School Use Only:
LASID
SASID
Bus#
Bus Stop:
Times:

Plateau Valley School District 50
56600 Highway 330
Collbran, CO 81624
970-487-3547
970-487-3150 Fax

Date: _____

Please print and fill in all information.

Section 1: Student Information

Last Name	**First Name**	**Middle Name**

Grade	**Gender M__ F__**	Has student attended a public U.S. school continuously for more than 3 full academic years? Yes___ No____

Currently Enrolled in Online School? _____Yes _____No	Currently being Homeschooled? _____Yes ____No	Are you a Refugee? _____Yes _____No

Resident Address	Temporary Housing Yes__ No__	City	State	Zip	Phone

Mailing Address (If different) Parent Email:

Date of Birth	**Social Security #**
Birth State	**Birth Country**
Preferred Name: (Please Print)	

Race/Ethnicity: You must answer both parts of the following questions.

Part A:

Do you consider yourself to be of Hispanic/Latino origin?
_____Yes _____No

Part B: Which of the following groups describe your race? (you may select more than one)

___1=American Indian or Alaska Native
___ 2=Asian
___ 3=Black or African American
___ 5=White
___ 6=Native Hawaiian or Other Pacific Islander

Is this student subject to a court order regarding school attendance, custody or a major decision making agreement? Yes_____ No _____
Please complete the attached custody statement.

Section 2: Parent /Guardian Information

1. Parent/Guardian Name Relationship	2. Parent/Guardian Name Relationship
Address Phone Cell	Address Phone Cell
Employer Work Phone	Employer Work Phone

List names of brothers, sisters and other school age children living in this home:

If student does not live with parent/guardian, student lives with: Name _____
Phone Address Relationship

Who makes major educational decisions for student?
Both Parents____ Mother____ Father____ Guardian____ Other____(Specify)

Section 3: Emergency Information if parent/guardian cannot be reached, please contact:

1. Last Name	First Name	Phone Home Work Cell	Relationship to Student
2. Last Name	First Name	Phone Home Work Cell	Relationship to Student

Section 4: Medical: A Health History Form must be filled out each school year (Form in Registration Packet)

Section 5: Previous School Information

Has student ever attended any Plateau Valley School or Preschool? ____Yes ____ No
Last School Attended? City/State
Has this student ever received special education services? Yes____ No____

Section 6: Home Language Survey **Mark only those that apply to your family (Please don't include languages you've learned in school)**

1. What was the first language spoken by the student?	English ____	Spanish ____	Other
2. Identify all languages spoken in the home	English ____	Spanish ____	Other
3. List all languages understood by student	English ____	Spanish ____	Other
4. Language spoken in the home by student	English ____	Spanish ____	Other

5. Has your child ever been enrolled in an English as a Second Language Program? No _____ Yes _____
6. Do you require district information translated in a language other than English? No ____ Yes____ If yes, what language?

I request the school to notify me in case of an emergency or serious illness. If I am unable to be reached, I grant permission for the school to contact appropriate emergency agency/facility.

Parent / Guardian Signature:_____ _____ _____Date_____

Pre-Enrollment Disclosure

Please complete if transferring from another school

Student Name:_____ Grade:_____ Age_____

Address:_____ City:_____ State:_____Zip:_____

State the reason(s) student has decided to enroll at this school:_____
_____

Last school attended: _____ City:_____ State: _____ Zip:_____

Dates of last attendance: ___/___/___ to ___/___/___ Cumulative number of credits earned:_____

Has student ever been retained? Yes___No___ What grade and school? _____
Has student attended Preschool, Daycare, or a Headstart program? Yes___No___Specify:_____
_____
Circle the number of days absent at previous school: (Current year) 5-10 10-15 15 or more
Reason_____
Does student require special education, related services or other accommodations in order to participate in or receive reasonable benefit from school programs or activities? Yes___No___ If "Yes", was there and individualized education plan (IEP), Section 504 accommodation plan, or individualized literacy plan (ILP) in place at his/her last school? Please specify:_____
_____

In order to maintain discipline, order, and safety, we require the following questions be answered.

Has student ever been suspended from school? Yes___No___ If yes, list date, school, and reason for each suspension:_____
Has student ever been expelled from school? Yes___No___ If yes, list date, school, and reason for each expulsion:_____
Has student ever been cited for or charged with a violation of the law (exclude minor traffic offenses)? Yes___No___ If yes, list date, location, and nature of each citation or charge:_____
_____
Has student ever been adjudicated or convicted by a court of committing any act that, if committed by and adult, would have constituted a felony or misdemeanor crime? Yes___No___ If yes, list date, place, and nature of each, including name and location of court:_____
_____
Has student ever received a deferred prosecution, deferred judgment or diversion to a juvenile justice program with a case before a juvenile or municipal court? Yes___No___ If yes, list date, place, and nature of each, including name and location of the court:_____
_____
Name of probation officer:_____

All information stated above is accurate to the best of my knowledge.

