- ☐ **ASIAN:** a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **BLACK:** a person having origins in any of the black racial groups of Africa.
- ☐ **WHITE:** a person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

\_\_\_\_\_  
Signature of Parent/Guardian/Other

\_\_\_\_\_  
Date

Relationship to Student (please check one): ☐ Mother ☐ Father ☐ Guardian ☐ Other: \_\_\_\_\_





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**TECHNOLOGY GUIDELINES FOR ACCEPTABLE STUDENT USE  
GRADES PRE-KINDERGARTEN-12  
USER AGREEMENT AND PARENT PERMISSION FORM - 2023-2024**

As a user of the Edwards-Knox Central School computer network, I hereby agree to comply with the stated rules on the reverse side- communicating over the network in a reliable fashion while honoring all relevant laws and restrictions.

**Student Name (please print)** \_\_\_\_\_

**Grade** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Student Signature** \_\_\_\_\_

As the parent or legal guardian of the student signing above, I grant permission for my son or daughter to use networked computer services at Edwards-Knox Central School as outlined in this document. I understand that my son or daughter will be held liable for the aforementioned violations.

**Parent Name (please print)** \_\_\_\_\_

**Street Address** \_\_\_\_\_

**Town** \_\_\_\_\_

**Home Telephone** \_\_\_\_\_

**Parents' Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

This form is required in order for your child to have a network account to use with student devices.

\*\*\*\*\*

**PHOTO RELEASE**

Please submit in writing to the Superintendent if you do not wish for your child to have his/her photo taken at school for publication in local newspapers and on the school website at any time during the school year.



## EDWARDS-KNOX CENTRAL SCHOOL ENROLLMENT OFFICE

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Hermon, NY 13652

Phone: (315) 562-8130  
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Fax: (315) 562-8137 (7-12)

### TECHNOLOGY GUIDELINES FOR ACCEPTABLE STUDENT USE

We are pleased to offer the students of Edwards-Knox Central School access to the district computer network for Internet access. To gain independent access (the use of the Internet during a student's free time) all students must obtain parental permission and must sign and return this form to the school.

Access to the Internet will enable students to explore thousands of libraries, databases, and bulletin boards throughout the world. Families should be warned that some material accessible via the Internet may contain items that are illegal, defamatory, and inaccurate or potentially offensive to some people. While our intent is to make Internet access available to further educational goals and objectives, students may find ways to access other materials as well. We believe that the benefits to students from access to the Internet, in the form of information resources and opportunities for collaboration, exceed any disadvantages. Edwards-Knox Central School teachers who utilize the Internet for instruction will review the guidelines for its use. Parents and guardians should help set and convey the standards that their children should follow when using media and information sources. To that end, Edwards-Knox Central School supports and respects each family's rights to decide whether or not to apply for independent access. However, by not approving Internet access a student's ability to research information will be limited.

#### **Guidelines for Acceptable Use - Users are expected to follow these rules of network etiquette:**

1. Users are to be polite and use appropriate language. Abusive and/or vulgar messages are not allowed.
2. Users are not to engage in illegal activities including sexually explicit material, gambling, and hate websites.
3. Users are not to reveal anyone else's address, phone number or personal information out over the Internet.
4. Users cannot hold the district responsible for materials that he/she acquires on the network.
5. Users files are NOT private. The District has access to all files and can monitor computer activity at all times.
  - Any messages relating to or in support of illegal activities may be reported to the authorities.
6. Users are not to use the network in any way that will be disruptive to other users.
7. Users are not to access, alter, or destroy any files.
8. Users may access the network ONLY for educational intent.
9. Users are not to investigate, download or play Internet games that are not approved by a teacher, use chat rooms (ICRs) or use Multi-Dimensions (MUDS).
10. Users are not to download or install any software to the computers.
11. Users are not to give out their username and password to anyone, nor are they to use another person's username and password to access the network.
12. Users will credit all materials in their work in keeping with copyright laws.
13. Users are not to employ the network for commercial purposes.
14. Users are to report any misuse of the system according to these rules to the administration.
15. Users are to treat the equipment with care and not abuse it.
16. Users are to follow printing guidelines and ARE NOT allowed to print in color unless given permission by an EK staff member and should only be done for academic purposes.
17. Users are not to use Proxy servers to access the Internet.
18. Users in grades 7-12 will have access to a school provided e-mail account and are expected to use this account within the intent of these guidelines. Grades K-6 will not have permission to access or use any e-mail accounts.
19. If you have any questions about using a computer not consistent with these guidelines, please ask a staff member.

#### **The following are possible consequences depending on the severity of the offense and the impact it may have on others:**

- \* Loss of privileges for 30 days.
- \* Loss of privileges for remainder of semester or 60 days.
- \* Loss of privileges for remainder of the year or 90 days.
- \* Students may be removed from the Network by the Network Administrator for inappropriate use of the network/Internet.
- \* A discipline referral needs to be filled out by faculty/staff to report violations.

