TITAN NATION

Welcome to the 2023-2024 school year!!

Please fill out the Household Income Survey at this time.

Please only fill out this survey once!

Once you are done completing the Household Survey, then click on "Register for 2023-2024"

Dear Parents/Guardians:

Schools, receive federal and state funding (learning-assistance programs, Erate funding for technology, Title Funds, etc.) when you complete the CONFIDENTIAL Household Income Survey. This is also the way your family may qualify for reduced or free fees and waivers for things like school fees and Driver's Education. Your children may qualify based on your household income if it falls at or below the limits on this chart. Even if you do not qualify for reduced/free fees and waivers, your participation in this survey helps our district receive federal and state funding.

This *Household Income Survey* provides Ruthven-Ayrshire CSD a way to collect household income information and receive the full amount of federal and state funding entitled to when free/reduced price meal applications are not collected.

It is important to you and our school district that you complete this survey, however if you do not want to do so, there is an opt-out option at the beginning of the survey.

Household Income Survey

HOW TO APPLY FOR FREE AND REDUCED PRICE SCHOOL MEALS/MILK

Please use these instructions to help you fill out the application for free or reduced price school meals/milk. You only need to submit **one** application per household, even if your children attend more than one school in **Ruthven-Ayrshire CSD.** Please follow these instructions in order. Each step of the instructions is the same as the steps on your application. The application must be filled out completely to certify your children for free or reduced price school meals. **Completed applications should be mailed or returned to** **Ruthven-Ayrshire CSD, PO Box 159 Ruthven, IA 51358** If at any time you are not sure what to do next, please contact **Dee Johnson; 712-837-5212 or email dejohn@gt.ratitans.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 **Ruthven-Ayrshire CSD.** *regardless of age*.

A) List each child's name and date of birth. Print each child's first name, middle initial, last name and date of birth (optional). Use one line of the application for each child. If there are more children present than lines on the application, attach a Supplemental Worksheet, which can be obtained from the school, with all required information for the additional children.

B) Is the child a student? Mark 'Yes' or 'No' under the column titled "student" to tell us which children attend Ruthven-Ayrshire CSD. If you marked 'Yes' write where the child attends school and write the grade level of the student in the "Grade" column to the right.

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. If you are *ONLY* applying for foster children, after finishing STEP 1, go to "STEP 4". Foster children who live with you may count as members of your household and should be listed on your application. If you are applying for both foster and non-foster children, go to step 3.

D) Are any children homeless, migrant, or runaway? If you believe any child listed in this section may meet this description, 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 CURRENTLY PARTICIPATE IN the Supplemental Nutrition Assistance Program (SNAP), Family Investment Program (FIP) OR FDPIR?

If anyone in your household (including you) currently participates in one or more of the assistance programs listed below, your children are eligible for free school meals:

- The Supplemental Nutrition Assistance Program (SNAP-formerly Food Assistance in Iowa)
- The Family Investment Program (FIP)
- The Food Distribution Program on Indian Reservations (FDPIR)

A) IF NO ONE IN YOUR HOUSEHOLD PARTICIPATES IN ANY OF THE ABOVE LISTED PROGRAMS:

- **Circle 'NO' and go to STEP 3. (Leave the rest of STEP 2 blank)**

B) IF ANYONE IN YOUR HOUSEHOLD PARTICIPATES IN ANY OF THE ABOVE LISTED PROGRAMS:

- **Circle 'YES' and provide a case number for SNAP, FIP, or FDPIR.** You only need to write **one** case number. If you participate in one of these programs and do not know your case number, it is located on your Notice of Decision. **You must provide a case number on your application if you circled "YES".**
- **Go to STEP 4.**

STEP 3: REPORT INCOME FOR ALL HOUSEHOLD MEMBERS

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.
- 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 also be counted as a zero. 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 investigated.
- Mark how often each type of income is received using the check boxes to the right of each field.

A) **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 affects your eligibility for free and reduced price meals.