Student Signature:_____ Parent Signature:_____

Enrollment Approval: Yes___No___ _____
Administrator Signature Date

Plateau Valley School District 50

56600 Hwy 330 Collbran, CO 81624-9776
(970) 487-3547 (970) 487-3150 Fax

Today's Educational Opportunity for Tomorrow's World

Date:_____

NAME AND ADDRESS OF SCHOOL PREVIOUSLY ATTENDED:

_____ PHONE:_____

_____ FAX: _____

_____

NAME OF STUDENT: _____

GRADE: _____ DATE OF BIRTH:_____ SOCIAL SECURITY #: _____

Dear Registrar:

Please fax the following information for the above named student who has transferred into our district:

Colorado SASID Number
Official transcript of credits and grades
Health records – Complete immunization record
Attendance record
Behavior/Conduct Reports
Standardized Test Results
Special Education Records, Including IEP (If Applicable)
All other pertinent information

Please forward all records to: Machelle Williams, Registrar
Fax: 970-487-3150 or email: mwilliams@pvsd50.org

Mrs. Joanna Gibbs – Counselor
Mr. LeRoy Gutierrez – Principal

I hereby give my permission for release of the above requested records/information.

_____ _____
Signature of Parent/Guardian Date

CUSTODY STATEMENT

Name Student Uses: _____
Last First Middle

Name as shown on birth certificate: _____
(Attach copy of birth certificate) Last First Middle

Who has legal custody or major decision making responsibility:
Mother_____ Father_____ Both _____ Other _____

Does a current legal custody agreement exist? Yes_____ No _____
If yes, please attach a copy of the agreement.

Who does the student live with during the school year:
Mother _____ Father _____ Other _____

Attendance, grades, etc., may be released to the following persons, if requested:
Mother _____ Father _____ Other _____

If both parents share joint decision-making regarding educational decisions and are unable to reach an agreement for the child, or in the absence of parent authorization, the school will make a decision based on the best interest of the child. Under the Privacy Act of 1974, parents are entitled to copies of their child's records, unless the courts have terminated their rights or the District has received a court restraining order specifically requesting we not release student records to the requesting parent.

PLEASE NOTE: If possible, both parents **must sign** this statement indicating they agree with the above information. If there is only one signature, the District requires an explanation as to why there is only one signature.

Parent Signature: _____ Parent Signature: _____

Date: _____ Date: _____

If only one signature, please explain why:

_____

_____

_____

_____

Migrant Education Program

Attn: Molly Greenlee, Coordinator 596 North Westgate Dr. Grand Junction, CO

Student Name: _____

School: _____

Telephone: _____

Does your family qualify for services?
Please answer 'yes' or 'no' to the following questions.

1.) Did your child move and change school districts in the last 18 months? _____

2.) Was the purpose of the move to obtain work in temporary/seasonal ***agriculture (farming, ranching, fishing, dairy, etc.?)*** _____

3.) Was the work an important part of providing a living for the worker and his or her family?

_____

Please return the form to school staff. Questions? Call 970-254-5495

¿Califica su familia para los servicios del programa?
Favor de contestar las siguientes preguntas, con 'sí' o 'no'.

1.) ¿Dentro de los últimos 18 meses, su niño se mudó y cambió de un distrito escolar a otro? _____

2.) ¿Fue el propósito del cambio para obtener trabajo temporal en la **agricultura (cosecha, ranchos, pesca, lechería, etc?)** _____

3.) ¿Fue el trabajo una parte importante para proveer económicamente a la familia?

Por favor, devuelva este formulario al personal de la escuela.

¿Preguntas en español? Llame al 970-254-5495.

RULES & REGULATIONS GOVERNING STUDENTS IN PLATEAU VALLEY SCHOOL DISTRICT 50 VEHICLES:

BEFORE LOADING:

1. Students must be at their designated bus stops five minutes prior to their pick-up time to ensure adherence to the bus schedule.
2. Students must stay off the roadway at all times while waiting for the bus to arrive.
3. Students must conduct themselves in a safe manner (no pushing, shoving, or horseplay) while waiting for the bus.
4. Students must show respect for all property at or near the designated bus stops.
5. All students are encouraged to stay off of private property.
6. Students must wait until the bus comes to a complete stop before attempting to get on the bus and be careful when approaching the bus.
7. Students must go directly to the bus after school to avoid being left at school. For safety reasons, the bus cannot stop to board students once the bus has started to move.

