



# Student Application Form

Hamza Academy

## Contact Details

POSTAL ADDRESS  
202 Stuart Avenue Valley  
Stream, New York 11580  
United States

TELEPHONE  
+516 285 1440  
EMAIL  
[administration@hamzaacademy.com](mailto:administration@hamzaacademy.com) WEBSITE  
[www.hamzaacademy.com](http://www.hamzaacademy.com)



# Welcome to Hamza Academy Admission Program

For detailed information about our courses and schools, please visit the Hamza Academy website:  
[www.hamzaacademy.com](http://www.hamzaacademy.com)

Alhumdullah, registration for our students currently enrolled in Nursery - 2nd grade is now open for 2019-2020 school year.

Please note that there will be a few changes/updates to the school board and school leadership for the 2019-2020 school year. This may alter a few of our programs. However, our vision and mission will remain the same and we will continue to provide quality education to our students in the hopes of cultivating Muslim identities. We will work together with the school leadership to accomplish our goals and create a welcoming and safe Islamic environment for our students, staff and community.

The registration/resource fee is \$300 per student and MUST be paid upon registration. **Queens Residents** will be required to pay an additional \$150.00 for Book Fees.

The tuition for 2019-2020 will be \$5,250 yearly for all grades. Siblings a lump sum discount will be applied, please check the attached tuition schedule for 2019-2020.

*Classroom sizing will be as follows:*

- Pre-K - Max number of students 20
- Kindergarten - Max number of students 20
- 1st Grade - Max number of students 15
- 2nd grade - Max number of students 20
- 3rd grade - Max number of student 8

## Registration Checklist

Below are the list of documents that must be submitted in order to re-register:

- ✓ Re-Registration Form
- ✓ 1 Recent Passport-Size photo of your child
- ✓ Updated Immunization Form
- ✓ Updated Physical Form
- ✓ Proof of Address ( ONLY if the address has changed since last registration )
- ✓ Registration/Resource Fee
- ✓ Original Birth Certificate - As Requested By District Registration Guidelines

*\* Certified copies of original documents are required. Documents that are not in English must be accompanied by accredited English translations.*

Complete this form electronically - save it to your computer and complete using Adobe Reader (free download available at - [get.adobe.com/reader](http://get.adobe.com/reader)); or you can print and complete the paper form. Note: If you complete this form using the 'Preview' application on an Apple Macintosh (Mac), you should save the file as a new PDF through the print menu (Select File -> Print -> PDF -> Save as PDF) to avoid compatibility issues.

## SECTION A – HAMZA ACADEMY POLICIES TUITION

*Please select a payment plan*

<i>Tuition Amount Annually</i>	PLAN 1 (Discount 5%)	PLAN 2 (Discount 2%)	PLAN 3
\$5,250- 1 Child \$10,130 - 2 Siblings \$14,600 - 3 Siblings	\$4,988 - 1 Child \$9,626 - 2 Siblings \$ 13,866 - 3 Siblings	\$5,146 - 1 Child \$9,930 - 2 Siblings \$14,304 - 3 Siblings	\$5,250 - 1 Child \$10,130 - 2 Siblings \$14,600 - 3 Siblings
<b><i>Payment Due On 8/31/19</i></b>	\$4,988 - 1 Child \$9,626 - 2 Siblings \$ 13,866 - 3 Siblings	\$2,573 - 1 Child \$4,965 - 2 Siblings \$7,152 - 3 Siblings	\$525 - 1 Child \$1,013 - 2 Siblings \$ 1,460 - 3 Siblings
<b><i>9/25/19</i></b>			\$525 - 1 Child \$1,013 - 2 Siblings \$ 1,460 - 3 Siblings
<b><i>10/30/19</i></b>			\$525 - 1 Child \$1,013 - 2 Siblings \$ 1,460 - 3 Siblings
<b><i>11/27/19</i></b>			\$525 - 1 Child \$1,013 - 2 Siblings \$ 1,460 - 3 Siblings
<b><i>12/18/19</i></b>			\$525 - 1 Child \$1,013 - 2 Siblings \$ 1,460 - 3 Siblings
<b><i>1/29/20</i></b>		\$2,573 - 1 Child \$4,965 - 2 Siblings \$7,152 - 3 Siblings	\$525 - 1 Child \$1,013 - 2 Siblings \$ 1,460 - 3 Siblings
<b><i>2/26/20</i></b>			\$525 - 1 Child \$1,013 - 2 Siblings \$ 1,460 - 3 Siblings
<b><i>3/25/20</i></b>			\$525 - 1 Child \$1,013 - 2 Siblings \$ 1,460 - 3 Siblings
<b><i>4/29/20</i></b>			\$525 - 1 Child \$1,013 - 2 Siblings \$ 1,460 - 3 Siblings
<b><i>5/27/19</i></b>			\$525 - 1 Child \$1,013 - 2 Siblings \$ 1,460 - 3 Siblings