B) **Provide the last four digits of your Social Security Number.** An adult household member must enter the last four digits of their Social Security Number in the space provided.

C) **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 SSN."

D) **Report all income earned or received by children.** Refer to the table below titled "Sources of Income for Children" and report the combined gross income for ALL children listed in Step 1 in your household in the box marked "Child Income**."** Only count foster children's income if you are applying for them with the rest of your household (income from a part-time job or from any funds provided to the child for the child's personal use). It is optional for the household to list foster children living with them as part of the household on an application for non-foster children.

Table 1. Sources of Income for Children

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 Child Income	Example(s)
• Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages. (Infrequent earnings, such as income from occasional babysitting or lawn mowing, are not counted as income.)
• Social Security o Disability Payments o 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.

FOR EACH ADULT HOUSEHOLD MEMBER:

E) **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.**

F) **Report earnings from work.** Refer to the chart below titled "Sources of Income for Adults" 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 self-employed business or farm owner, you will report your net income. If you need assistance with this, ask your children's school for the Supplemental Worksheet which has self-employment calculations.

Who should I list here?

When filling out this section, please include **all** adult 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.

What if I am self-employed?

If you are self-employed, report income from work as a **net** amount. This is calculated by subtracting the total operating expenses of your business from its gross receipts and revenue. Ask your school for a Supplemental Worksheet to assist you in determining your monthly gross annual income before deductions.

G) **Report income from public assistance/child support/alimony.** Refer to the chart below titled "Sources of Income for Adults" 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 report court-ordered payments. Informal but regular payments should be reported as "other" income in the next part.

H) **Report income from pensions/retirement/all other income**. Refer to Table 2 below titled "Sources of Income for Adults" and report all income that applies in the "Pensions/Retirement/All Other Income" field on the application.

Table 2. Sources of Income for Adults

Earnings from Work	Public Assistance/ Alimony/Child Support	Pensions/Retirement/All Other Income
• Salary, wages, cash bonuses • **Net** income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) **Allowances for off-base housing, food and clothing**	• Unemployment benefits • Worker's compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veteran's benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Regular 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) Print and sign your name and write today's date. Print the name of the adult signing the application and sign in the box labeled "Signature of adult completing the form."

C) Mail or return completed form to: Ruthven-Ayrshire CSD, PO Box 159, Ruthven, IA 51358. Please do not mail completed form to the Department of Agriculture as this will delay processing.

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. If you do not select race or ethnicity, one will be selected for you based on visual observation.

E) Decline having your information released to Hawki. If you do not want your household information shared with Hawki**, print, sign and date in the box provided.**

F) Obtaining translated applications. If you need a translated application with instructions, they can be found in 49 languages at: https://www.fns.usda.gov/school-meals/translated-applications.

2023-2024 Iowa Application for Free & Reduced Price School Meals/Milk Return completed form to: Ruthven-Ayrshire CSD

Complete one application per household. Use a pen (not a pencil). This application cannot be approved unless complete eligibility information is submitted. **Date Received:**_________

STEP 1 List ALL Household Members who are infants, children, and students up grade 12 (if more spaces are required for additional names, attach the supplemental worksheet)

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.

Child's First Name	MI	Child's Last Name	Date of Birth	Student Yes	Student No	Child's School	Grade	Check all that apply: Foster Child	Homeless, Migrant, Runaway

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, FIP, or FDPIR?

Check one:☐ Yes/☐ No **If No, go to STEP 3. If you answered Yes, write a case number here then go to STEP 4 (Do not complete STEP 3).**

Write only one case number in this space.
Medicaid, Title XIX & EBT card numbers are not acceptable.

Case Number: _ _ _ _ _ _ - _ _ - _ - _

To Apply On-Line go to:

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

A: Total Number of All Household Members (Children + Adults) ______

B. Last Four Digits of Social Security Number (SSN) of Adult Household Member: **XXX-XX-** _ _ _ _

C. Check **No SSN** (adult): ☐

Are you unsure what income to include here? 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.