WHILE ON THE BUS:

1. The bus driver is in charge of the students and the bus. Students must obey the driver's instructions promptly and explicitly.
2. No "horseplay" is permitted in or around the bus.
3. Classroom conduct is to be observed at all times by the students riding the bus.
4. Students must not try to get off the bus or move around while the bus is in motion.
5. Students are not allowed to extend arms or heads out of the bus windows or throw objects of any kind from the bus.
6. NO SKATEBOARDS, ROLLERBLADES, SCOOTERS OR SMALL TOYS are allowed.
7. Glass or heavy metal objects are prohibited. Lunch boxes are acceptable.
8. Animals of any kind are prohibited.
9. Eating and drinking on the bus is at the discretion of the bus driver.
10. Damage to a bus caused by a student must be paid for by the student.
11. Failure to follow these regulations may result in the suspension of bus riding privileges.
12. No profanity or harassment is allowed at any time.

EXTRA-CURRICULAR TRIPS

1. All rules and regulations apply to any trip under school sponsorship.
2. Students shall respect the wishes of a competent chaperone appointed by the school.

AFTER LEAVING THE BUS:

1. Students will cross the road when necessary at least 10 feet in front of the bus only after looking to make sure no traffic is approaching from either direction and upon the OK signal of the driver.
2. Students are asked to help look after the safety and comfort of younger children.
3. Students must be alert to any danger signal from the driver.
4. The driver will not discharge students at places other than the regular bus stop or at school without prior written and approved consent by the parent(s) and the school.

MISCONDUCT NOTICES:

FIRST NOTICE – Students must return all required copies, signed by a parent/guardian, to the bus driver or the student may not be permitted to ride the bus again.
SECOND NOTICE – A parent/guardian must call the transportation director's office at 487-3549 extension 271 in addition to the procedures required on the First Notice.
THIRD NOTICE – The student is automatically suspended from school transportation for a minimum of 5 (five) school days until a meeting can be arranged with the following in attendance: The school principal, a parent/guardian, the student, and the transportation director.
FOURTH NOTICE – The student is automatically suspended for up to 60 (sixty) school days. At the end of this period and upon the request of the parent/guardian, a decision by the school officials and the contractor may be made to determine if transportation may be resumed.

THE FOLLOWING WILL BE CONSIDERED AN AUTOMATIC THIRD NOTICE:

1. The use or possession of any and all tobacco products, drugs, or alcohol.
2. The use or possession of matches and/or lighters.
3. The use or possession of laser pointers in or around school buses.

THE FOLLOWING WILL BE CONSIDERED AN AUTOMATIC FOURTH NOTICE:
Exiting through an emergency exit door without authorization or fighting/assault. The sheriff may be notified and charges may be filed with the District Attorney.

THE FOLLOWING OFFENSE MAY RESULT IN A MINIMUM OF A ONE CALENDAR YEAR SUSPENSION OF BUS RIDING PRIVILEGES:
Possession of any and all explosive devices and/or the possession of any dangerous weapons.

AUTOMATIC ADVANCES IN MISCONDUCT NOTICES MAY BE GIVEN BY SCHOOL OFFICIALS FOR ANY MISCONDUCT, MISBEHAVIOR, OR DANGEROUS OFFENSE.

Parent Signature: _____

Date: _____

Student Name(s): _____

Route# and times: _____

Administering Medications to Students

School personnel shall not administer prescription or nonprescription medications to students unless appropriate administration cannot reasonably be accomplished outside of school hours and the student's parent/guardian is not available to administer the medication during the school day.

Medication may be administered to students by school personnel whom a registered nurse has trained and delegated the task of administering such medication. For purposes of this policy, the term "medication" includes both prescription medication and nonprescription medication. The term "nonprescription medication" includes but is not limited to over-the-counter medications, homeopathic and herbal medications, vitamins and nutritional supplements. Medication may be administered to students by the school nurse or other school designee only when the following requirements are met:

1. Medication shall be in the original properly labeled container. If it is a prescription medication, the student's name, name of the medication, dosage, how often it is to be administered, and name of the prescribing health care practitioner shall be printed on the container.

2. The school shall have received written permission to administer the medication from the student's health care practitioner with prescriptive authority under Colorado law.