**Additional disciplinary action may be determined at the building level for infractions that may violate existing practices (i.e. inappropriate language.) When applicable, law enforcement agencies may be involved.**



**NEW YORK STATE MIGRANT EDUCATION PROGRAM**  
**IDENTIFICATION & RECRUITMENT OFFICE**  
**PARENT SURVEY**

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, regardless of their nationality or legal status. This program is free of charge to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take few minutes to complete this questionnaire.

**Has anyone in your family worked, or looked for work at the following occupations during the past 3 years?**

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answer YES, please provide your contact information below:

Parent/Guardian Name: \_\_\_\_\_

Home address: \_\_\_\_\_

Telephone number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Best time to be reached: \_\_\_\_\_AM/PM

Previous Address: \_\_\_\_\_

Student name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Student name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program-  
Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.





STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234  
Office of P-12

Lisette Colón-Collins, Assistant Commissioner  
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594  
Brooklyn, New York 11217  
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB  
Albany, New York 12234  
(518) 474-8775 / Fax: (518) 474-7948

## Home Language Questionnaire (HLQ)

*Dear Parent or Guardian:*  
*In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.*

STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
<input type="checkbox"/> Male		
<input type="checkbox"/> Female		
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name		
First Name		
Relation to		

HOME LANGUAGE CODE

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### Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	specify
	<input type="checkbox"/> Guardian(s)		specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write

### THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
Edwards-Knox Central School 2512 CR 24, Hermon, NY 13652	
District Name (Number) & School	Address

## Home Language Questionnaire (HLQ)—Page Two

<i>Educational History</i>	
8. Indicate the total number of years that your child has been enrolled in school _____	
9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.	
Yes* <input type="checkbox"/>	No <input type="checkbox"/> Not sure <input type="checkbox"/> *If yes, please explain: _____
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below	
10b. <u>*If referred for an evaluation</u> , has your child ever <u>received</u> any special education services in the past?	
<input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____	
Age at which services received (Please check all that apply):	
<input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)	
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)	
12. In what language(s) would you like to receive information from the school? _____	

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Parent or of Person in Parental Relation* *Date*

Relationship to student: ☐ Mother ☐ Father ☐ Other: \_\_\_\_\_

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ	
NAME: _____	POSITION: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:	
NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW	
NAME: _____	POSITION: _____
ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>**DATE OF INDIVIDUAL INTERVIEW:</b> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MO. _____</span> <span>DAY _____</span> <span>YR. _____</span> </div>	<b>OUTCOME OF INDIVIDUAL INTERVIEW:</b> <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
<b>DATE OF NYSITELL ADMINISTRATION:</b> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>MO. _____</span> <span>DAY _____</span> <span>YR. _____</span> </div>	<b>PROFICIENCY LEVEL ACHIEVED ON NYSITELL:</b> <div style="display: flex; justify-content: space-between; width: 100%;"> <span><input type="checkbox"/> ENTERING</span> <span><input type="checkbox"/> EMERGING</span> <span><input type="checkbox"/> TRANSITIONING</span> <span><input type="checkbox"/> EXPANDING</span> <span><input type="checkbox"/> COMMANDING</span> </div>
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:	

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**  
**TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**

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

**STUDENT INFORMATION**

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

<b>Allergies</b> <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Environmental	

<b>Asthma</b> <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	

<b>Seizures</b> <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

<b>Diabetes</b> <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____	Date Drawn: _____

**Risk Factors for Diabetes or Pre-Diabetes:**

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

**BMI** \_\_\_\_\_ kg/m2 **Percentile (Weight Status Category):** ☐ <5<sup>th</sup> ☐ 5<sup>th</sup>-49<sup>th</sup> ☐ 50<sup>th</sup>-84<sup>th</sup> ☐ 85<sup>th</sup>-94<sup>th</sup> ☐ 95<sup>th</sup>-98<sup>th</sup> ☐ 99<sup>th</sup> and >

**Hyperlipidemia:** ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>TESTS</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Other Pertinent Medical Concerns</b>
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
<b>Lead Level Required Grades Pre- K &amp; K</b>		<b>Date</b>		<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10$ $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____
<input type="checkbox"/> <b><u>System Review and Exam Entirely Normal</u></b>				

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____
<input type="checkbox"/> Additional Information Attached		