D. Child Income: Sometimes children in the household earn or receive income. Please include the TOTAL gross earned income by all Children listed in STEP 1 here.

Total Income Received by All Children	Weekly	Bi-weekly	2x Month	Monthly	Yearly
$	☐	☐	☐	☐	☐

E. All Adult Household Members (include yourself): List all Household Members not listed in STEP 1 **even if they do not receive income.** 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. Applications with blank income fields will be processed as complete**. If more spaces are required for additional names, attach the supplemental worksheet.**

Names of All Adult Household Members (First and Last Names. Include children who are temporarily away at school or in college.)	Gross Earnings from Work/All Other Income (Report income **before deductions or taxes** in whole dollars)	Weekly	Bi-weekly	2x Month	Monthly	Yearly	Gross Public Assistance/Child Support/Alimony (Report income **before deductions or taxes** in whole dollars)	Weekly	Bi-weekly	2x Month	Monthly	Gross Pension/Retirement (Report income **before deductions or taxes** in whole dollars)	Weekly	Bi-weekly	2x Month	Monthly
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

STEP 4 Contact Information and Adult Signature

"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."

Signature of adult completing the form	Printed name of adult completing the form	Today's Date

Street Address (if available)	Apt. #	City	State	Zip	Daytime Phone (optional)	Email (optional)

DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY **Application #:** _____________ **Date Received by SFA:**_________

Annual Income Conversion	☐ Weekly x52	☐ Bi-Weekly x26	☐ Twice Monthly x24	☐ Monthly x12	☐ Yearly

Household Size: _________ **Annual Household Income:** $_________

Application Approval ☐ Income ☐ Foster Child ☐ FIP/SNAP ☐ Head Start (documentation required) ☐ Homeless/Migrant/Runaway-Local Official Documentation Required

Eligibility Determination ☐ Free ☐ Reduced ☐ Free Milk Application Denied: ☐ Incomplete ☐ Over Income Limits

Signature & Effective Date of Determining Official	Signature & Date of Confirming Official	Signature & Date of Follow-Up

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. If you do not select race or ethnicity, one will be selected for you based on visual observation.

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

Low-Cost Health Insurance for Children

If your children do not have health insurance, many families getting free or reduced price meals can also get free or low-cost health insurance for their children. The law requires public schools to share your free and reduced price meal eligibility information with Medicaid & Hawki, the State's medical insurance program for children. Private schools, RCCIs and childcare organizations may choose to share this information. Specifically, we will give them your child's name, your name & address. Medicaid & Hawki can only use the information to identify children who may be eligible for free or low-cost health insurance and contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose or to share it with any other entity or program. You are not required to allow us to share this information, it will not affect your child's eligibility for free or reduced price meals. **If you do NOT want your information shared with Medicaid or Hawki, you must tell us by completing the information below.** If you want further information, you may call Hawki at 1-800-257-8563. Also, if you are already receiving Medicaid or Hawki, please sign below. This will avoid another contact.

My signature below indicates I DO NOT want school officials to share information from my free and reduced price meal application with Medicaid or Hawki.

Parent/Guardian Name (Printed)__________________________________**Signature**________________________**Date**____________

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 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), Family Investment Program (FIP) 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.

USDA Nondiscrimination Statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

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

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. *** mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

***only use this address if you are filing a complaint of discrimination."**

This institution is an equal opportunity provider.

Iowa Non-Discrimination Statement: "It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, age, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.6, 216.7, and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office building, 400 E. 14th St. Des Moines, IA 50319-1004; phone number 515- 281-4121, 800-457-4416; website: https://icrc.iowa.gov/."

