

**2016-2017 Student Data Form
Pottsville Elementary School**

K

Date: _____

Social Security# (optional) _____ First Name _____ Middle Name _____ Last Name _____

Sex: (circle) M F Date of Birth: _____ Grade: _____

Previous School: _____

School Address: _____

City, State, Zip: _____

Ethnic Code:		
Black	Asian	Indian
White	Hispanic	

Home Mailing Address _____

Home Physical Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Home Phone: _____ Name / Ages / Grades of Siblings: _____

GUARDIAN / CUSTODIAL INFORMATION

Living With: (Circle One)	A – Alone D - Father/ Stepmother E - Mother / Stepfather	F – Father Only G – Grandparents H – Homeless	I - Institution L – Legal Guardian M – Mother Only	P – Both Parents S – Spouse T – Foster Parents
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Guardian 1

Guardian 2

Code: (Circle One) 1-Both Parents 2-Father 3-Mother 4-Guardian

Code: (Circle One) 1-Both Parents 2-Father 3-Mother 4-Guardian

Name: _____

Name: _____

Address: _____

Address: _____

City,State,Zip: _____

City,State,Zip: _____

Home Phone: _____

Home Phone: _____

Cell Phone: _____

Cell Phone: _____

Employer: _____

Employer: _____

Work Phone: _____

Work Phone: _____

Emergency Contact Person: _____	_____
Name/Relationship to Student	Phone Number
Emergency Contact Person: _____	_____
Name/Relationship to Student	Phone Number
Emergency Contact Person: _____	_____
Name/Relationship to Student	Phone Number

My child has been expelled from school in another school district or is a party to an expulsion proceeding. Yes No

In addition as guardian, my signature indicates that my child is a legal student at Pottsville Elementary because of being (1) _____ a legal transfer, (b) _____ school choice, or (c) _____ a resident of the school district. Any person who knowingly gives a false residential address for purposes of public school enrollment is guilty of a misdemeanor and subject to the appropriate fine.

Parent/Guardian _____ Date: _____

Pottsville Elementary School

Fecha: _____

Seguro Social # _____ Primer nombre _____ Segundo Nombre _____ Apellido (Nombre Pasado) _____

Sexo: (círculo) M F Fecha de nacimiento: _____ Grado: _____

Escuela Anterior: _____

Escuela Dirección: _____

Ciudad, Estado, Código postal: _____

Código Étnico: (círculo uno)		
Negro	Asiático	Indio
Blanco	Hispano	

Dirección caja postal _____

dirección de la casa _____

Ciudad, Estado, Código postal: _____

Ciudad, Estado, Código postal: _____

teléfono casa _____ Nombres/ Edades/ Grados de hermanos: _____

TUTOR/ INFORMACIÓN DE LA CUSTODIA

Viven con:	A - Solamente	F - Padre Solamente	I - Institución	P - Ambos Padres
(ponga un círculo)	D - Padre/ Madrastra	G - Abuelos	L - Tutor Legal	S - Esposo
	E - Madre/ Padrastra	H - Sin Hogar	M - Madre Solamente	T - Padres Adoptivos

Tutor 1

Tutor 2

código: (Círculo Uno) 1-Ambos Padres 2-Padre 3-Madre 4-Tutor

código: (Círculo Uno) 1-Ambos Padres 2-Padre 3-Madre 4-Tutor

Nombre: _____

Nombre: _____

Dirección: _____

Dirección: _____

Ciudad, Estado, Código postal: _____

Ciudad, Estado, Código postal _____

Teléfono Casa: _____

Teléfono Casa: _____

Teléfono De EL Celular: _____

Teléfono De EL Celular: _____

Patrón: _____

Patrón: _____

Teléfono Del Trabajo: _____

Teléfono Del Trabajo: _____

Persona a contactar en caso de emergencia:	Nombre / Relación al estudiante	Número De Teléfono
Persona a contactar en caso de emergencia:	Nombre / Relación al estudiante	Número De Teléfono
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Han expulsado de escuela en otro distrito de la escuela o es un partido a mi niño a un procedimiento de la expulsión. SI? NO

Además como tutor, mi firma indica que mi niño es un estudiante legal en Pottsville elemental debido a ser (1) _____ a la transferencia legal, (opción del b) _____ school, o (c) _____ un residente del distrito de la escuela. Cualquier persona que dé con conocimiento una dirección residencial falsa para los propósitos de la inscripción de la escuela pública es culpable de un delito menor y conforme a la multa apropiada.

Padre / tutor: _____

Fecha: _____

POTTSVILLE SCHOOL DISTRICT
STUDENT MEDICAL INFORMATION
(PLEASE PRINT CLEARLY)

Student's Name _____

S.S. # _____ Birthdate _____ Sex _____ Grade _____

Ethnic Code (Circle One) Asian Black Hispanic Indian White Other _____
Mailing Address _____ City _____ Zip _____

Parent / Guardian _____ Home Phone _____

Father's Work _____ Phone _____ Cell# _____

Mother's Work _____ Phone _____ Cell# _____

Name and ages of all siblings _____

E-Mail Address (Optional) _____

Please list two local people to contact if above cannot be reached:

Name _____

Home Phone _____ Work Phone _____ Cell# _____

Name _____

Home Phone _____ Work Phone _____ Cell# _____

Family Doctor _____ Clinic _____ Phone _____

Does Student Take Any Medication? Yes _____ No _____

If yes, indicate type of medication: _____

Side Effects (if any) _____ Any Drug Allergy _____

***SEE SCHOOL DISTRICT MEDICATION POLICY FOR ANY MEDICATION NEEDED WHILE AT SCHOOL**

(SEE HANDBOOK FOR CURRENT MEDICATION POLICY)

Has a Licensed Professional diagnosed student with ADD/ADHD? Yes _____ No _____

****If Yes, Please provide a copy of evaluation confirming ADD/ADHD****

Does student have any health problems that the teacher and school nurse should know about?
(Diabetes, asthma, epilepsy, hearing problems, allergy to bee or wasp stings, etc.) Yes _____ No _____

If YES, please explain here _____

May this information be shared with staff involved with your child? Yes _____ No _____

Does Student Have An ARKIDS 1st/Medicaid Card? Yes _____ No _____ (#) _____

Can Medicaid information be shared for 3rd party Medicaid billing? Yes _____ No _____
(Billing for Vision and hearing screenings only)

_____ Date

_____ Signature of Parent or Guardian

DISTRITO ESCOLAR POTTSVILLE
INFORMACION MÉDICA DEL ESTUDIANTE

(Escriba claramente)

Nombre del estudiante: _____
Núm. de seguro social: _____ Fecha de Nac. _____ Sexo _____ Grado _____
Código étnico (circular) Asiático Negro Hispano Indígena Blanco Otro _____
Domicilio _____ Ciudad _____ Zona P. _____
Padre/Tutor _____ Tel. de casa _____
Lugar de trabajo del padre _____ Tel. _____ Cel. _____
Lugar de trabajo de la madre _____ Tel. _____ Cel. _____
Nombres y edad de los hermanos (as) _____
Correo electrónico (opcional) _____

Favor de proporcionar dos contactos en caso de no encontrar a los enlistados anteriormente.