Name:			DOB:	
SCREENINGS				
<b>Vision</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Notes</b>
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
<b>Hearing</b>	<b>Right dB</b>	<b>Left dB</b>	<b>Referral</b>	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Scoliosis</b> Required for boys grade 9	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	
And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
<b>Recommendations:</b>				
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>				
<input type="checkbox"/> <b>Full Activity</b> without restrictions including Physical Education and Athletics.				
<input type="checkbox"/> <b>Restrictions/Adaptations</b> Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
<input type="checkbox"/> <b>No Contact Sports</b> <b>Includes:</b> baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
<input type="checkbox"/> <b>No Non-Contact Sports</b> <b>Includes:</b> archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
<input type="checkbox"/> <b>Other Restrictions:</b>				
<input type="checkbox"/> <b>Developmental Stage for Athletic Placement Process ONLY</b> Grades 7 & 8 to play at high school level <b>OR</b> Grades 9-12 to play middle school level sports Student is at <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> <b>Accommodations:</b> Use additional space below to explain				
<input type="checkbox"/> Brace*/Orthotic <input type="checkbox"/> Colostomy Appliance* <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Insulin Pump/Insulin Sensor* <input type="checkbox"/> Medical/Prosthetic Device* <input type="checkbox"/> Pacemaker/Defibrillator* <input type="checkbox"/> Protective Equipment <input type="checkbox"/> Sport Safety Goggles <input type="checkbox"/> Other:				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School attached</b>				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIS		Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No
HEALTH CARE PROVIDER				
Medical Provider Signature:				<b>Date:</b>
Provider Name: <i>(please print)</i>				Stamp:
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				



# 2022-23 School Year

## New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

**NOTES:**

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

**Dose requirements MUST be read with the footnotes of this schedule**

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



1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
  - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
  - c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
  - d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 and 7: 10 years; minimum age for grades 8 through 12: 7 years)
  - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
  - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2021-2022, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 and 7; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 8 through 12.
  - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
  - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
  - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
  - d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
  - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
  - c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
  - d. Rubella: At least one dose is required for all grades (prekindergarten through 12).
6. Hepatitis B vaccine
  - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
  - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
  - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 and 8: 10 years; minimum age for grades 9 through 12: 6 weeks)
  - a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
  - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
  - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
  - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
  - d. If dose 1 was received at 15 months or older, only 1 dose is required.
  - e. Hib vaccine is not required for children 5 years or older.
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
  - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
  - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
  - e. PCV is not required for children 5 years or older.
  - f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: [www.health.ny.gov/prevention/immunization/schools](http://www.health.ny.gov/prevention/immunization/schools)

For further information, contact:

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

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

Date Withdrew \_\_\_\_\_

Attachment Va F \_\_\_\_ R \_\_\_\_ D \_\_\_\_

**2023-2024 Application for Free and Reduced Price School Meals/Milk**

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below**. Call **(315) 562-8130**, if you need help. Additional names may be listed on a separate paper.

**Return Completed Applications to:** **Edwards-Knox Central School**  
**2512 County Route 24**  
**Hermon, NY 13652**

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

2. SNAP/TANF/FDPIR Benefits:

If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. **Skip to Part 4, and sign the application.**

Name: \_\_\_\_\_ CASE #: \_\_\_\_\_

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

**All Household Members (including yourself and all children that have income).**

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

Name of household member	Earnings from work before deductions <i>Amount / How Often</i>	Child Support, Alimony <i>Amount / How Often</i>	Pensions, Retirement Payments <i>Amount / How Often</i>	Other Income, Social Security <i>Amount / How Often</i>	No Income
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>

Total Household Members (Children and Adults)

 

\*Last Four Digits of Social Security Number: XXX-XX- \_\_\_\_ - \_\_\_\_

 I do not  
have a  
SS# ☐

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

4. Signature: An adult household member must sign this application before it can be approved.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school will get federal funds; the school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Address: \_\_\_\_\_

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or LatinoRace (Check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Island ☐ White**DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY****Annual Income Conversion (Only convert when multiple income frequencies are reported on application)****Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12**☐ SNAP/TANF/Foster☐ Income Household: Total Household Income/How Often: \_\_\_\_\_ / \_\_\_\_\_ Household Size: \_\_\_\_\_☐ Free Meals ☐ Reduced Price Meals☐ Denied/Paid

Signature of Reviewing Official

Date Notice Sent:

## APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, complete only one application for your household using the instructions below. Sign the application and return the application to Edwards-Knox Central School.

If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help: (315) 562-8130. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

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### PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

- (1) Print the names of the children, including foster children, for whom you are applying on one application.
- (2) List their grade and school.
- (3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

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### PART 2 HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

- (1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
- (2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

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### PART 3 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 4.

- (1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
- (2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.
- (3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
- (4) The application must include the last four digits only of the social security number of the adult who signs **PART 4** if Part 3 is completed. If the adult does not have a social security number, check the box. **If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.**
- (5) An adult household member must sign the application in PART 4.

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**OTHER BENEFITS:** Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

### USE OF INFORMATION STATEMENT

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs.

We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

### DISCRIMINATION COMPLAINTS

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint), (AD-3027) found online at: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint> and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

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

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