Translated applications are available at:
http://www.fns.usda.gov/school-meals/translated-applications

Return completed form to:
Ruthven-Ayrshire CSD
PO Box 159
Ruthven, IA 51358

Waiver Information

2023-2024 Iowa Application for Free and Reduced Price School Meals/Milk Optional Supplemental Worksheet

Additional Children in Your Household (not listed on page 1)

Child's First Name	MI	Child's Last Name	Date of Birth	Student		Child's School	Grade	Check all that apply	Foster Child	Homeless, Migrant, Runaway
				Yes	No					

Any income earned by the above listed children should be included under Step 3 A on the first page of the application.

Additional Adults in Your Household (Not listed on page 1)

Names of All Adult Household Members	Gross Earnings from Work/All Other Income	How Often?					Gross Public Assistance/Child Support/Alimony	How Often?				Gross Pension/Retirement	How Often?			
First and Last Names. Include children who are temporarily away at school or in college.	Report income **before deductions or taxes** in whole dollars	Weekly	Bi-weekly	2x Month	Monthly	Yearly	Report income **before deductions or taxes** in whole dollars	Weekly	Bi-weekly	2x Month	Monthly	Report income **before deductions or taxes** in whole dollars	Weekly	Bi-weekly	2x Month	Monthly
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

Self-Employment Income Calculations

This guidance will assist you in calculating the amount to report if you engage in farming, are self-employed or have income from other sources.

Self-employed persons may use income tax records for the preceding calendar year as a base to project the current year's net income, unless the current monthly income provides a more accurate measure. Report income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as interest on home payments, medical expenses, and other similar non-business deductions are not allowed in reducing gross business income. Additional income from other kinds of employment must be treated as separate and apart from the income generated or lost from your business venture. For example, if you operated a business at a net loss, but held additional employment for which a salary was received, the income for purposes of applying for reduced price or free meals would be the income from the salary only. The loss from the business cannot be deducted from a positive income earned in other employment. For purposes of this application, it is not possible to report a negative income from any business venture. The least income possible is zero (no income). The necessary information for arriving at allowable income from private business operation may be taken from your most recent U.S. Individual Income Tax Return - Form 1040 or 1040-SR and Schedule 1. Add together the amounts reported on the following lines:

Capital Gain or (Loss) Form 1040 or 1040-SR, LINE 7 $_______________

Business Income or (Loss) Schedule 1 Part 1, LINE 3 $_______________

Other Gains or (Losses) Schedule 1 Part 1, LINE 4 $_______________

Rental real estate, royalties, partnerships, S corporations, trusts, etc. Schedule 1 Part 1, LINE 5 $_______________

Farm Income or (Loss) Schedule 1 Part 1, LINE 6 $_______________

TOTAL $_________________Gross Annual Income Before Any Deductions. Report in Step 3 under All Other Income (**Computed Monthly Income $** ________Gross Annual Income ÷ 12)

Sources of Child Income
• Earnings from work • Social Security(disability payments and survivor's benefits) • Income from person outside the household • Income from any other source

Earnings from Work (Adult Income Sources)	Public Assistance/Alimony/Child Support (Adult Income Sources)	All Other Income (Adult Income Sources)
• Salary, wages, cash bonuses (before deductions or taxes) • Net income from self-employment (farm or business) • If you are in the U.S. Military: a. Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) b. Allowances for off-base housing, food and clothing	• Cash Assistance from State/local government • Supplemental Security Income • Unemployment benefits • Worker's compensation • Alimony or child support payments • Veteran's benefits • Strike benefits	• Social Security • Disability benefits • Regular income from trusts or estates • Annuities • Investment income • Rental income • Regular cash payments from outside household

WAIVER STATEMENT

If your child(ren) qualifies for free or reduced price meals, you may also be eligible for other benefits. If you sign this waiver, your child(ren) will be considered for a full or partial waiver of school fees. I understand that I will be releasing information that will show that I applied for free and reduced price school meals for my child(ren). I give up my rights to confidentiality for waiver of school fees ONLY. I certify that I am the parent/guardian of the child(ren) for whom application is being made. **YOU DO NOT HAVE TO COMPLETE THIS WAIVER TO GET FREE OR REDUCED PRICE SCHOOL MEALS.**

Signature of Parent/guardian ____Date _________________

"Feed The Children"

This program is for Students who qualify for Free/Reduced Lunches.