3. The school shall have received written permission from the student's parent/guardian to administer the medication to the student.

4. The parent/guardian shall be responsible for providing all medication to be administered to the student.

5. Students are prohibited from possessing or self-administering medical marijuana on school grounds or any school-sponsored event. C.R.S. 22-1-119.3(3)(c).

Self-Administration of Medication for Asthma, Allergies or Anaphylaxis

A student with asthma, a food allergy, other severe allergies, or a related life-threatening condition may possess and self-administer medication to treat the student's asthma, food or other allergy, anaphylaxis or related, life-threatening condition. Self-administration of such medication may occur during school hours, at school-sponsored activities, or while in transit to and from school or a school-sponsored activity. Student possession and self-administration of such medication shall be in accordance with the regulation accompanying this policy.

Plateau Valley School District 50, Collbran, Colorado

File: JLCD

Authorization for a student to possess and self-administer medication to treat the student's asthma, food or other allergy, anaphylaxis or other related, life-threatening condition may be limited or revoked by the school principal after consultation with the school nurse and the student's parent/guardian if the student demonstrates an inability to responsibly possess and self-administer such medication.

Use of Stock Epinephrine Auto-injectors in Emergency Situations

The district shall have a stock supply of epinephrine auto-injectors for use in emergency anaphylaxis events that occur on school grounds. Any administration of a stock epinephrine auto-injector to a student by a district employee shall be in accordance with applicable state law, including applicable State Board of Education rules.

The district's stock supply of epinephrine auto-injectors is not intended to replace student-specific orders or medication provided by the student's parent/guardian to treat the student's asthma, food or other allergy, anaphylaxis or related, life-threatening condition.

Student possession, use, distribution, sale or being under the influence of medication inconsistent with this policy shall be considered a violation of Board policy concerning drug and alcohol involvement by students and may subject the student to disciplinary consequences, including suspension and/or expulsion, in accordance with applicable Board policy.

Administering Medications to Students

If under exceptional circumstances a student is required to take medication during school hours, only the school nurse or the nurse's designee may administer the medication to the student in compliance with the following regulation. In the alternative, the parent/guardian may come to school to administer the medication.

1. All directives of the accompanying policy shall be followed.

2. Written orders from the student's health care practitioner with prescriptive authority under Colorado law shall be on file in the school stating:

   a. Student's name
   b. Name of medication
   c. Dosage
   d. Purpose of the medication
   e. Time of day medication is to be given
   f. Anticipated number of days it needs to be given at school
   g. Possible side effects

3. The medication shall be brought to school in a container appropriately labeled by the pharmacy or health care practitioner.

4. An individual record shall be kept of medications administered by school personnel.

5. Medication shall be stored in a clean, locked cabinet or container. Emergency medications (such as epinephrine) shall be kept in a secure location accessible to designated school staff.

Unless these requirements are met, medication will not be administered to students at school.

Self-Administration of Medication for Asthma, Allergies or Anaphylaxis

A school shall permit a student to possess and self-administer medication, such as an inhaler or epinephrine, if all of the following conditions are met:

1. Written authorization signed by the student's health care practitioner must be on file with the school which shall include the student's name; the name, purpose, prescribed dosage, frequency, and length of time between dosages of the medication(s) to be self-administered; and confirmation that the student has been instructed and is capable of self-administration of the medication.

2. The school nurse or school administrator, in consultation with the school nurse, the student's health care practitioner, and the student's parent/guardian collaborate to make an assessment of the student's knowledge of his or her condition and ability to self-administer medication.

3. A written statement signed by the student's parent/guardian must be on file with the school, which shall include permission for the student to self-administer his/her medication and a release from liability for any injury arising from the student's self-administration of such medication.

4. A written contract between the school nurse, school administrator, the student, and the student's parent/guardian must be on file with the school, assigning levels of responsibility to the student's parent/guardian, student, and school employees.

A treatment plan authorizing a student to possess and self-administer medication for asthma or anaphylaxis shall be effective only for the school year in which it is approved.

A student shall report to the school nurse or designee or to some adult at the school immediately after the student uses an epinephrine auto-injector during school hours. Upon receiving such report from a student, the school nurse, designee, or other adult will provide appropriate follow-up care to the student, which shall include making a 911 emergency call.

Over-the-Counter Medication/First Aid/Immunization Records Consents

Plateau Valley School District #50

Name of Student	Date of Birth	Grade	Phone
_____	_____	_____	_____

I, the parent/legal guardian of the above named student of Plateau Valley School District #50 **WANT** my child to be allowed to take the following checked **NON-PRESCRIPTION** (Over-the-Counter) **MEDICATIONS** at school if he/she becomes ill, but could possibly remain in school if given relief by taking it.