Nombre _____ Tel de casa _____
Tel de trabajo _____ Cel. _____
Nombre _____ Tel. de casa _____
Tel. de trabajo _____ Cel. _____
Médico familiar _____ Clínica _____ Tel. _____

¿El estudiante, toma algún medicamento? Sí ___ No ___

¿Qué tipo de medicina? _____
Efectos secundarios: _____ ¿Alergia a alguna medicina? _____

***VER LA POLIZA ESCOLAR DE MEDICAMENTO PARA CUALQUIER MEDICINA
NECESARIA MIENTRAS ESTE EN LA ESCUELA**

(Ver el manual actual para la póliza de medicamento)

¿Algún profesionista certificado ha diagnosticado al estudiante con ADD/ADHD? Sí ___ No ___

**** Si es así, proporcionar una copia de la evaluación que lo confirma****

¿El estudiante padece algún problema de salud del cual el maestro/enfermera deben ser notificados? (diabetes, asma, epilepsia, problemas auditivos, alergia, mordidas de avispa, abejas, etc.)? Sí ___ No ___

Si es ASI favor de explicar _____

¿Puede ser compartida esta información con el personal involucrado con su hijo? Sí ___ No ___

¿Tiene el estudiante cobertura de ARKIDS 1st/Medicaid? YES ___ NO ___ (Núm.) _____

¿Por motivo de facturación a terceros, podemos compartir le información de Medicaid? Sí ___ No ___

Fecha

Firma del padre/tutor

Pottsville Elementary
After-School Student Dismissal Information

3:05 Early Car-Rider

3:10 Parents who need to park in the lot and walk to building to pick up child

3:25 Late Car-rider (Siblings from Middle-School)

3:25 Bus Riders

- As always, the safest method of picking up your child is through the car-rider line. Whoever is picking up your child should have a car-rider tag.
- If you need to park in the lot and walk to the building to pick up your child, you will be issued a "pass" to identify you with your child. Please use the following procedures if you have this need:
 - Please park on the south side of the parking lot (nearest the middle school).
 - Report to the awning nearest the 1st/2nd Grade hallway.
 - Students will be kept inside the hallway and designated personnel will bring your child out.
 - A "pass" will be issued to the person responsible for picking up your child.

- Students with siblings walking from the middle school to the elementary will dismiss at 3:25.
- Anytime your child's pick-up time or method changes please send a note to his/her teacher or call the office (968-2133).

Child's Name: _____

Child's Teacher: _____

Please check one of the following:

My child will dismiss at:

- 3:05 Early Car-Rider***
- 3:10 Parents needing to park and walk to building to pick up child***
- 3:25 Late Car-rider (Siblings from Middle-School)***
- 3:25 Bus Riders***

Bus Number: _____

Parent's Signature: _____

Pottsville Elementary School
Special Information Sheet
(Optional)

Child's Name: _____

Date of Birth: _____

Grade: _____

Dear Parents: In order that we may better serve your child, please answer the following questions.

- | | Yes | No |
|---|-------|-------|
| 1. My child was enrolled in a special program.
Name of program: _____ | _____ | _____ |
| 2. My child was seeing a speech therapist. | _____ | _____ |
| 3. My child needs to wear glasses at school. | _____ | _____ |
| 4. My child has a hearing problem. | _____ | _____ |
| 5. My child takes medication.
Name of medication: _____ | _____ | _____ |
| 6. My child has special needs. | _____ | _____ |
| 7. My child was in a gifted and talented program. | _____ | _____ |
| 8. My child was seeing the school counselor. | _____ | _____ |
| 9. Can child be released to either parent?
(If not, are custody papers on file in your child's records?) | _____ | _____ |

Other Information:

Escuela Primaria de Pottsville
Informacion Especial
(Opcional)

Nombre del Niño(a): _____

Fecha de Nacimiento: _____

Grado: _____

Queridos Padres: Para que podamos ayudarle mejor a su hijo(a), por favor conteste las siguientes preguntas:

	Si	No
1. Mi hijo(a) a estado inscrito en un programa especial. Nombre del Programa: _____	_____	_____
2. Mi hijo(a) estaba visitando a un terapeuta del habla	_____	_____
3. Mi hijo(a) necesita usar lentes en la escuela.	_____	_____
4. Mi hijo(a) tiene problemas auditivos.	_____	_____
5. Mi hijo(a) toma medicina. Nombre de la medicina: _____	_____	_____
6. Mi hijo(a) tiene necesidades especiales.	_____	_____
7. M hijo(a) estaba en un programa de niños dotados y talentosos	_____	_____
8. Mi hijo(a) estaba visitando a la consejera de la escuela	_____	_____
9. Puede el niño(a) ser recogido por cualquiera de los padres? (Si no se puede, estan los papeles de custodia en archivo con los documento del niño(a)?)	_____	_____

Otra Informacion:



HOME STATUS SURVEY

If you (the student) are living with one or both parents in a one family dwelling, please disregard this form.

Complete this form ONLY if:

- student is living with either parent in a multi-family dwelling (more than one family in the home)
- student is living in a motel
- student is living in a shelter
- student is living in sub-standard environment
- student is living with someone other than parent

Child's Name: _____ Age: _____ Sex: _____

Grade: _____ Homeroom Teacher: _____

Parent's Name: _____ Home Phone: _____

Address: _____

Do you live in: (check one)

- | | |
|----------------------|---------------------|
| Apartment _____ | Youth Shelter _____ |
| House _____ | Park/Campsite _____ |
| Vehicle _____ | Mobile Home _____ |
| (Car, camper, bus) | |
| Family Shelter _____ | Other _____ |

Do you live with:

- Parent _____ Friend _____ Aunt/Uncle _____ Foster Parent _____
Sister/Brother _____ Grandparent(s) _____ Other _____

Is the person you live with your legal guardian? Yes _____ No _____

(Parent Signature)

McKinney-Vento Homeless Assistance Act- No Child Left Behind Act of 2001

For office use only:

Secretary file one (1) copy and give one (1) copy to cafeteria supervisor.

(Signature)

POTTSVILLE SCHOOL DISTRICT
HOME STATUS SURVEY

Si usted (el estudiante) está viviendo con un o ambo padres en una vivienda de una familia, desatienda por favor esta forma.

Llene este formulario SOLAMENTE: Si

- El estudiante está viviendo con cualquier padre en una vivienda multifamiliar (más de una familia en el hogar) Student is living in a motel
- El estudiante está viviendo en un casa hogar
- el estudiante está viviendo en el ambiente inferior al nivel normal
- El estudiante está viviendo con alguien con excepción de padre

nombre del niño: _____ Edad: _____ Sexo: _____

Grado: _____ Profesor De tiempo completo: _____

Nombre Del Padre: _____ Teléfono de la casa: _____

dirección: _____

estas viviendo en: (compruebe uno)

Apartamento _____

Casa hogar juvenil _____

Casa _____

parque/ sitio para acampar _____

Vehículo _____
(coche, campista, autobús)

hogar móvil _____

Casa hogar _____

Otro _____

usted vive con:

Padre _____ Amigo _____ Tía/ Tío _____ Padre Adoptivo _____

hermana/ hermano _____ Abuelos _____ Otro _____

¿Vive usted consu guardian legal? Si _____ No _____

(Firma Del Padre)

Acto sin hogar de la ayuda de McKinney - de Vento - ningún niño se fue detrás del acto de 2001

Para el uso de la oficina solamente:

Copia y elasticidad del archivo uno de la secretaria (1) una (1) copia al supervisor de la cafetería..