The local community organization will provide two weekend meals for Grades Pre-K thru 6th to take home once a week.

Do you want your child(ren) to participate?

_______ Yes ________ No

Student Name	Grade
____________________________________	________________________
____________________________________	________________________
____________________________________	________________________
____________________________________	________________________
____________________________________	________________________
____________________________________	________________________
____________________________________	________________________

____ __________________

Parent Signature ***Dat***

PARENTAL INSURANCE WAIVER

Student's Name/s____

____

Ruthven-Ayrshire Community School District

We, the undersigned, feel we have adequate insurance protection for our Son/Daughter while practicing or participating in Interscholastic Sports, or other School Sponsored Activities.

Parent's/Guardian's Signature:_________________________________

Date:______________________

Ruthven-Ayrshire Community School District

Student Emergency/Health Information for Returning Students

School Year ___________________

Student's Name ______________________________ Grade __________ D.O.B ___________ Age ____

Permission for Medication Administration at School

I hereby give my consent to administer the below indicated medication to my student in the event of fever, or student headache symptoms. I understand that I will be contacted if student requires any mediation for more than one consecutive day. This will not prevent the school from notifying me in the case of fever and the need for my child to go home.

Tylenol/acetaminophen (generic): | ___ 500mg | ___ 160mg (chewable)| ___ Liquid 160mg/5mL-# of cc ____

Ibuprofen: ___ 200mg | ___ 160mg chewable | ___Liquid 160mg/5mL / # of cc ____

I, ________________________, give my permission for my child ______________________ to receive the above indicated medication in the event of the above described symptoms. (Dose: As I have indicate above or dose per bottle.)

Signature: _____________________________________ Date: _____________________

CURRENT HEALTH:

Does the student have asthma? _____Yes _____No

Medical Concerns: _____Yes _____No | If yes, ____

Prescribed medications to be taken at school: ____

Over-the-counter/prescribed medications taken at home: ____

State any allergies (food, medication, and/or environmental: ____

State any serious illnesses, injuries, or surgeries in the past year: ____

State any immunizations received and date/day given in the past year: ____

Does your child have any emotional, social, or other conditions that might affect his/her school performance? ____Yes ____No | If yes, ____

Does your child use any assistive devices? (hearing aid, glasses, braces, etc.) ____________________________________

Does your child have any activity restrictions? ____

Current Health Insurance: _____No Insurance _____Medicaid _____Hawk-I _____Private/Name ___________________

If a medical emergency should arise, I agree to assume full financial responsibility for my child's medical care. I understand I am responsible for updating this information as needed. I grant my permission to share health and emergency information as stated with school staff on a need to know basis.

Signature of Parent/Guardian ____ Date: _________________________

Ruthven-Ayrshire Community School District

Student Emergency/Health Information for Returning Students

School Year ___________________

Student's Name ______________________________ Grade __________ D.O.B ___________ Age ____

Permission for Medication Administration at School

I hereby give my consent to administer the below indicated medication to my student in the event of fever, or student headache symptoms. I understand that I will be contacted if student requires any mediation for more than one consecutive day. This will not prevent the school from notifying me in the case of fever and the need for my child to go home.

Tylenol/acetaminophen (generic): | ___ 500mg | ___ 160mg (chewable)| ___ Liquid 160mg/5mL-# of cc ____

Ibuprofen: ___ 200mg | ___ 160mg chewable | ___Liquid 160mg/5mL / # of cc ____

I, ________________________, give my permission for my child _______________________ to receive the above indicated medication in the event of the above described symptoms. (Dose: As I have indicate above or dose per bottle.)