[ ] Yes	[ ] No	1.	IBUPROFEN (Advil)
[ ] Yes	[ ] No	2..	ACETAMINOPHEN (Tylenol)
[ ] Yes	[ ] No	3.	TUMS ANTACID CHEWABLE TABLETS
[ ] Yes	[ ] No	4.	BENADRYL (Diphenhydramine – an antihistamine)
[ ] Yes	[ ] No	5.	CARMEX (applied to a clean q-tip for chapped lips)
[ ] Yes	[ ] No	6.	HALLS COUGH DROPS (for coughs and sore throats)
[ ] Yes	[ ] No	7.	STING KILL (numbing solution for insect bites/stings
[ ] Yes	[ ] No	8.	BACITRACIN ANTIBIOTIC OINTMENT
[ ] Yes	[ ] No	9.	HYDROCORTISONE CREAM (for itching)

[ ] **I DO NOT WANT** my child to be allowed to take any of the above named over-the-counter medications at school.

ANY MEDICATION NOT LISTED ABOVE (prescription OR non-prescription) that a student needs to take at school
requires a written consent signed by the parent/guardian AND the prescribing health care provider

****

[ ] Yes [ ] No Qualified school personnel may do a physical assessment to the extent that is appropriate (take temperature, examine ears, throat, breath sounds, abdomen, etc.) for my child in the event of illness or injury.

[ ] Yes [ ] No Qualified school personnel may give immediate and temporary FIRST AID to care for my child in the event of illness or injury. 911 will be called in the event of serious or life-threatening illness or injury. All efforts possible will be made to notify a parent if 911 is called.

If my child is too ill to remain in school, but it is not an emergency, and I cannot be reached, my child will be released only to those people designated on the enrollment form. School personnel may share pertinent health information about my child with this caregiver.

*PLEASE MAKE SURE THAT INFORMATION REGARDING WHO YOUR CHILD MAY BE RELEASED TO IS KEPT UPDATED AT THE MAIN OFFICE.

My child's primary physician is _____ Phone Number _____

Any specific health problems that could result in a crisis situation at school are noted (allergies, diabetes, seizure disorder, heart condition or any ongoing medication programs:

_____

Permission to share immunization records: Plateau Valley School District #50 may share the immunization records on file at school for my child with Public Health officials or with my child's Health Care Provider.

[ ] Yes [ ] No Comments: _____

These permissions are granted/denied, as checked, for the current school year at Plateau Valley School District #50 unless the school is notified in writing to the contrary.

_____ _____

Parent/Guardian Signature Date

Plateau Valley School District # 50
Health History
(to be completed by parent/guardian)

Student Name: _____ Date of Birth _____ Grade_____

Physician Name_____ Telephone #_____

Date of last physical exam_____
Overall health of student: o Excellent o Good o Poor(chronic health problems or issues)

Does your child take any medications on a regular basis? (Including medication for asthma or ADHD):

o At Home o Needs to take at school

Medication(s): _____

Time(s) given:_____

Reason for taking medication: _____

ALLERGIES
Allergies to Medications: _____

Environmental Allergies: _____

Food Allergies: _____

Medical History (Please mark all that apply)

o Frequent Headaches	o Frequent colds	o Asthma
o Seizures	o Diabetes	o Anemia
o Frequent ear infections	o Frequent Strep Throat	o Rheumatic fever
o Hayfever/Seasonal Allergies	o Meningitis	o German Measles
o Vision problems	o Liver Disease	o Measles
o Wears glasses or contacts	o Kidney disease	o Chicken Pox
o Hearing problems	o Heart problems	When? _____
o Wears hearing aids	o Skin rashes/hives/eczema	o ADD/ADHD
o Pneumonia (RSV, Whooping Cough, other severe respiratory illness)		o Autism/Aspergers

o Other health problems or chronic health concerns:
_____

Any physical limitations or need special equipment? o Yes o No
If yes, please describe: _____

_____

Past hospitalization/surgeries? o Yes o No
If yes, please describe and include dates:

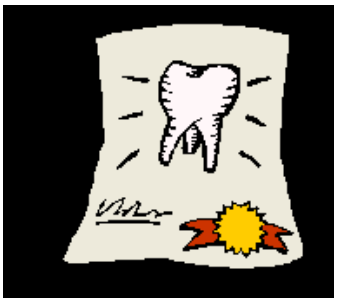
_____

_____

Parent/Guardian Signature **Date**

PVSD Rev 3/08

Information for Parents
About Fluoride Varnish



What is fluoride varnish?
Fluoride varnish is one type of topical fluoride. This type of fluoride is painted on the teeth. Fluoride varnish helps to prevent cavities by putting minerals into the tooth enamel, making the tooth stronger.