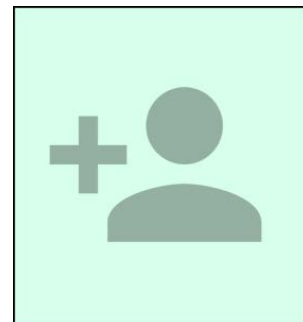
PAYMENTS DUE DATES SUBJECT TO CHANGE\*\*\*

# SECTION A: REGISTRATION RENEWAL FORM FOR CURRENT STUDENTS



## STUDENT INFORMATION 2019-2020

Please paste student photo



Last Name:	First Name:	Middle Name:
Date of Birth:	City, Country of Birth:	Ethnicity :

<input type="checkbox"/> Check if Hamza Academy has the most updated home address, if not please provide it below with proof of address (2 utility bills)		
Home Address:	City, State, Zip Code :	Home School District:

<input type="checkbox"/> Check if Hamza Academy has the most updated family contact information, if not please provide below	
Mother's Phone Number:	Father's Phone Number:
Mother's Email:	Father's Email:
Student lives with (Please circle one): Both Parents / Mother / Father / Foster Parents / Other Relative	
<b>Please note: If you would like to add/remove a person to the pick-up list and/or emergency contact list, please visit the main office</b>	

Name of Current Doctor/Clinic:	Phone:
Allergies:	
Any Medical Issues:	Medication(s):
Any Behavioral Issues :	Special Considerations:
Latest Vision Test Date:	Latest Dental Check Date:
<b>Please note: Hamza Academy staff is not permitted to administer daily medications to students</b>	

FOR OFFICE USE ONLY	
Date Entered Hamza Academy:	Current Grade To Be Enrolled:
Date Application Submitted:	Accepted / Not Accepted (Please circle one)
School Director Signature:	



## SECTIONB – HAMZA ACADEMY POLICIES CONTRACT

- I understand that I will familiarize myself with school rules and policies and require my child to follow them at all times.
- I understand that I am responsible for the enrollment fees during the time of registration which are refundable if my child is not accepted.
- I understand that I am responsible for paying each month's tuition on time. I understand that I have to fulfill all financial agreements, including the daily \$10 service fee for overdue tuition. I understand that If I plan to go away for a month (or more) during the school year, I am still responsible for the remaining balance. My child may need to be discharged and re-enrolled upon our return. I understand that this may impact my child's academic standing.
- I understand that, per our family handbook, my child/ren will be discharged from the school, if 2 payments are missed for the upcoming school year.
- I understand that Hamza Academy reserves the right to discharge a student at any time (due to safety, behavioral, academic reasons or non-payment of fees). Hamza Academy reserves the right to request parents to enroll in a special needs student at another facility, in order for the student to receive professional special needs services that Hamza Academy cannot provide. Hamza Academy reserves the right for academic/behavioral or other screening of any student. If further evaluation is recommended, the school district and/or parents will be notified.
- I understand that If I must follow the school parking lot policy during school hours. This includes not blocking the exit points during the school drop off or pick up timings and no loitering, waiting, or socializing during the parking lot/ playground during school hours.
- I understand that parents and students must abide by all school rules and regulations (e.g. uniform, I.D., etc.). The school reserves the right to fail any student who do not meet school standards.
- I understand that tuition is non refundable or transferable for any reason such as suspensions, expulsions, or school closings. In order to re-register, all previous accounts must be paid in full. Parents who withdraw their children anytime during the school year are responsible for ONE MONTH tuition due to our penalty withdrawal policy. Upon withdrawal from the school, all payments must be paid in cash or money order (no checks). School transcripts/records and all official letters will be held until all accounts are paid in full.
- I understand that my child's enrollment status and/or student records may be affected if 1) tuition and fees are not fulfilled by the given deadlines or 2) a school policy is broken, pending the decision of the School Director and Board. Fees are subject to change and you will be notified of any changes. I understand that returned/bounced checks due to "insufficient funds" will incur a fee of a minimum of \$25 per check. Parents are responsible for paying for any lost/stolen textbooks. Parents are entitled to all workbooks. I understand that I give the school authorization for immediate medical care, in the event that my child needs Immediate emergency attention.
- I understand that students must be picked up by dismissal time. They will only be released to their parents or an authorized person on the pick-up list. Students left by parents/guardians in the school building before/after school hours will not be the responsibility of the school. Students who are picked up after dismissal time will be charged a late pick-up fee of \$25.00 daily.
- I understand that if deemed necessary by school personnel, I authorize Hamza Academy to initiate any evaluations through the School District office relating to my child's needs. I understand that initiating this process may result in services being provided in order to meet my child's needs. I will be informed prior to any actions taken regarding my child.
- I understand that my child may participate in interviews, the use of quotes, photographs, movies, and/or videos that may be published in print and/or electronically. Hamza Academy may use photographs of my child and his/her name for any lawful purposes, including publicity, school newsletter, school website, school brochure, school advertising, school web content, etc. I also hereby release Hamza Academy and its school's representatives and employees from all claims, demands, and liabilities whatsoever in connection with the above. (Parents may file written "do not photograph/do not record" statement with main office in the form of a letter)

## SECTION B (Contd) – HAMZA ACADEMY POLICIES CONTRACT

- I Understand that Hamza Academy cannot be held accountable for any liability resulting from student participation in any physical activities provided by Hamza Academy including but not limited to gym, except in the case of its sole and gross negligence, for damages because of bodily injury, including death at any time resulting therefrom, sustained by any child or by any person or persons, or on account of damage to property arising out of such participation. Parents may file written “non-participation” statement from the student’s doctor detailing temporary or permanent physical limitations due to a medical condition with school office.
- I understand that my child’s attendance at Hamza Academy is very important. We are concerned about the academic growth of your child. Hamza Academy is mandated by as well as compliance with New York State Law to monitor and report attendance. If your child is going to be absent, we ask that you call our school to notify us BEFORE 9:00 AM, and also provide the reason. If we do not hear from you, an office staff from Hamza Academy will call you. Additionally, according to New York State mandates, if your child has frequent absences in a week, you are required to provide a medical note from your child’s primary physician. I understand that I am required to provide documentation from my child’s primary physician for three consecutive days or more that my child has not been present at school. I understand that a notice of extended leave of absence form must be completed prior to traveling time and tuition installments must be fulfilled prior to leave.
- I understand that students are expected to attend school all day, and every day that school is in session. Parents are asked to cooperate with this expectation and not ask to have children leave before regular dismissal time (2:45
- m.) Interruptions to the school day should be avoided. I understand that I should schedule any medical and dental appointments after school hours, so learning time is not disrupted.
- I understand that I will update the school with any changes with the information provided on the application.
- I understand that by registering and maintaining enrollment, parents and students agree to abide by all school policies, terms, and conditions until the child is enrolled in the school.
- Hamza Academy cannot be held accountable for any liability resulting from student participation in field trips, except in the case of its sole and gross negligence, for damages because of bodily injury, including death at any time resulting therefrom, sustained by any child or by any person or persons, or on account of damage to property arising out of such participation. A permission slip must be signed by parents for every trip separately.

***By signing below, I understand all of Hamza Academy terms and policies stipulated in the Family Handbook, which can be found Online, and stated on the previous page and above.***

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

Parent/Guardian Signature: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION C – RECORDS RELEASE AGREEMENT

Under the Family and Education Rights and Privacy Act (FERPA), schools have the right to disclose information records, without consent, to the following parties or under the following conditions (34 CFR § 99.31):

- School officials with legitimate educational interest;
- Other schools to which a student is transferring;
- Specified officials for audit or evaluation purposes;
- Appropriate parties in connection with financial aid to a student;
- Organizations conducting certain studies for or on behalf of the school;
- Accrediting organizations;
- To comply with a judicial order or lawfully issued subpoena;
- Appropriate officials in cases of health and safety emergencies; and
- State and local authorities, within a juvenile justice system, pursuant to specific State law.

I hereby authorize Hamza Academy to release any student records as necessary.

I also hereby authorize Hamza Academy to obtain all \_\_\_\_\_'s

student records from: \_\_\_\_\_

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

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

## SECTION D – CUSTODY REQUIREMENTS

If you are legally separated or divorced, the law requires you to provide Hamza Academy with a copy of the child custody order or decree indicating full or joint (shared) custody and indicate the residential parent for school purposes. These papers must be court stamped and include the signature page. Also, whenever there is a modification of the order or decrees, the custodial parent/guardian shall provide the school with a copy of the updated order of decree that makes the modification. The order should be included with this form.

- ☐ I am the child's legal guardian.
- ☐ I have legal full or joint (shared) custody of the child as assigned by the courts.
- ☐ I do not have full or joint (shared) custody of the child as assigned by the courts. Please explain:

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

Parent/Guardian Signature: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Date: \_\_\_\_\_





**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.*

**Please write clearly when completing this section.**

**STUDENT NAME:**

First Middle Last

**DATE OF BIRTH:**

Month Day Year

**GENDER:**

☐ Male  
☐ Female

**PARENT/PERSON IN PARENTAL RELATION INFO:**

Last Name First Name Relation to Student

HOME LANGUAGE CODE

### 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	_____ specify <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not write

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

**SCHOOL DISTRICT INFORMATION:**

District Name (Number) & School

Address

**STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:**

## Home Language Questionnaire (HLQ)—Page Two

### Educational History

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\*    No    Not sure

☐    ☐    ☐    \*If yes, please explain: \_\_\_\_\_

How severe do you think these difficulties are?    ☐ Minor    ☐ Somewhat severe    ☐ Very severe

10a. Has your child ever been referred for a special education evaluation in the past?    ☐ No    ☐ Yes\* \*Please complete 10b below

10b. \*If referred for an evaluation, has your child ever received any special education services in the past?

☐ No    ☐ Yes – Type of services received: \_\_\_\_\_

Age at which services received (Please check all that apply):

☐ Birth to 3 years (Early Intervention)    ☐ 3 to 5 years (Special Education)    ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)?    ☐ No    ☐ 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? \_\_\_\_\_

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

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_  
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:    ☐ No    ☐ Yes

\*\*DATE OF INDIVIDUAL  
INTERVIEW:

MO. DAY YR.

OUTCOME OF  
INDIVIDUAL  
INTERVIEW:

☐ ADMINISTER NYSITELL  
☐ ENGLISH PROFICIENT  
☐ REFER TO LANGUAGE PROFICIENCY TEAM

### NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

DATE OF NYSITELL  
ADMINISTRATION:

MO. DAY YR.

PROFICIENCY LEVEL  
ACHIEVED ON  
NYSITELL:

☐ ENTERING    ☐ EMERGING    ☐ TRANSITIONING    ☐ EXPANDING    ☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

2018-2019 Household Application for Free and Reduced Price School Meals

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

STEP 1

List ALL infants, children, and students up to and including grade 12 who are Household Members

If more spaces are required for additional names, attach another sheet of paper.

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Child's First Name	MI	Child's Last Name	Grade	School the child attends or NA if not in school	Foster Child	Homeless, Migrant, Runaway	Head Start
					<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"/>

STEP 2

Do any Household Members (including you) currently participate in any of the following assistance programs: FoodShare, W-2 Cash Benefits, or FDPIR?

☐ Yes / ☐ No

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

Case Number

Program Name (Required)

Write only one case number in this space.

Medicaid & Badger Care does not qualify

STEP 3

Report Income for ALL Household Members (skip this step if you answered 'Yes' to STEP 2)

Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income

Sometimes children in the household earn income. Please include the TOTAL income earned by all infants, children and students up to and including grade 12 listed in STEP 1 here.

Child income

How often?

Weekly

Bi-Weekly

2x Month

Monthly

\$

B. All Adult Household Members (including yourself)

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

Name of Adult Household Members (First and Last Name)	C. Earnings from Work	D. Public Assistance/ Child Support/ Alimony/SSI/VA Benefit	E. Pensions/Retirement/ Social Security, Other Income	F. Seasonal Workers, and others with fluctuating income, project the annual income and report here.
	<div>Earnings from Work</div> <div>How often?</div> <div>Weekly</div> <div>Bi-Weekly</div> <div>2x Month</div> <div>Monthly</div> <div>\$</div> <div></div> <div></div> <div></div> <div></div>	<div>Public Assistance/ Child Support/ Alimony/SSI/VA Benefit</div> <div>How often?</div> <div>Weekly</div> <div>Bi-Weekly</div> <div>2x Month</div> <div>Monthly</div> <div>\$</div> <div></div> <div></div> <div></div> <div></div>	<div>Pensions/Retirement/ Social Security, Other Income</div> <div>How often?</div> <div>Weekly</div> <div>Bi-Weekly</div> <div>2x Month</div> <div>Monthly</div> <div>\$</div> <div></div> <div></div> <div></div> <div></div>	<div>Seasonal Workers, and others with fluctuating income, project the annual income and report here.</div> <div>How often?</div> <div>Weekly</div> <div>Bi-Weekly</div> <div>2x Month</div> <div>Monthly</div> <div>\$</div> <div></div> <div></div> <div></div> <div></div>
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G. Total Household Members (Children and Adults)—REQUIRED

H. Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member—REQUIRED or check box if no SSN

X

X

X

X

X

Check box if no SSN

☐

STEP 4

Contact information and adult signature

Return completed form to your school.

Insert your school district mailing address here

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Street Address (if available)

Apt #

City

State

Zip

Daytime Phone and Email (optional)

Printed Name OR Signature of Adult Completing this Application—REQUIRED

Today's Date Mo./Day/Yr.

## INSTRUCTIONS

## Source of Income

## Sources of Income for Children

Sources of Child Income	Example(s)
- Gross earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability payments - Survivor's benefits	- 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
- Income from person outside the household	- A friend or extended family member regularly gives a child spending money
- Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

## Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	Pensions / Retirement / All Other Income
<ul style="list-style-type: none"> <li>Gross salary, wages, cash bonuses</li> <li>Net income from self-employment (farm or business); <b>FARM</b>—refer to line 18 of the 1040 or line 34 from Schedule F; <b>BUSINESS</b>—refer to line 12 of 1040 or line 31 from Schedule C.</li> <li>If you are in the U.S. Military:</li> <li>Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances)</li> <li>Allowances for off-base housing, food and clothing</li> </ul>	<ul style="list-style-type: none"> <li>Unemployment benefits</li> <li>Worker's compensation</li> <li>Supplemental Security Income (SSI)</li> <li>Cash assistance from State or local government</li> <li>Alimony payments</li> <li>Child support payments</li> <li>Veteran's benefits</li> <li>Strike benefits</li> </ul>	<ul style="list-style-type: none"> <li>Social Security (including railroad retirement and black lung benefits)</li> <li>Private pensions or disability benefits</li> <li>Regular income from trusts or estates</li> <li>Annuities</li> <li>Investment income</li> <li>Earned interest</li> <li>Rental income</li> <li>Regular cash payments from outside household</li> </ul>

## OPTIONAL

## Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity *Check one*

☐

Hispanic or Latino

☐

Not Hispanic or Latino

Race *Check one or more*

☐

American Indian or Alaskan Native

☐

Asian

☐

Black or African American

☐

Native Hawaiian or Other Pacific Islander

☐

White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity 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](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

Mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW Washington, D.C. 20250-9410

Fax: (202) 690-7442; or

Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

**The above address is for discrimination complaint purposes only.  
Please return this complete application to your school, not to USDA.**

## Do not fill out

## For School Use Only

Annual Income Conversion: Weekly x 52, Bi-weekly (Every 2 Weeks) x 26, Twice a Month x 24, Monthly x 12

Total Income	How often?					Household Size	Categorical Eligibility	Eligibility			Date Denied	Reason for Denial or Withdrawal
	Weekly	Bi-Weekly	2x Month	Monthly	Yearly			Free	Reduced	Denied		
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	
Determining Official's Signature	Date Mo./Day/Yr.		Confirming Official's Signature		Date Mo./Day/Yr.		Verifying Official's Signature		Date Mo./Day/Yr.			
<input type="text"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>			
			Required for Verification process only						Required for Verification process only			

**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: _____

☐ **System Review and Exam Entirely Normal****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				
Vision	Right	Left	Referral	Notes
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				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis <small>Required for boys grade 9</small>	Negative	Positive	Referral	
<small>And girls grades 5 &amp; 7</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:	Trunk Rotation Angle:			
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<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:				Date:
Provider Name: <i>(please print)</i>				Stamp:
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				