(Firma)

Pottsville School District
Home Language Survey
(Encuesta de Lenguaje en Casa)

Student's Name _____ School _____
(Nombre de estudiante) (Escuela)

Date of Birth _____ Gender _____ Age _____
(Fecha de Nacimiento) (Genero) (Edad)

Teacher _____ Grade _____
(Maestra/maestro) (Grado)

	English (Inglés)	Spanish (Español)	Other (Otro)
What language is spoken in your home most of the time? (¿Cuál es el idioma que habla más en su casa?)			
What language does the student speak most of the time? (¿Cuál es el idioma que habla más el estudiante?)			
What language do parents/guardians speak to the student most of the time? (¿Cuál es el idioma que le hablan más los padres al estudiante?)			

What services has your child received in previous schools?
(¿Qué servicios ha recibido su hijo/a en su escuela anterior?)

ESL (ELL)
 Gifted & Talented (G.T.)
 Special Education (Educación Especial)
 Speech (Discurso)
 Other (Otro)

What grade did your child first enroll in Arkansas schools? _____
(¿En qué grado se inscribió su hijo cuando llegó a una de la escuela de Arkansas por primera vez?)

What grade did your child first enroll in any U.S. school? _____
(¿En qué grado se inscribió su hijo por primera vez en los estados unidos?)

What written language would you prefer to receive school communications (such as attendance letters, etc.)?
(¿En qué idioma prefiere recibir información escrita por parte de la escuela (tal como cartas de asistencia, etc.)?)

English (Inglés)
 Spanish (Español)
 Other (Otro)

Parent/Guardian's Signature
(Firma del padre/guardián)

Date
(Fecha)



Pottsville Elementary School

87 South B Street

Pottsville, AR 72858

PHONE: (479) 968-2133 FAX: (479) 968-7672

shannon.davis@pottsville.k12.ar.us

Larry Dugger
Superintendent

Shannon Davis
Principal

Dear Parents:

The Arkansas Department of Education has asked the schools to collect information on entering kindergarten students concerning preschool. This information is necessary to provide and collect well-defined pre-school/early childhood data for entering kindergarten students. It will provide the school districts and state with valuable trend data.

My child, _____, has attended a four-year-old Pre-school program for at least 20 hours a week for 9 months.

_____ Arkansas Better Choice (ABC)

_____ Early Childhood Special Education

_____ Even Start

_____ Head Start

_____ Public School Pre-school

_____ Private Pre-school or Other

Thank you for your time in completing this form.



Pottsville Elementary School

87 South B Street
Pottsville, AR 72858

PHONE: (479) 968-2133 FAX: (479) 968-7672
shannon.davis@pottsville.k12.ar.us

Larry Dugger
Superintendent

Shannon Davis
Principal

Estimados Padres:

El Departamento de Arkansas de la Educación ha pedido que las escuelas reuniera información en estudiantes entrantes de jardín de la infancia con respecto a preescolar. Esta información es necesaria para proporcionar y reunir bien definido preescolar/los datos tempranos de niñez para entrar a estudiantes de jardín de la infancia. Proporcionará los distritos de la escuela e indicará con datos valiosos de tendencia.

Mi niño, _____, ha asistido un programa Preescolar de cuatro años para por lo menos 20 horas una semana para 9 meses.

- _____ Arkansas Mejor Elección (ABC)
- _____ La Niñez temprana la Educación Especial
- _____ Empiece aún
- _____ Dirija el Comienzo.
- _____ El público Educa Preescolar
- _____ Privado Preescolar u otro

Gracias para su tiempo a completar esta forma.



AGRICULTURAL QUESTIONNAIRE FORM
Pottsville Public Schools

Your children may qualify for tutoring, books, school supplies, preschool information, high school correspondence courses, college or vocational/technical scholarships, and limited health services.

STUDENT'S NAME _____ GRADE _____ DATE _____

PARENT'S NAME (S) _____

PHONE # _____ MESSAGE/CELL PHONE # _____

STREET NAME _____ HOUSE OR APT. # _____

CITY/STATE _____ ZIP CODE _____

Has your family moved across a school district line within the past three years to look for or do any of the following types of jobs?

YES _____ NO _____

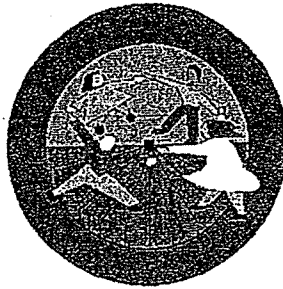
- FOOD PROCESSING--(Chicken, turkey, beef, hog, vegetables, fruits)
- FARM WORK - (Cattle, Dairy, Chicken, Hog, Fruits, Vegetables, Sod, Plant Nursery)
- CHICKEN CATCHING, CHICKEN VACCINATING
- HARVESTING TREES -(Planting, marking, girdling, cutting, skidding)
- SOD FARMING
- WORKING WITH BEES
- WORKING ON A FISH FARM, FISHING FOR AN INCOME
- WORKING AT A COTTON GIN OR GRANARY

When is the best time to contact you to determine if your children qualify for these free services? _____

PLEASE RETURN THIS QUESTIONNAIRE TO SCHOOL TOMORROW.

Thank you!

PLEASE INCLUDE THIS
FORM IN ENROLLMENT
PACKETS.



Cuestionario de Empleo para Agricultura Escuela Públicas de Pottsville

SUS NIÑOS PUDEN CALIFICAR PARA CLASES PRIVADAS, LIBROS, UTILES ESCOLARES, PAQUETES PREESCOLARES, CURSOS POR CORRESPONDENCIA de PREPARATORIA, las BECAS PARA el COLEGIO O VO-TECNOLOGIA, Y SERVICIOS DE SALUD LIMITADOS.

NOMBRE de ESTUDIANTE _____ GRADO _____ FECHA _____

NOMBRE de PADRE (S) _____

TELEFONO # _____ MENSAJE/NUMERO de CEL _____

NOMBRE del CALLE _____ NUMERO de CASA O APARTEMENTO _____

CIUDAD/ESTADO _____ CODIGO POSTAL _____

¿HA MUDADO CON SU FAMILIA A TRAVES DE la LINEA del DISTRITO de la ESCUELA DENTRO de LOS PASADOS TRES AÑOS a BUSCAR O TRABAJAR EN CUALQUIERA de LOS TRABAJOS SIGUIENTES?

SI _____

NO _____

- PROCESAMIENTO DE POLLO/PAVO
- AGADANDO POLLO, o VACUNAR POLLO
- AGRICULTURA/AVECULTURA
(Por ejemplo: ganado, Lechería, Pollo, Frutas, Verduras, El césped)
- CORTAR O PLANTAR ARBOLES (Plantar, marcando, cortando)
- TRABAJAR CON ABEJAS
- COSECHAR FRUTA O VERDURAS
- PUDIENDO FRUTO O VERDURAS
- TRABAJAR EN UN GRANERO
- TRABAJAR EN UNA PISCIFACTOÍA, PESCANDO POR DINERO.
- LIMPIADORA DE ALGODÓN

POR FAVOR VUELVA ESTE SOLICITUD A LA ESCUELA MAÑANA.

GRACIAS!