Why do we recommend putting fluoride varnish on children's teeth?
Cavities are one of the most common preventable diseases seen in children. Cavities can cause pain and effect children's ability to eat, speak, sleep and learn properly. Fluoride varnish is used to help prevent new cavities and to help stop cavities that have already started.

Is fluoride varnish safe?
Yes, fluoride varnish can be used on babies from the time they have their first teeth. Only a very small amount of fluoride varnish is used and little or no fluoride is swallowed by the child. Fluoride varnish is endorsed by the American Dental Association. Although rare, children with allergies to colophony (colophonium) and pine nuts could have allergic reactions to fluoride varnish.

How is it put on the teeth?
The varnish is painted on the teeth. It is quick and easy to apply and does not have a bad taste. Your child's teeth may be dull or yellow after the fluoride varnish is painted on. This is normal, and your child's teeth will be white and shiny again once the fluoride varnish is brushed off the next morning!

Fluoride Varnish Program
Parent/Guardian Consent

Dear Parent/Guardian:

A preventive dental program is available for your child. Two times during the school year, a licensed dental provider will provide a free basic dental screening and apply a protective coating called fluoride varnish to your child's teeth as a preventive measure against tooth decay.

To receive these **no-cost** services, you must provide consent.

___ **Yes**, I want my child to receive fluoride varnish.

___ **No**, I do not want my child to receive these preventive fluoride varnish services.

Name of Child: _____Date of Birth: _____

Male: ___ Female: ___ Age: ___ Grade: _____ Teacher: _____

Is your child allergic to pine nuts or colophony (colophonium)? Yes: ____ No: ____
Is your child allergic to Red Dye 40? Yes: ____ No: ____

In order to continue providing valuable preventive services at **no-cost** to your family, we ask that you provide your child's dental insurance information so the dental provider may submit and accept fees for services rendered. This will help offset the cost of the fluoride varnish and dental supplies.

Medicaid State ID:_____
CHP+ Member ID:_____

I understand that fluoride varnish helps to protect teeth from cavities. My child's teeth may look yellow for 24 hours. After receiving a fluoride varnish application, it is acceptable for my child to drink cool liquids and eat soft foods right away. For the treatment to be most effective, I have been advised to avoid serving my child hard, crunchy foods for 6 hours and to wait until the next morning to resume brushing and flossing.

Parent/Guardian Signature: _____ Date:_____

FOR OFFICE USE ONLY
Varnish placed on: _____ and _____ by: _____
Comments:
_____

****This service does not replace a comprehensive evaluation. It is our recommendation that a dentist regularly examine your child. ****

Updated 2017

Free and Reduced Price School Meal Application Instructions

If you, or someone in your household receives SNAP (Supplemental Nutrition Assistance Program, TANF/CO Works (Temporary Assistance for Needy Families; State Diversion or Basic Cash Assistance) or FDPIR (Food Distribution Program on Indian Reservations), follow the instructions listed below:
STEP 1: List all students first and last names; Check the box if student does not have income. Optional: Provide date of birth and grade.
STEP 2: List a case number if you or someone in your household participates in SNAP, TANF or FDPIR
STEP 3: Skip.
STEP 4: Sign the application. Optional: Provide contact information for purposes of receiving eligibility notification.
STEP 5: If you **do not want your information shared** with Medicaid/SCHIP and/or school/district programs, you must complete this step.
Optional: Complete the Children's Racial and Ethnic Survey on the back of the application.

If you are applying for a Foster Child, a student that qualifies for your districts Head Start program or is a Runaway, Homeless or Migrant student, follow the instructions listed below:
STEP 1: List all students first and last names; Check the box if student does not have income. Optional: Provide date of birth and grade.
Check the appropriate box if the student is a Foster Child, Head Start, Runaway, Homeless or Migrant.
STEP 2: Skip.
STEP 3: Skip.
STEP 4: Sign the application. Optional: Provide contact information for purposes of receiving eligibility notification.
STEP 5: If you **do not want your information shared** with Medicaid/SCHIP and/or school/district programs, you must complete this step.
Optional: Complete the Children's Racial and Ethnic Survey on the back of the application.