Signature: _____________________________________ Date: _____________________

CURRENT HEALTH:

Does the student have asthma? _____Yes _____No

Medical Concerns: _____Yes _____No | If yes, ____

Prescribed medications to be taken at school: ____

Over-the-counter/prescribed medications taken at home: ____

State any allergies (food, medication, and/or environmental: ____

State any serious illnesses, injuries, or surgeries in the past year: ____

State any immunizations received and date/day given in the past year: ____

Does your child have any emotional, social, or other conditions that might affect his/her school performance? ____Yes ____No | If yes, ____

Does your child use any assistive devices? (hearing aid, glasses, braces, etc.) _____________________________________

Does your child have any activity restrictions? ____

Current Health Insurance: _____No Insurance _____Medicaid _____Hawk-I _____Private/Name ___________________

If a medical emergency should arise, I agree to assume full financial responsibility for my child's medical care. I understand I am responsible for updating this information as needed. I grant my permission to share health and emergency information as stated with school staff on a need to know basis.

Signature of Parent/Guardian ____ Date: _________________________

Ruthven-Ayrshire Community School District

Student Emergency/Health Information for Returning Students

School Year ___________________

Student's Name ______________________________ Grade __________ D.O.B ___________ Age ____

Permission for Medication Administration at School

I hereby give my consent to administer the below indicated medication to my student in the event of fever, or student headache symptoms. I understand that I will be contacted if student requires any mediation for more than one consecutive day. This will not prevent the school from notifying me in the case of fever and the need for my child to go home.

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I, ________________________, give my permission for my child _______________________ to receive the above indicated medication in the event of the above described symptoms. (Dose: As I have indicate above or dose per bottle.)

Signature: _____________________________________ Date: _____________________

CURRENT HEALTH:

Does the student have asthma? _____Yes _____No

Medical Concerns: _____Yes _____No | If yes, ____

Prescribed medications to be taken at school: ____

Over-the-counter/prescribed medications taken at home: ____

State any allergies (food, medication, and/or environmental: ____

State any serious illnesses, injuries, or surgeries in the past year: ____

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Ruthven-Ayrshire Community School District

Student Emergency/Health Information for Returning Students

School Year ___________________

Student's Name ______________________________ Grade __________ D.O.B ___________ Age ____

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Ruthven-Ayrshire Community School District

Student Emergency/Health Information for Returning Students

School Year ___________________

Student's Name ______________________________ Grade __________ D.O.B ___________ Age ____

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Ruthven-Ayrshire Community School District

Student Emergency/Health Information for Returning Students

School Year ___________________

Student's Name ______________________________ Grade __________ D.O.B ___________ Age ____

Permission for Medication Administration at School

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I, ________________________, give my permission for my child _______________________ to receive the above indicated medication in the event of the above described symptoms. (Dose: As I have indicate above or dose per bottle.)

Signature: _____________________________________ Date: _____________________

CURRENT HEALTH:

Does the student have asthma? _____Yes _____No

Medical Concerns: _____Yes _____No | If yes, ____

Prescribed medications to be taken at school: ____

Over-the-counter/prescribed medications taken at home: ____

State any allergies (food, medication, and/or environmental: ____

State any serious illnesses, injuries, or surgeries in the past year: ____

State any immunizations received and date/day given in the past year: ____

Does your child have any emotional, social, or other conditions that might affect his/her school performance? ____Yes ____No | If yes, ____

Does your child use any assistive devices? (hearing aid, glasses, braces, etc.) ____________________________________

Does your child have any activity restrictions? ____

Current Health Insurance: _____No Insurance _____Medicaid _____Hawk-I _____Private/Name ___________________

If a medical emergency should arise, I agree to assume full financial responsibility for my child's medical care. I understand I am responsible for updating this information as needed. I grant my permission to share health and emergency information as stated with school staff on a need to know basis.

Signature of Parent/Guardian ____ Date: _________________________

Ruthven-Ayrshire Community School District
Parental Permission for Administering PRESCRIPTION Medication at School

Student Name: ____ D.O.B: ________________________

Medication: ________________________________ Dosage: _________________________________

Reason for Medication: ____

Time Medication is to be Given: ____

Physician/Prescriber's Name: ____________________________ Phone Number: _________________

Special Instructions: ____

I request that the prescribed medication be administered by a qualified staff person according to the written directions given. I agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for damages as a result of the administration of medication where the person administering the medication acts as an ordinary reasonable prudent person would under the same circumstances and that the school district and the school nurse incur no liability, except for gross negligence, as a result of injury arising from the administration of medication. I will comply with the procedure listed on the back of this form related to administration of medication at school.

Parent/Guardian Name: ____

Signature of Parent/Guardian: ____________________________________ **Date**: ________________

Home Phone #: ______________________________ Work Phone #: ___________________________

MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IF IT HAS AN IMPROPER LABEL. PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.

Permission for disposal of unused medication at the end of the school year – Please check one.

_____ I will pick up any unused medication at the end of the school year.

_____ Please send any unused medication home with my child. The school district will not be responsible for the medication once it is in the possession of my child.

_____ Please discard any unused medication.

Parent/Guardian Signature: ______________________________________ **Date**: ________________

Permission for Inhalers: Iowa law requires that students who carry inhalers throughout the school day must have written parent consent and written prescriber's consent with the purpose of the medication, dosage, times or special circumstances under which the medication is to be given. **If your child is to carry his/her inhaler with them at all times, please have the prescriber fill out the information at the top of the page AND both sign below.**

I have instructed the above named student in the proper way to use his/her inhaler. It is my professional opinion that he/she should be allowed to carry and use that medication by himself/herself.

Physician/Prescriber Signature: ___________________________________ **Date:** ________________

I request the above named student carry and self-administer his/her inhaler during school and school activities according to the authorization and instructions given.

Parent/Guardian Signature: ______________________________________ **Date:** ________________

Ruthven-Ayrshire Community School District
Parental Permission for Administering PRESCRIPTION Medication at School

Student Name: ____ D.O.B: ________________________

Medication: ________________________________ Dosage: _________________________________

Reason for Medication: ____

Time Medication is to be Given: ____

Physician/Prescriber's Name: ____________________________ Phone Number: _________________

Special Instructions: ____

I request that the prescribed medication be administered by a qualified staff person according to the written directions given. I agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for damages as a result of the administration of medication where the person administering the medication acts as an ordinary reasonable prudent person would under the same circumstances and that the school district and the school nurse incur no liability, except for gross negligence, as a result of injury arising from the administration of medication. I will comply with the procedure listed on the back of this form related to administration of medication at school.

Parent/Guardian Name: ____

Signature of Parent/Guardian: ____________________________________ **Date**: ________________

Home Phone #: _______________________________ Work Phone #: ___________________________

MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IF IT HAS AN IMPROPER LABEL. PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.

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Parent/Guardian Signature: _______________________________________ **Date**: ________________

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Physician/Prescriber Signature: ___________________________________ **Date:** ________________

I request the above named student carry and self-administer his/her inhaler during school and school activities according to the authorization and instructions given.

Parent/Guardian Signature: ______________________________________ **Date:** ________________

Ruthven-Ayrshire Community Schools

Field Trip Permission Form

I/We the undersigned, hereby grant permission for my child/children listed below:

____

____

To accompany a class on any field trip scheduled during the child/children's year as a student at Ruthven-Ayrshire. Notification of each trip will be sent before the day of the trip with the understanding that the group will be properly supervised and the teacher will always be present.

____ _______________________

Signature of parent/legal guardian Date

RUTHVEN-AYRSHIRE COMMUNITY SCHOOL

RUTHVEN, IOWA 51358

PARENT AND STUDENT

The State Law required that students in laboratories while experiments are being conducted in Industrial Art classes, while machines are in operation or tools are used and during Science classes while demonstrations are being conducted must wear protective goggles.

I understand the above regulations and will inform our children so they will be aware of this state directive and follow it in all cases.

I further give ____________________________ permission to wear the goggles

(Name of student)

Provided so the requirements of this law will be fulfilled.

____ ________________

Signature of Parent/Guardian Date

____

Signature of Student

This form must be signed by both the student and parent/guardian.

Thank you for your cooperation in this matter.

PARENTAL EMERGENCY MEDICAL/DENTAL CONSENT

Permission for medical/dental care in parental absence (This form must be presented upon admission for treatment.)

Child's Name and Birthdate:________________________________ __/__/__
Child's Name and Birthdate:________________________________ __/__/__
Child's Name and Birthdate:________________________________ __/__/__
Child's Name and Birthdate:________________________________ __/__/__

If you and the family physician/dentist as indicated below cannot be reached in an emergency and if, in the judgment of the school authorities, immediate medical, dental and/or hospital attention is indicated do you authorize responsible school authorities to send your child, properly accompanied, to an available hospital or physician, and do accept full responsibility for all expenses incurred in such care?

YES_________ NO__________
DATE____________________ ______________________________
Signature of parent/guardian

Name of parent or legal guardian____
Address____
HomePhone_______________CellPhone_________________WorkPhone________

Physician________________________Address_________________Phone________

Dentist__________________________Address_________________Phone________

Special health condition____

Person to be contacted in emergency if parents are not available:
Name:_________________________Relationship to child:_____________________

HomePhone___________CellPhone__________________WorkPhone__________

This consent will be in effect beginning__________________and continuing while enrolled Graettinger-Terril CSD.

PARENTAL EMERGENCY MEDICAL/DENTAL CONSENT

Permission for medical/dental care in parental absence (This form must be presented upon admission for treatment.)

Child's Name and Birthdate:______________________________ __/__/__
Child's Name and Birthdate:______________________________ __/__/__
Child's Name and Birthdate:______________________________ __/__/__
Child's Name and Birthdate:______________________________ __/__/__

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YES________ NO__________
DATE____________________

____
Signature of parent/guardian

Name of parent or legal guardian____
Address____
HomePhone_______________CellPhone_________________WorkPhone________

Physician________________________Address_________________Phone________

Dentist__________________________Address_________________Phone________

Special health condition____

Person to be contacted in emergency if parents are not available:
Name:_________________________Relationship to child:_____________________

HomePhone___________CellPhone__________________WorkPhone___________

This consent will be in effect beginning__________________and continuing while enrolled Graettinger-Terril CSD.

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YES_________ NO__________
DATE____________________ ________________________________
Signature of parent/guardian

Name of parent or legal guardian____
Address____
HomePhone_______________CellPhone_________________WorkPhone________

Physician________________________Address_________________Phone________

Dentist__________________________Address_________________Phone________

Special health condition____

Person to be contacted in emergency if parents are not available:
Name:_________________________Relationship to child:_____________________

HomePhone___________CellPhone__________________WorkPhone___________

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YES_________ NO__________
DATE_____________________ ________________________________
Signature of parent/guardian

Name of parent or legal guardian____
Address____
HomePhone________________CellPhone__________________WorkPhone________

Physician_________________________Address__________________Phone________

Dentist___________________________Address__________________Phone________

Special health condition____

Person to be contacted in emergency if parents are not available:
Name:__________________________Relationship to child:______________________

HomePhone____________CellPhone___________________WorkPhone___________

This consent will be in effect beginning___________________and continuing while enrolled Graettinger-Terril CSD.

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YES_________ NO__________
DATE____________________

____
Signature of parent/guardian

Name of parent or legal guardian____
Address____
HomePhone________________CellPhone__________________WorkPhone________

Physician_________________________Address__________________Phone________

Dentist__________________________Address__________________Phone________

Special health condition____

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HomePhone____________CellPhone__________________WorkPhone___________

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