POTTSVILLE KINDERGARTEN REGISTRATION INFORMATION

Child's Full Name _____ S.S.# _____

Child's Birthday: Month _____ Day _____ Year _____ Age _____

911 Address _____

Mailing Address _____

Phone # _____

Parents: Mother _____ Occupation _____ Work phone _____

Father _____ Occupation _____ Work phone _____

Address of parents if different from the address listed above _____

Names of other siblings and ages of each: _____

Person (s) to notify in case of an emergency _____

Phone # _____

Day Care or Preschool Experience: (List the names of the facilities and the teachers if possible)

How long did your child attend the day care or preschool? _____

How many people are living in your child's household? _____ Is someone other

than the parents the primary caregiver of the child? _____ If so, who? _____

Will your child ride the bus, or be a car rider? _____

RECEPCIÓN
INFORMACIÓN DEL REGISTRO DEL JARDÍN DE LA INFANCIA DE POTTSVILLE

Nombre Completo Del Niño: _____ SS# _____

Cumpleaños Del Niño: Mes: _____ día _____ año _____ edad _____

911 dirección: _____

Dirección Que envía: _____

telefono #: _____

Padres: Madre _____ ocupación _____ teléfono del trabajo : _____

Padre _____ ocupación _____ teléfono del trabajo: _____

La dirección de padres si es diferente de la dirección enumeró arriba: _____

Nombres de otros hermanos y edades de cada uno: _____

Person(s) a notificar en caso de que de la emergencia: _____

_____ telefono # _____

Cuidado del día o experiencia del pre-entrenamiento: (enumere los nombres de las instalaciones y de los profesores si es posible)

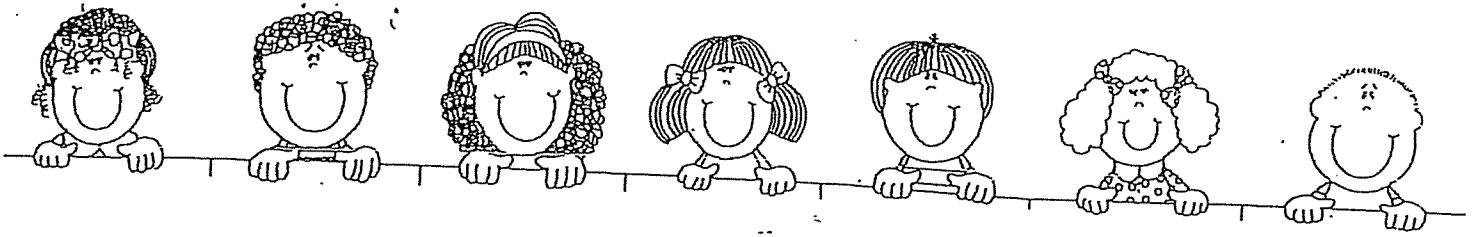
Cuánto tiempo hizo a su niño atiende al cuidado o al pre-entrenamiento del día? _____

Cuánta gente está viviendo en la casa de su niño? _____

¿Es alguien con excepción de los padres el caregiver primario del niño? _____

Si es así ¿quién?

Voluntad su paseo del niño el autobús, ¿o sea un jinete del coche?



List any persons who will be responsible for picking up your child from school.

Please check any of the following that apply to your child.

Is your child able to:

_____ recognize basic shapes (circle, square, triangle, etc...)

_____ write his/her first name

_____ recognize his/her first name

_____ count to 5

_____ say or sing the alphabet

_____ tie his/her shoes

_____ dress him/herself (snap buttons, close zippers, etc...)

_____ use the restroom alone

_____ sit while a story is being read

Child's pediatrician or doctor _____

Clinic _____ Address or phone _____

Does your child have any medical or special conditions or needs? _____ If so, please explain. _____

Is your child currently on any type of medication? _____ If so, please list the medications and the reason for taking this medication. _____

Enumere a cualquier persona que sea responsable de escoger encima de su niño de la escuela:

Compruebe por favor cualquiera del siguiente que aplíquese a su niño:

Es su niño capaz a:

_____ reconozca las formas básicas (círculo, cuadrado, triángulo, etc.)

_____ escriba el suyo su nombre

_____ escriba el suyo su nombre

_____ cuenta a 5

_____ diga o cante el alfabeto

_____ atar suella zapatos

_____ vístalo/ ella misma

_____ utilice el restroom solo

_____ siéntese mientras que se está leyendo una historia

Pediatra o doctor del niño _____

Clínica _____ Dirección o teléfono _____

¿Su niño tiene condiciones o necesidades médicas o especiales? _____ Si es así explique por favor

¿Está su niño actualmente en tipo de medicación? _____ Si es así enumere por favor las medicaciones y la razón de tomar esta medicación.



Has your child been on any medication in the past year? If so what medication and what was the medication used for? _____

Does your child easily run fever or have headaches? _____

Has your child ever had any type of seizure? _____ Does your child presently have seizures? If so, please explain. _____

Does your child have any known allergies or asthma? _____

Does your child take any medication or treatments for allergies or asthma? _____

Does your child have nosebleeds? _____

Does your child have any vision or hearing problems? _____

Does your child wear glasses or hearing aids? _____

Has your child previously seen an eye doctor? _____

What was your child's weight at birth? _____

Was your child's birth normal? Were there any complications during the pregnancy?

Has your child been in the hospital since birth? If so, please explain _____

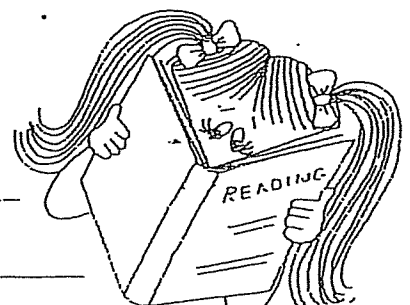
Have you noticed any speech problems or mispronunciations in your child's spoken language? If so, please explain: _____

At what approximate age did your child:

walk _____ talk _____ sit up _____

Does your child sleep through the night? _____

What is your child's bedtime? _____



¿Su niño ha estado en medicación en el último año? ¿Si tan qué medicación y para cuál eran la medicación usada? _____

¿Su niño funciona fácilmente fiebre o tiene dolores de cabeza? _____

¿Su niño ha tenido siempre tipo de asimiento? _____ ¿Actualmente tiene su niño los ataques? Si eso es el caso, explica por favor.

¿Hace sus de niño ha sabido cualquiera alergias o asma? _____

¿Toma su niño cualquier medicina o los tratamientos para alergias o asma? _____

¿Tiene su niño las hemorragias nasales? _____

¿Tiene su niño cualquier visión o los problemas de oído? _____

¿Lleva su niño gafas o audífonos? _____

¿Ha visto previamente su niño a un oculista? _____

¿Qué era su peso de niño al nacer? _____

¿Era su nacimiento del niño normal? ¿Había cualquier complicación durante el embarazo?

¿Ha estado su niño en el hospital desde que el nacimiento? Si eso es el caso, explica por favor

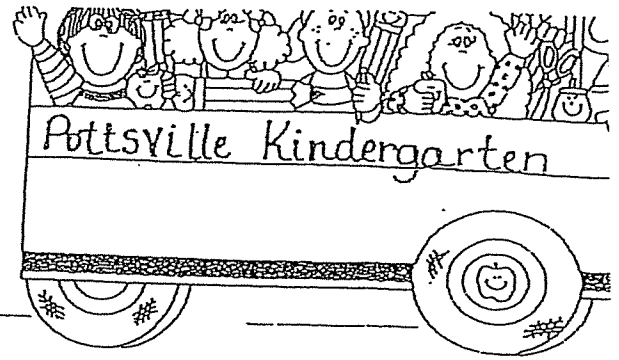
¿Ha advertido usted que cualquier problemas de discurso o malas pronunciaciones en su niño ha hablado el idioma? Si eso es el caso, explica por favor:

En lo que se aproxima la edad hizo a su niño:

Caminata _____ discurso _____ incorpórese _____

¿Duerme su niño por la noche? _____

¿Qué es su hora de acostarse de niño? _____



Does your child take naps? _____

Is your child toilet trained? If not, please explain. _____

Who is the disciplinarian in the home? (e.g. both parents, mother, father, etc...) _____

What methods of discipline are used in the home? _____

Please explain the types of discipline you feel are effective with your child _____

Does your child respect and obey authority? (teachers, parents, adults, etc...) _____

Does your child ever throw temper tantrums? If so, please explain. _____

Does your child pout or cry when he/she does not get his/her way? _____

Does your child ever show aggression toward other children or adults? (e.g. hitting, biting, pinching, or cursing) If so, please explain. _____

Has your child previously spent any length of time away from home? _____

Does your child become upset easily when separated from parents or familiar surroundings? _____

Does your child have any specific worries or fears? _____

¿Toma su niño las siestas? _____

¿Se entrena su lavabo del niño? Si no, explique por favor _____

¿Quién es el ordenancista en el hogar? (Por ejemplo. ambos crían, la madre, el padre, etc..)

¿Qué métodos de la disciplina se utilizan en el hogar? _____

Explique por favor los tipos de la disciplina que usted se siente son efectivos con su niño

Hace su respeto de niño y obedece la autoridad (maestros, los padres, los adultos, etc. ¿)?

¿Tira jamás su niño el genio las rabetas? Si eso es el caso, explica por favor:

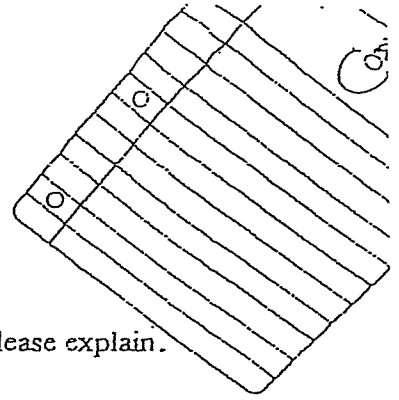
¿Dice haciendo pucheros su niño o llora cuando él/ella no obtiene su manera? _____

¿Hace su reprendió jamás agresión de exposición hacia otros niños o adultos? ¿ (Golpeando, morder, pellizcar, o maldiciendo)? Si eso es el caso, explica por favor; _____

¿Ha gastado previamente su niño cualquier plazo de tiempo lejos de casa? _____

¿Llega a ser su niño trastornó fácilmente cuando separado de padres o alrededores familiares?

¿Tiene su niño alguna preocupación o los temores específicos? _____



Does your child have duties or responsibilities in the home? If so, please explain.

How often is your child read to? (e.g., nightly, weekly, other)

Does your child enjoy playing with others or does your child prefer to play alone?

What is your child's favorite food?

What is your child's favorite T.V. program?

What is your child's favorite toy?

Does your child have a pet?

Does your child have any specific foods that he/she dislikes or cannot eat?

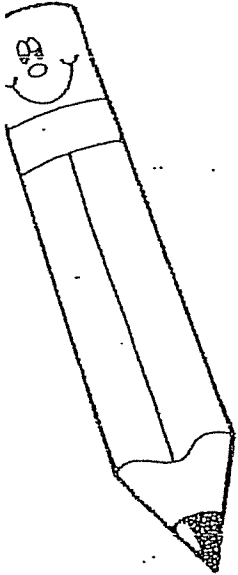
Is there a specific place or restaurant that your child enjoys visiting?

Does your child or your family have any hobbies or interests?

What are some favorite games or activities that your child enjoys doing?

What are some of the best things your child can do?

List something special you really like about your child.



¿Tiene su niño los deberes o responsabilidades en el hogar? Si eso es el caso, explica por favor.

¿Con qué frecuencia es su niño leyó a? (por ejemplo. noche, semanal, otro) _____

¿Goza su niño jugar con otros o prefiere su niño para jugar sólo?

¿Qué es su alimento favorito de niño? _____

¿Qué es su programa de televisión favorito de niño? _____

¿Qué es su juguete favorito de niño? _____

¿Tiene su niño un animal favorito? _____

¿Tiene su niño ningún alimento específico que él/ella tiene aversión a ni no puede comer?

¿Hay un lugar o el restaurante específicos que su niño goza visitar? _____

¿Tienen su niño o su familia cualquier pasatiempo o los intereses? _____

¿Qué es algunos juegos o las actividades favoritos que su niño goza hacer? _____

¿Qué es parte de las mejores cosas que su niño puede hacer? _____

Liste algo especial usted quiere realmente acerca de su niño. _____

ARKANSAS DEPARTMENT OF EDUCATION
HEALTH HISTORY

Developed By A Committee of the Arkansas Health Care Access Council

NOTE: To be completed by the parent/guardian of the Kindergarten student prior to the physical examination/nursing assessment (please print).

Student Name (Last, First, Middle)	Birth Date (MO/DAY/YR) / /	School	Medicaid Number
			Physician

Parent/Guardian Name (Male)	Phone	Parent/Guardian (Female)	Phone
-----------------------------	-------	--------------------------	-------

Physician Name/Address (if no regular physician, write "NONE") Phone

Dentist Name/Address (if no regular dentist, write "NONE") Phone

Other source(s) from which the student receives health care (if none, write "NONE")

Name /address of private health insurance carrier with number

To be completed by the parent/guardian (please circle one):

1. Does your child pay attention when being read to? Yes No
2. Can your child play quietly alone for over ½ hour? Yes No
3. Does your child mind adults and follow instructions? Yes No
4. Does your child speak clearly enough for others to understand? Yes No
5. Does your child have any speech problems (stammering, delayed speech development, etc.)? Yes No
6. Does your child object to being left with a sitter? Yes No
7. Can your child dress without help? Yes No
8. Does your child ever wet or soil him/herself? Yes No

ARKANSAS DEPARTMENT OF EDUCATION
HEALTH HISTORY

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NOTE: To be completed by the parent/guardian of the Kindergarten student prior to the physical examination/nursing assessment (please print).

Student Name (Last, First, Middle)	Birth Date (MO/DAY/YR) / /	School	Medicaid Number
			Physician

Parent/Guardian Name (Male)	Phone	Parent/Guardian (Female)	Phone
-----------------------------	-------	--------------------------	-------

Physician Name/Address (if no regular physician, write "NONE")	Phone
--	-------

Dentist Name/Address (if no regular dentist, write "NONE")	Phone
--	-------

Other source(s) from which the student receives health care (if none, write "NONE")

Name /address of private health insurance carrier with number

To be completed by the parent/guardian (please circle one):

1. Does your child pay attention when being read to? Yes No
2. Can your child play quietly alone for over ½ hour? Yes No
3. Does your child mind adults and follow instructions? Yes No
4. Does your child speak clearly enough for others to understand? Yes No
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6. Does your child object to being left with a sitter? Yes No
7. Can your child dress without help? Yes No
8. Does your child ever wet or soil him/herself? Yes No

9. Do you have any concerns about your child's general health
(eating and sleeping habits, bowel/bladder, posture, teeth,
skin, weight, etc.)? Yes No
10. Does your child have any ear/hearing problems (frequent earaches,
difficulty hearing, draining ears, uses a hearing aid, etc.)? Yes No
11. Does your child have any eye problems (difficulty seeing,
crossed eyes, watery/red eyes, contact lenses)? Yes No
12. Does your child have any allergies (food, drugs, pollens, etc.)? Yes No
13. Does your child have any specific sickness which might in your
opinion affect his school performance or program? Yes No
- (a) Has your child received any medical or other evaluation, the
findings of which could help school personnel in meeting
his/her health or educational needs? Yes No
- (b) Does this problem require any health care in school? Yes No
- (c) Does your child take any medication? Yes No
14. Do you have any concerns about your child's developmental behavior
or emotional well-being that the school should be aware of? Yes No

If you answered YES to any of the preceding questions, please describe your concern below.

Question Number	Description

Information on this form may be shared with appropriate personnel for health and educational purposes.

Parent's Signature _____ Date _____

9. Usted tiene cualquier preocupación por su salud general de los child?s (que come y los hábitos dormir, intestínovejiga, postura, dientes, piel, peso, etc.)? Sí No
10. Hace a su niño tienen cualquier oídroproblemas de la audiencia (earaches frecuentes, audiencia de la dificultad, drenaje de los oídos, utiliza una prótesis de oído, etc.)? Sí No
11. Hace a su niño tienen cualquier problema del ojo (dificultad que ve, ojos cruzados, acuoso ojos rojos, lentes de contacto)? Sí No
12. Hace a su niño tienen cualquier alergia (alimento, drogas, pollens, etc.)? Sí No
13. Hace a su niño tienen cualquier enfermedad específica que pudiera en su opinión afectar su funcionamiento o programa de la escuela? Sí No
- a) Tiene su niño recibió cualquier evaluación médica u otra, los resultados de los cuales podría ayudar a personal de la escuela en resolver el suyosu salud o necesidades educativas?
 Sí No
- b) Hace este problema requieren cualquier cuidado médico en escuela? Sí No
- c) Hace su toma del niño cualquier medicación? Sí No
14. Usted tiene cualquier preocupación por el comportamiento de desarrollo o el bienestar emocional de su niño que la escuela debe estar enterada de? Yes No

Si usted contestó SÍ a cualesquiera de las preguntas precedentes, describa por favor su reocupación abajo.

Número de la pregunta	descripción

La información sobre esta forma se puede compartir con el personal apropiado para la salud y los propósitos educativos.

Firma Del Padre: _____ fecha: _____

Health History

Please check the following problems/disease your child has or has had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Red Measles | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> 3 day German Measles | <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Seizures | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Low Blood Anemia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Sickle Cell Trait |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> High Blood | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Yellow Jaundice/
Hepatitis | <input type="checkbox"/> Pressure | <input type="checkbox"/> Rheumatic Heart
Disease |
| <input type="checkbox"/> VD (venereal disease) | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Sugar Diabetes | <input type="checkbox"/> Other Lung Disease |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Disabled |
| | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Severe Reaction to
Immunizations |

Does the child's mother (M), child's father (F), child's grandparent (GP), or child's brother/sister (S) have any of the following? (Put the correct letter in blank. For example, an M by Heart Disease means that the child's mother has heart disease.)

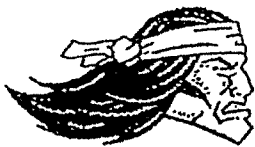
- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sugar Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Deafness | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Steroid Use |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Sickle Cell Trait | <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Retardation | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Vision Problems | |

Compruebe por favor los problemas siguientes/ enfermedad que su niño tiene o que ha tenido:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pox Del Pollo | <input type="checkbox"/> escarlatina | <input type="checkbox"/> infección del oído |
| <input type="checkbox"/> sarampión rojo | <input type="checkbox"/> fiebre reumática | <input type="checkbox"/> tonsilitis |
| <input type="checkbox"/> sarampión alemán de 3 días | <input type="checkbox"/> alergias | <input type="checkbox"/> depresión |
| <input type="checkbox"/> papéras | <input type="checkbox"/> asma | <input type="checkbox"/> droga/ abuso de alcohol |
| <input type="checkbox"/> tos ferina | <input type="checkbox"/> asimientos | <input type="checkbox"/> pulmonía |
| <input type="checkbox"/> anemia baja de la sangre | <input type="checkbox"/> estreñimiento | <input type="checkbox"/> enfermedad del riñón |
| <input type="checkbox"/> sangría anormal | <input type="checkbox"/> diarrea | <input type="checkbox"/> rasgo de la célula de la hoz |
| <input type="checkbox"/> enfermedad del hígado | <input type="checkbox"/> tensión arterial alta | <input type="checkbox"/> enfermedad de la célula de la hoz |
| <input type="checkbox"/> ictericia amarilla/ hepatitis | <input type="checkbox"/> úlceras del estómago | <input type="checkbox"/> enfermedad cardíaca reumática |
| <input type="checkbox"/> VD (enfermedad venérea) | <input type="checkbox"/> diabetes del azúcar | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> fiebre del heno | <input type="checkbox"/> la otra enfermedad de la pulmón |
| <input type="checkbox"/> cáncer/ tumor | <input type="checkbox"/> problemas del ojo | <input type="checkbox"/> lisiado |
| | | <input type="checkbox"/> reacción severa a las inmunizaciones |

Hace a madre de su niño (m), padre del niño (f), abuelo del niño (GP), o hermano del niño ¿la hermana (s) tiene cualquiera del siguiente? (puesto la letra correcta en el espacio en blanco. Por ejemplo, un M por enfermedad cardíaca significa que la madre del niño tiene enfermedad cardíaca)

- | | | |
|---|---|---|
| <input type="checkbox"/> enfermedad cardíaca | <input type="checkbox"/> diabetes del azúcar | <input type="checkbox"/> artritis |
| <input type="checkbox"/> tensión arterial alta | <input type="checkbox"/> precio | <input type="checkbox"/> bocio |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> enfermedad mental | <input type="checkbox"/> uso esteroide |
| <input type="checkbox"/> cáncer | <input type="checkbox"/> rasgo de la célula de la hoz | <input type="checkbox"/> abuso de alcohol de la droga |
| <input type="checkbox"/> defectos de nacimiento | <input type="checkbox"/> célula de la hoz | <input type="checkbox"/> otro (especifique) |
| <input type="checkbox"/> enfermedad del riñón | <input type="checkbox"/> asimientos | |
| <input type="checkbox"/> alergias | <input type="checkbox"/> retraso | |
| <input type="checkbox"/> asma | <input type="checkbox"/> problemas de la visión | |



Pottsville Elementary School

87 South B Street

Pottsville, AR 72858

PHONE: (479) 968-2133 FAX: (479) 968-7672

shannon.davis@pottsville.k12.ar.us

Larry Dugger
Superintendent

Shannon Davis
Principal

Dear Parent or Guardian:

Pottsville Elementary School receives federal funds for Title I, Part A programs. Throughout the school year, we will be providing you with important information about this law and your child's education. This letter lets you know about your right to request information about the qualifications of the classroom staff working with your child.

Parents have the right to request information regarding the professional qualifications of the classroom teachers(s) who instructs your child. If you request this information, the district or school will provide you with the following information in a timely manner:

1. Whether your child's teacher has met the state requirements for licensure and certification for the grade level and subject in which the teacher is providing instruction;
2. Whether the teacher is teaching under emergency or other provisional status for which state licensing requirements have been waived;
3. The college degree majors and any other graduate certification or degree held by the teacher, and the fields of discipline of the certification or degree; and
4. Whether your child is provided services by a paraprofessional, and if so, his or her qualifications.

If you would like to request this information, please contact me by phone at 968-2133 or by e-mail at shannon.davis@pottsville.k12.ar.us.

If at any time your student has been taught for four (4) or more consecutive weeks by a teacher(s) that is not highly qualified, you will be notified by the school of this information.

Should you have any other questions regarding your child's education, please don't hesitate to call me at the number below.

Respectfully,

Shannon Davis
Pottsville Elementary School Principal
479-968-2133

Escuela Primaria Pottsville

87 South B Street
Pottsville, AR 72858

Teléfono: (479) 968-2133 FAX: (479) 968-7672

Shannon.davis@pottsvilleschools.org

Larry Dugger
Superintendente

Shannon Davis
Director

Estimados padres/tutores:

La escuela primaria Pottsville recibe fondos federales para los programas Parte A, Título 1. Durante el año escolar, le estaremos dando información importante de esta ley y de la educación de su hijo. Esta carta es para hacer de su conocimiento que Ud. Tiene el derecho de pedir informes acerca de las calificaciones del personal que trabaja con su hijo en su aula escolar.

Los padres tienen el derecho de pedir informes referentes a las calificaciones profesionales de las maestras que instruyen a su hijo. Si Ud. Pide esta información, el distrito o la escuela le proveerán la siguiente información de manera oportuna.

1. Si el maestro de su hijo ha cumplido con los requisitos estatales u otro status provisional para su licenciatura y certificación para el nivel de grado y materia en las cuales el maestro imparte su enseñanza.
2. Si el maestro esta enseñando bajo un status de emergencia o provisiona por lo cual los requisitos del estado para la licencia han sido cedidos.
3. Los títulos universitarios con especialidades y cualquier otra certificación o titulo que el maestro posea, y el ámbito de disciplinario de la certificación o titulo; y
4. Si su hijo está recibiendo servicios a través de un paraprofesional (asistente de maestro), y si así fuera, se le mostraran sus aptitudes.

Sí, a Ud. le gustaría obtener esta información, por favor comuníquese conmigo al Tel. # 968-2133 o vía correo electrónico: shannon.davis@pottsvilleschools.org

Sí, en cualquier momento su hijo ha recibido instrucción por cuatro (4) semanas o más, a través de un maestro(s) que no esté altamente calificado, Ud. será notificado por la escuela sobre este caso.

Sí, tiene alguna inquietud sobre la educación de su hijo(a), no dude en llamar.

Respetuosamente,

Shannon Davis
Director del plantel
479 968-2133

FREQUENTLY ASKED QUESTIONS ABOUT FREE AND REDUCED PRICE SCHOOL MEALS

Dear Parent/Guardian:

Children need healthy meals to learn. Pottsville School District offers healthy meals every school day. Breakfast costs 1.10; lunch costs 1.85/K-3 2.10/4-12. 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) 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.

2. H
C
W

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

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 Pottsville School District

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: Kathy Cynova 87 So B Street Pottsville AR 72858.
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. If any children in your household were missing from your eligibility notification, contact Kathy Cynova 479-968-8625 or Kathy.cynova@pottsvilleschools.org immediately.

5. CAN I APPLY ONLINE? NO We are not currently taking On-Line applications
6. 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.
7. 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.
8. WILL THE INFORMATION I GIVE BE CHECKED? Yes. We may also ask you to send written proof of the household income you report.
9. 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.
10. 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: Larry Dugger 479-968-8101 or larry.dugger@pottsvilleschools.org
11. 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.
12. 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.
13. 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.
14. 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, or receive Family Subsistence Supplemental Allowance payments, 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.
15. 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 Kathy Cynova 479-968-8625 to receive a second application.
16. MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR? To find out how to apply for Supplemental Nutrition Assistance Program (SNAP) or other assistance benefits, contact your local assistance office or call [State hotline number].

If you have other questions or need help, call 479-968-8625.

Sincerely,

Kathy Cynova

HOW TO APPLY FOR FREE AND REDUCED PRICE SCHOOL MEALS

Please use these instructions to help you fill out the application for free and reduced price school meals. You only need to submit one application per household, even if your children attend more than one school in [School District]. The application must be filled out completely to certify your children for free or reduced price school meals.

Please follow these instructions in order! Each step of the instructions is the same as the steps on your application. If at any time you are not sure what to do next, please contact Pottsville Schools 479-968-8625 or Kathy.cynova@pottsvilleschools.org

PLEASE USE A PEN (NOT A PENCIL) WHEN FILLING OUT THE APPLICATION AND DO YOUR BEST TO PRINT CLEARLY.

STEP 1: LIST ALL HOUSEHOLD MEMBERS WHO ARE INFANTS, CHILDREN, AND STUDENTS UP TO AND INCLUDING GRADE 12

Tell us how many infants, children, and school students live in your household. They do NOT have to be related to you to be a part of your household.

Who should I list here?

When filling out this section, please include all members in your household who are:

- Children age 18 or under and are supported with the household's income;
- In your care under a foster arrangement, or qualify as homeless, migrant, or runaway youth;
- Students attending Pottsville Schools], *regardless of age.*

A) *List each child's name.* For each child, print their first name, middle initial and last name. Use one line of the application for each child. When printing names, write one letter in each box. Stop if you run out of space. If there are more children present than lines on the application, attach a second piece of paper with all required information for the additional children.

B) *Is the child a student at Pottsville Schools?* Mark 'Yes' or 'No' under the column titled "Student" to tell us which children attend Pottsville Schools. Include the name of the school and the grade for each child that is a student at the school district.

C) *Do you have any foster children?* If any children listed are foster children, mark the "Foster Child" box next to the child's name. Foster children who live with you may count as members of your household and should be listed on your application. If you are *only* applying for foster children, after completing STEP 1, skip to STEP 4 of the application and these instructions.

D) *Are any children homeless, migrant, or runaway?* If you believe any child listed in this section may meet this description, please mark the "Homeless, Migrant, Runaway" box next to the child's name and complete all steps of the application.

STEP 2: DO ANY HOUSEHOLD MEMBERS (INCLUDING YOU) CURRENTLY PARTICIPATE IN THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)?

If anyone in your household participates in the Supplemental Nutrition Assistance Program (SNAP), your children are eligible for free school meals.

- A) IF NO ONE IN YOUR HOUSEHOLD PARTICIPATES IN Supplemental Nutrition Assistance Program (SNAP):
- Circle 'NO' and skip to STEP 3 on these instructions and STEP 3 on your application.
 - Leave STEP 2 blank.
- B) IF ANYONE IN YOUR HOUSEHOLD PARTICIPATES IN Supplemental Nutrition Assistance Program (SNAP):
- Circle 'YES' and provide a SNAP case number or SNAP Identifier Number. You only need to write one case number or identifier. If you participate in this program and do not know your case number or identifier number, contact: Dept of Human Services 479-968-5596]. You must provide a case number or identifier on your application if you circled "YES".
 - THIS IS NOT THE SIXTEEN (16) DIGIT EBT CARD NUMBER
 - Skip to STEP 4

STEP 3: REPORT INCOME FOR ALL HOUSEHOLD MEMBERS

A) **CHILD INCOME:** Report all income earned by children. Refer to the chart titled "Sources of Income for Children" in these instructions and report the combined gross income for ALL children listed in Step 1 in your household in the box marked "Total Child Income." Only count foster children's income if you are applying for them together with the rest of your household. It is optional for the household to list foster children living with them as part of the household.

What is Child Income?

Child income is money received from outside your household that is paid directly to your children. Many households do not have any child income. Use the chart below to determine if your household has child income to report.

Sources of Income for Children

Sources of Child Income	Example(s)
<ul style="list-style-type: none">Earnings from work	<ul style="list-style-type: none">A child has a job where they earn a salary or wages.
<ul style="list-style-type: none">Social Security<ul style="list-style-type: none">Disability PaymentsSurvivor's Benefits	<ul style="list-style-type: none">A child is blind or disabled and receives Social Security benefits.A parent is disabled, retired, or deceased, and their child receives social security benefits.
<ul style="list-style-type: none">Income from persons <i>outside</i> the household	<ul style="list-style-type: none">A friend or extended family member <i>regularly</i> gives a child spending money.
<ul style="list-style-type: none">Income from any other source	<ul style="list-style-type: none">A child receives income from a private pension fund, annuity, or trust.

B) FOR EACH ADULT HOUSEHOLD MEMBER:

Who should I list here?

When filling out this section, please include all members in your household who are:

- Living with you and share income and expenses, *even if not related and even if they do not receive income of their own.*

Do not include people who:

- Live with you but are not supported by your household's income and do not contribute income to your household.
- Children and students already listed in Step 1

How do I fill in the income amount and source?

FOR EACH TYPE OF INCOME:

- Use the charts in this section to determine if your household has income to report.
- Report all amounts in gross income ONLY. Report all income in whole dollars. Do not include cents.
 - Gross income is the total income received before taxes or deductions.
 - Many people think of income as the amount they "take home" and not the total, "gross" amount. Make sure that the income you report on this application has NOT been reduced to pay for taxes, insurance premiums, or any other amounts taken from your pay.
- Write a "0" in any fields where there is no income to report. Any income fields left empty or blank will be counted as zeroes. If you write '0' or leave any fields blank, you are certifying (promising) that there is no income to report. If local officials have known or available information that your household income was reported incorrectly, your application will be verified for cause.

- List Adult Household member's name.** Print the name of each household member in the boxes marked "Names of Adult Household Members (First and Last)." Do not list any household members you listed in STEP 1. If a child listed in STEP 1 has income, follow the instructions in STEP 3, part A.
- Report earnings from work.** Refer to the chart titled "Sources of Income for Adults" in these instructions and report all income from work in the "Earnings from Work" field on the application. This is usually the money received from working at jobs. If you are a self-employed business or farm owner, you will report your net income.

What if I am self-employed?

If you are self-employed, report income from that work as a net amount. This is calculated by subtracting the total operating expenses of your business from its gross receipts or revenue.

- *Report income from Public Assistance/Child Support/Alimony.* Refer to the chart titled "Sources of Income for Adults" in these instructions and report all income that applies in the "Public Assistance/Child Support/Alimony" field on the application. Do not report the value of any cash value public assistance benefits NOT listed on the chart. If income is received from child support or alimony, only court-ordered payments should be reported here. Informal but regular payments should be reported as "other" income in the next part.
- *Report income from Pensions/Retirement/All other income.* Refer to the chart titled "Sources of Income for Adults" in these instructions and report all income that applies in the "Pensions/Retirement/All Other Income" field on the application.
- *Report total household size.* Enter the total number of household members in the field "Total Household Members (Children and Adults)." This number MUST be equal to the number of household members listed in STEP 1 and STEP 3. If there are any members of your household that you have not listed on the application, go back and add them. It is very important to list all household members, as the size of your household determines your income cutoff for free and reduced price meals.
- *Provide the last four digits of your Social Security Number.* The household's primary wage earner or another adult household member must enter the last four digits of their Social Security Number in the space provided. You are eligible to apply for benefits even if you do not have a Social Security Number. If no adult household members have a Social Security Number, leave this space blank and mark the box to the right labeled "Check if no SS#."

Sources of Income for Adults

Earnings from Work	Public Assistance/Alimony/ Child Support	Pensions/Retirement/ All Other Income
<ul style="list-style-type: none"> • Salary, wages, cash bonuses • Net income from self-employment (farm or business) • Strike benefits <p>If you are in the U.S. Military:</p> <ul style="list-style-type: none"> • Basic pay and cash bonuses (<i>do NOT include combat pay, FSSA or privatized housing allowances</i>) • Allowances for off-base housing, food, and clothing 	<ul style="list-style-type: none"> • Unemployment benefits • Worker's compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veteran's benefits 	<ul style="list-style-type: none"> • Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

STEP 4: CONTACT INFORMATION AND ADULT SIGNATURE

All applications must be signed by an adult member of the household. By signing the application, that household member is promising that all information has been truthfully and completely reported. Before completing this section, please also make sure you have read the privacy and civil rights statements on the back of the application.

A) *Provide your contact information.* Write your current address in the fields provided if this information is available. If you have no permanent address, this does not make your children ineligible for free or reduced price school meals. Sharing a phone number, email address, or both is optional, but helps us reach you quickly if we need to contact you.

B) *Sign and print your name.* Print your name in the box "Printed name of adult completing the form." And sign your name in the box "Signature of adult completing the form."

C) *Write Today's Date.* In the space provided, write today's date in the box.

D) *Share children's Racial and Ethnic Identities (optional).* On the back of the application, we ask you to share information about your children's race and ethnicity. This field is optional and does not affect your children's eligibility for free or reduced price school meals.

2016-2017 Application for Free and Reduced Price School Meals

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

STEP 1

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.

Names of ALL Children (First, Middle Initial, Last)	School	Grade	Student		Foster Child	Homeless, Migrant, Runaway
			Yes	No		
			<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"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check all that apply

STEP 2

If you answered NO > Complete STEP 3. If you answered YES > Write a SNAP case number or identifier here then go to STEP 4 (Do not complete STEP 3)

Case Number or Identifier:

Write only one case number or identifier in this space (this is NOT the 16-digit EBT card number)

STEP 3

A. Child Income

Sometimes Children in the household earn income. Please include the TOTAL income earned by all Household members who are infants, children, and students listed in STEP 1 here.

Total Child(ren) Income	How Often?	
	Weekly	Monthly
\$	<input type="radio"/>	<input type="radio"/>

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

Name of Adult Household Members (First and Last)	Earnings from work	How Often?		Public Assistance/Child Support/Alimony	How Often?		Pension/Retirement/ Other Income	How Often?	
		Weekly	Monthly		Weekly	Monthly		Weekly	Monthly
	\$	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>
	\$	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>
	\$	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>
	\$	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<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

Please read How to Apply for Free and Reduced Price School Meals for more information. The Sources of Income for Children section will help you with the Child Income question. The Sources of Income for Adults section will help you with the All Adult Household Members Section

STEP 4

I certify (promise) that all information on the 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)	City	State	Zip
Daytime Phone and Email (optional)			

OPTIONAL **Complains Regarding Eligibility**

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) case number or other SNAP identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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

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

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

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

This institution is an equal opportunity provider.

Disclosure (Optional)
 I do not want school officials to share information from my free and reduced price meal application with Medicaid or the State Children's Health Insurance Program (ArKids 1st).

School use only

Total Income: _____

Per: Week Every 2 Weeks Twice a Month Month Year

Household Size: _____ SNAP: _____ Categorically Eligible: _____ Date Withdrawn: _____

Eligibility: Free Reduced Denied

Reason for denial: _____

Determining Official's Signature: _____ Determination Date: _____

Annual Income Conversion: show calculations

Weekly _____ X 52= _____

2x/month _____ X 24= _____

Every 2 wks _____ X 26= _____

Monthly _____ X 12= _____

Annual _____ X 1= _____