If you are applying based of income eligibility or you are applying based on income and other source categorical eligibility (i.e. Foster Child, Head Start, Runaway, Homeless or Migrant), follow the instructions listed below:
STEP 1: List all students first and last names; Check the box if student does not have income. Optional: Provide date of birth and grade.
Check the appropriate box if the student is a Foster Child, Head Start, Runaway, Homeless or Migrant.
STEP 2: Skip this part.
STEP 3:

A. **Student Income:** Report the combined gross income (before taxes and other deductions) for ALL students' listed in Step 1 in your household in the box marked "Student 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. Refer to "Sources of Income for Students at the bottom of this page.

B. **All Other Household Members (including yourself):** Print the name of each household member in the boxes marked "Names of Other Household Members." 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. Do not list any household members you listed in STEP 1. If a student listed in STEP 1 has income, follow the instructions in STEP 3, part A.

Report Gross Income (total income before taxes and deductions) for each Household Member:

- *Earnings from work*: example: See "Earnings from Work" below. If you are paid $500.00 bi-weekly, please record $500.00 in the income blank and mark the bi-weekly check box. If you do not normally receive over-time pay, do not include in your reported income.
- *Income from Public Assistance/Child Support/Alimony:* See "Public Assistance/Child Support/Alimony" below. List the total amount each person received from **any public assistance programs (do not include income from SNAP, TANF or FDPIR), child support or alimony**. For example: If you receive $500.00 monthly for child support, please record $500.00 in the income blank and mark the monthly check box.
- *Pensions/Retirement/All Other Income:* See "Pensions/Retirement/All Other Income" below. Report net income for self-owned business, farm, or rental income. Report gross income for pension or retirement income. Next to the amount, check how often the person receives it. If you are in the Military Housing Privatization Initiative, do not include this housing allowance.

Report total household members. The total must equal all names listed on the application.
Provide the last four of the Social Security Number (SSN), or "Check if no SSN".

STEP 4: Sign the application. Optional: Provide contact information for purposes of receiving eligibility notification.
STEP 5: If you **do not want your information shared** with Medicaid/SCHIP and/or school/district programs, you must complete this step.
Optional: Complete the Children's Racial and Ethnic Survey on the back of the application.

Sources of Income to Report:

Sources of Income for Students:
Earnings from work
Social Security – Disability or Survivor's payments
Any other type of regularly received income

Public Assistance/Child Support/Alimony:
Public assistance payments
Welfare payments
Alimony payments
Child support payments

Earnings from Work:
Wages/salaries/tips
Strike benefits
Unemployment Compensation
Worker's Compensation
Net income from self-owned business or farm

Pensions/Retirement/All Other Income:
Pensions
Supplemental Security Income
Retirement income
Veteran's benefits
Social Security
Disability benefits
Cash regularly withdrawn from savings
Interest/Dividends
Income from Estates/Trusts/Investments
Regular contributions from people not living in the household
Net royalties/annuities/rental income
Any other regularly received income

Plateau Valley School 2017-2018 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 student's attending Plateau Valley School (if more spaces are required for additional names, attach another sheet of paper)

Student's First Name	MI	Student's Last Name	No Income	Birth Date M M	D D	Y Y	Grade	Foster Child	Head Start	Runaway	Homeless	Migrant

Check all that apply. Read **How to Apply for Free and Reduced Price School Meals** for more information.

STEP 2 If household members (including you) currently participate in one of the following assistance programs: SNAP, TANF, or FDPIR list the case number below.

Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF/Colorado Works – Basic Cash Assistance or State Diversion), or Food Distribution Program on Indian Reservations (FDPIR). **Provide case number and skip to Step 4.**

SNAP Case Number | TANF Case Number | FDPIR Case Number

STEP 3 Report income for ALL household members (Skip this step if you provided a case number in STEP 2)

A. Student Income

Please include the **TOTAL** income, if any, received by all students' listed above.

Student Income $ ____ How Often? Weekly / Bi-Weekly / 2x Month / Monthly / Annually

B. All Other Household Members (including yourself)

List all other 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 (BEFORE TAXES AND OTHER DEDUCTIONS)** for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying that there is no income to report.

Names of Other Household Members (First and Last)	Earnings from Work	How Often? Weekly / Bi-Weekly / 2x Month / Monthly / Annually	Public Assistance/ Child Support/Alimony	How Often? Weekly / Bi-Weekly / 2x Month / Monthly / Annually	Pensions/Retirement/ All Other Income	How Often? Weekly / Bi-Weekly / 2x Month / Monthly / Annually
	$		$		$	
	$		$		$	
	$		$		$	
	$		$		$	

Total Household Members (Students' and Adults)

Last four digits of Social Security Number (SSN) of adult signing this form or mark 'NO SSN' **ONLY if Step 3B has been completed.** **XXX-XX** ____ **Check if no SSN** ☐

STEP 4 Contact information and adult signature. Mail signed and completed application to: **Plateau Valley School 56600 Hwy 330, Collbran, CO 81624**

"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."

Mailing Address or PO Box | Apt. # or Lot # | City | CO | Zip Code | Email Address

Phone | **SIGNATURE** of Adult Household Member | Printed First and Last Name of Signer | Today's Date

STEP 5 Release of Information

The information provided on this application will be used in conjunction with state educational programs and may be shared with Medicaid or State Children's Health Insurance Program (SCHIP) offices to seek enrollment of children into the above programs. Also, if your students are eligible to receive free or reduced price meals this information may be shared with the school/district for the purpose of waiving certain school/district program fees that your child(ren) might otherwise be required to pay. The school/district is not permitted to share your information with anyone else. You are not required to consent to the release of your information; this will not affect your student(s)' eligibility for school meals. *Your information **WILL** be shared unless you check one of the boxes below.*

☐ Do **NOT** share my information with Medicaid/SCHIP Offices

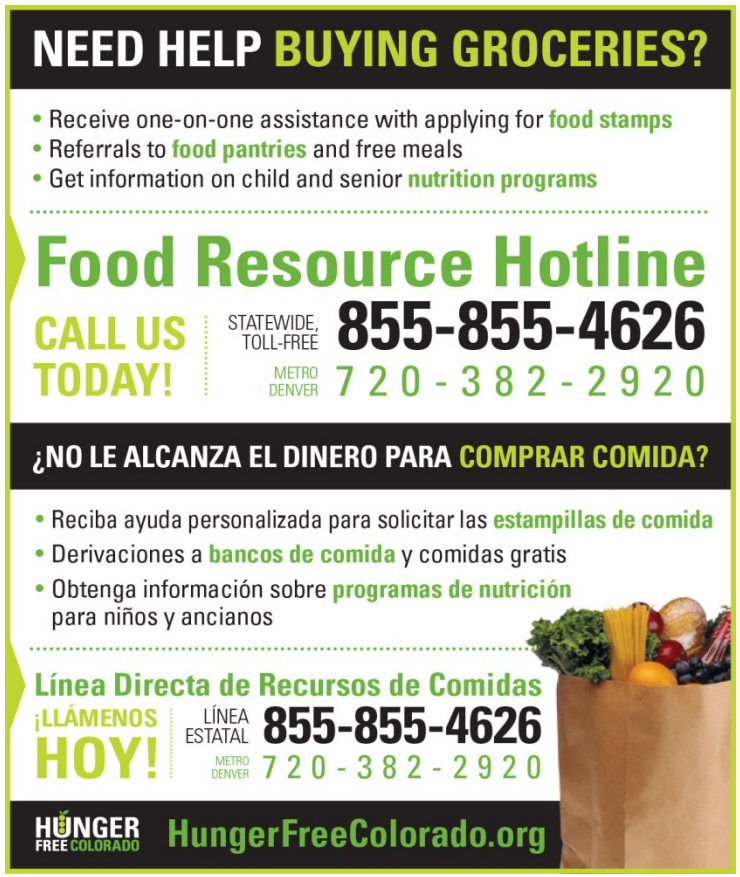
OPTIONAL Children's Racial and Ethnic Identities

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 ☐ White

You may also qualify for the Supplemental Nutrition Assistance Program! See more information below.



COLORADO PEAK

Colorado PEAK is an online service for Coloradans to screen and apply for medical, food and cash assistance programs.

Visit **coloradopeak.force.com** to learn more.

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

DISTRICT USE ONLY. DO NOT WRITE BELOW THIS LINE.

Annual Income Conversion: Weekly x 52; Bi-Weekly x 26; 2 Times per Month x 24; Monthly x 12

Application Type:	Application Status:
❑ Total Household Income: $_____ Household Size:_____ Household Income Frequency - ❑ Weekly ❑ Bi-Weekly ❑ 2x/Month ❑Monthly ❑Annually ❑Categorical Eligibility - ❑SNAP ❑FDPIR ❑TANF ❑Foster ❑Homeless/Migrant/Runaway/Head Start	Approved - ❑Free ❑Reduced Denied - ❑Over Income Guidelines ❑Incomplete/Missing:_____ Notes:_____

Determining Official Signature: Approval/Denial Date: Notification Sent: