Dear Parent or Guardian,

We are excited to begin another preschool adventure! Thank you for allowing us to be part of your child's first school experience. Our goal is to work closely with families and children to promote kindergarten readiness and success for all. Below you will find dates and valuable information to help make your child's preschool transition a success.

Our program supports the health, well-being, social, and cognitive growth of all children. Part of our health program requires that we maintain files on each preschool child. The following items are needed to complete your child's enrollment process.

Please provide copies of the following items with your completed enrollment packet.

☐ **Birth Certificate (copy of original)**	
☐ **Social Security Card (copy)**	
☐ **Physical Exam**	**Date:**_____
☐ **Vision Exam**	**Date:**_____
☐ **Immunization Record**	**Date:**_____
☐ **Dental Exam**	**Date:**_____
☐ **Household Income Form**	

Thank you,

Melissa Latimer
Preschool Coordinator
Greenup County Preschool
606-473-7936
Melissa.latimer@greenup.kyschools.us

Greenup County Preschool
Student Data Collection Form

☒ 2021-2022 ☐ 3 by August 1 ☐ 4 by August 1

Program Registration	☐ Preschool ☒ Head Start

Last Name:_____

First Name: _____

Middle Name:_____

Physical/E911 Address:_____

Mailing Address:_____

City:_____

State_____Zip:_____

Social Security #: _____

Date of Birth _____/_____/_____

Sex: Male Female

School:_____

Transportation: ☒ Bus ☒ Parent

Bus# AM_____ PM_____

Phone #:(_____) _____

For Office Use Only:
☐ Income ☐ Disability ☐ KSI

Student's Race: ☐ White/Non-Hispanic ☐ Hispanic ☐ American Indian/Alaskan Native ☐ Black/Non-Hispanic ☐ Other ☐ Asian/Pacific Islander

Who's identifying a student's race? ☐ Parent/Guardian ☐ Child ☐ Observer ☐ Unknown

First Language Your Child Began to Speak:_____ Country of Origin:_____

Language Spoken Most Often by Student in the Home:_____

Language Spoken Most Frequently in the Home/Primary Language Spoken to Child:_____

Does your child have any special needs that require accommodations at school? ☐ Yes ☐ No

If Yes, What needs? _____

Guardian Information Collection Form

Guardian #1	Guardian #2
Full Name:_____	Full Name:_____
DOB:_____	DOB:_____
Physical/E911 Address:_____	Physical/E911 Address:_____
Mailing Address:_____	Mailing Address:_____
City:_____ State: _____ Zip:_____	City:_____ State: _____ Zip:_____
Phone:_____	Phone:_____
Relation:_____	Relation:_____
Employer:_____	Employer:_____
Address:_____	Address:_____
Work Phone:_____	Work Phone:_____
Race:_____ Primary Language:_____	Race:_____ Primary Language:_____
E-Mail Address:_____	E-Mail Address:_____

Please list any siblings living at home and the school, if any they attend._____

_____

HOME DIRECTIONS

Please give directions to your home:_____

*Notify the school when there is a change of address, phone, etc.

Greenup County Preschool--Student Data Collection Form
2021/2022
EMERGENCY INFORMATION

Is your child on any routine medication? ☐ Yes ☐ No If yes, please list below:

_____

Does your child have allergies (such as allergic to medication(s) or insect bites? ☐ Yes ☐ No
If yes, please specify _____
Does your child have a history of ☐ heart disease ☐ diabetes ☐ T.B. ☐ anxiety ☐ Trauma
☐ epilepsy ☐ ear infection ☐ seizure ☐ asthma ☐ other _____
If so, please check and describe any special emergency treatment that may be required: _____

_____

Please list any regular medications your child currently takes: _____
Doctor's Name: _____ Phone Number: _____
Address: _____

In case of emergency, accident, or serious illness of the above named child, I request the school to contact Guardian 1 or Guardian 2 listed on this form. If school personnel are unable to contact Guardian 1 or Guardian 2, I hereby authorize them to call the person(s) listed below:

Name (First, Middle, Last)	Relationship	Phone Number

*** Anyone picking up a child from school must be prepared to present a photo I.D.**

Are there court orders concerning the custody and/or visitation of your child? ☐ Yes ☐ No
☐ If yes, have you provided the school with an official copy of the legal documents to place in your child's folder? ☐ Yes ☐ No

*** Legal documents must be on file in order to permit or deny a parent the right to pick his/her child up from school.**

EARLY DISMISSAL

In the event of early dismissal, your child will follow normal daily transportation methods unless specified otherwise. When school is dismissed early for any reason, I would prefer the following:

☐ My child will ride the bus home
☐ My child will be picked up at school in a timely manner
☐ Other:

_____

I swear or affirm that to the best of my knowledge or belief, the statements and information contained above are true, factual, and complete. If it is impossible to contact the physician named above, I hereby authorize the school to take action necessary to maintain the student's health.

Parent/Guardian's Signature:	Date: _____/_____/_____

PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE INDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____ Gender: M F Grade: _____

Date of Birth: _____ Age: _____ yrs _____ months Preferred Language: _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies: _____

_____

_____

_____

Current Prescribed Medications to be taken daily at school: _____

_____

_____

_____

Significant Historical Information: _____

_____

_____

_____

SCREENING RESULTS:

Height: _____ ft _____ inches _____ Weight _____ BMI: _____ BMI% _____ B/P: _____

Vision	Right 20/_____	Passed ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☐	Failed ☐	Referred ☐
	Left 20/_____		Hearing - Left	Passed ☐	Failed ☐	Referred ☐

Optional: Hct/HGB: _____ Lead: _____ Urinalysis: _____

Gross dental (teeth and gums)	☐ Normal	☐ Abnormal _____	Refer/Tx:	_____
Head/scalp/skin	☐ Normal	☐ Abnormal _____	Refer/Tx:	_____
Eyes/Ears/Nose/Throat	☐ Normal	☐ Abnormal _____	Refer/Tx:	_____
Chest/Lungs/Heart	☐ Normal	☐ Abnormal _____	Refer/Tx:	_____
Abdomen	☐ Normal	☐ Abnormal _____	Refer/Tx:	_____
Scoliosis assessment	☐ Normal	☐ Abnormal _____	Refer/Tx:	_____

(Over)

This child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

_____

☐ This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

_____

Recommendations (Attach additional sheet if necessary): _____

_____

(Please Check One)

☐ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

_____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☐ SCHOOL READINESS
- Establish routines
- After-school care/activities
- Friends
- Bullying
- Communicate with teachers

☐ MENTAL HEALTH
- Family time
- Anger management
- Discipline for teaching not punishment
- Limit TV, computer

☐ NUTRITION AND PHYSICAL ACTIVITY
- Healthy weight
- Well-balanced diet, including breakfast
- Fruits, vegetables, whole grains, dairy
- 60 minutes of exercise/day

☐ ORAL HEALTH
- Regular dentist visits
- Brushing/Flossing
- Fluoride

☐ SAFETY
- Sexual safety
- Pedestrian safety
- Safety helmets
- Swimming safety
- Fire escape plan
- Smoke/carbon monoxide detectors
- Guns
- Sun
- Appropriately restrained in all vehicles

Additional comments or recommendations: _____

_____

_____

_____

_____

_____

Signed: _____ Date: _____

Physician/APRN/PA/EPSDT Provider

Address: _____ Telephone: _____

COMMONWEALTH OF KENTUCKY
CERTIFICATE OF IMMUNIZATION STATUS

Certificate Issuing Office Name and Address

Name of Child: _____ Birthdate: _____
(Last) (First) (Middle) (Suffix) (MM/DD/YYYY)

Name of Parent: _____
(Last) (First) (Middle) (Suffix)

Address: _____
(Street) (City) (State) (Zip Code)

VACCINE	DOSE 1 MM/DD/YYYY	DOSE 2 MM/DD/YYYY	DOSE 3 MM/DD/YYYY	DOSE 4 MM/DD/YYYY	DOSE 5 MM/DD/YYYY
Hepatitis B	/ /	/ /	/ /	/ /	
Alt. Adult Hepatitis B[1]	/ /	/ /			
DTaP/DTP/DT[2]	/ /	/ /	/ /	/ /	/ /
Hib[3]	/ /	/ /	/ /	/ /	
Pneumococcal (PCV13)	/ /	/ /	/ /	/ /	
Polio	/ /	/ /	/ /	/ /	/ /
Influenza	/ /	/ /			
MMR	/ /	/ /			
Varicella	/ /	/ /	Had Chickenpox or Zoster Disease Yes No		/ /
Hepatitis A	/ /	/ /			
Meningococcal	/ /	/ /			
Td	/ /	/ /			
Tdap	/ /	/ /			
Rotavirus	/ /	/ /	/ /		
HPV	/ /	/ /	/ /		
Men B	/ /	/ /	/ /		
Pneumococcal (PPSV23)	/ /	/ /			

[1]Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age. [2]DTaP, DTP, or DT. [3]Hib not required at 5 years of age or more.

☐ This child is current for immunizations until ___/___/____, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

☐ This child is not up-to-date at this time. This certificate is valid until ___/___/____, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

Reason child is not up-to-date:

☐ **Provisional Status** - Child is behind on required immunizations.

☐ **Medical Exemption** - The following immunizations are not medically indicated: _____

_____

If Medical Exemption, can these vaccines be administered at a later date? **No:** _____ **Yes:** _____ **Date:** ___/___/___

☐ **Religious Objection**

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

_____ _____
(Signature of physician, APRN, PA, pharmacist, LHD administrator, RN or LPN designee) (Date)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

Kentucky

OFO/DSS

Kentucky Dental Screening/Examination Form for School Entry

KDESHS005

Kentucky law, KRS 156.160(i), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

Student Name: _____
Last First Middle

Birth date: ____/____/____ Gender: ☐ 0 Male ☐ 1 Female

Parent or Guardian: _____
Name Relationship

Address: _____ City: _____

Phone Number: _____ School: _____

Date of Exam/Screening ____/____/____

Test Type (check one)

☐ Screening

☐ Exam

Screener's Name: _____

Screener's Address: _____

_____

Phone Number: _____ Screening Date: _____

Screener's Signature: _____

Professional affiliation: (Please check one)

☐ Dentist ☐ Dental Hygienist

☐ Physician Assistant ☐ Registered Nurse with training

☐ APRN ☐ Physician

Untreated Decay: (Check one)

☐ 0 No untreated cavities

☐ 1 Untreated cavities

Treated Decay: (Check one)

☐ 0 No treated cavities

☐ 1 Treated cavities

Pattern of Early Childhood Cavities: (Check one)

☐ 0 No Early Childhood Cavities

☐ 1 Early Childhood Cavities Present

Treatment Urgency: (Check one)

☐ 0 No obvious problem

☐ 1 Early dental care needed

☐ 2 Referral for Urgent Care
NOTE: Comment required if marked.

Comments:

KDE/DSS **Kentucky Eye Examination Form for School Entry** **KDESHS00**

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION

Date of student's enrollment: _____ **Date of Vision Examination:** _____

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

CASE HISTORY

Date of Exam: _____

Ocular History: Normal or Positive for: _____

Medical History: Normal or Positive for: _____

Drug Allergies: NKDA or Allergic to: _____

Family Ocular and Medical History: ☐ Amblyopia ☐ Strabismus ☐ Glaucoma ☐ Diabetes

Other: _____

Other Pertinent Information: _____

Refraction with cycloplegic? (Please indicate one.) ☐ YES ☐ NO

	OD	OS
Unaided Acuity	20/	20/
Best Corrected Acuity	20/	20/

Type of Examination	Normal	Abnormal	Notable to Assess
External Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

Diagnosis:

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: ☐ YES ☐ NO

2 _____

3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

- ☐ Educate (parents/patients) about eye/vision disorders and needed vision care
- ☐ Counsel (parents/patients) regarding eye safety
- ☐ Stress importance of early, preventative eye care
- ☐ Recommend re-examination, as appropriate

Signed: _____ Date: _____

Optometrist/Ophthalmologist

Address: _____ Telephone: ( ) _____

GREENUP MINI MUSKETEERS

Preschool Parent Survey
Academic Year 2021

To: Parents/Guardians of All Greenup County Preschool Students

Our preschool program aims to assist families in school readiness. Healthy families are essential to a child's immediate and future success. Please allow us to assist you in meeting your family goals for health and education. Please check any of the following items that you are interested in learning more about.

- ❑ GED programs for adults
- ❑ Literacy programs for adults
- ❑ College information for adults including, (FAFSA, enrollment, classes and programs available)
- ❑ Addiction or Mental Health Services
- ❑ Parent training on any of the following
  - o Behavior
  - o Autism
  - o Developmental Delay
  - o Speech-Language Delay
  - o Child nutrition and development
  - o Meeting a child's sensory needs
  - o First Steps for children birth to 3
  - o HANDS for first time parents
  - o Kentucky Strengthening Families
  - o Kindergarten Readiness
  - o Other _____

- ❑ Other suggestions _____

What is the best way for you to receive information? ☐ E-mail ☐Newsletter ☐ Parent Training/Workshop
☐ Phone ☐Facebook-Online Party ☐ Printed Materials ☐Home Visit ☐ Conference

During NTI or Non-traditional Instruction Days: My child prefers to participate through,

☐ **Google Meet** ☐ **Online Program** ☐ **Take Home Kit**

Parent or Guardian's Signature_____ **Date** _____

Address_____

Phone _____ **Additional Contact Number** _____

For more information or questions, please contact:
Melissa Latimer, Greenup County Preschool Programs for Families at 606-473-7936
melissa.latimer@greenup.kyschools.us

*** All responses are confidential.**

45 Musketeer Drive, Greenup, KY 41144

Traysea Moresea, Superintendent

GREENUP COUNTY SCHOOLS

Dear Parent/Guardian:

Thank you for beginning the process for determining if your child is eligible to attend the state funded preschool program. The state funded preschool program is an intervention program,provided to families who meet income eligibility guidelines and/or who's child is identified with a developmental delay or disability. Each family wishing for their child to attend the state funded preschool program must complete a household and income form.

1. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD? You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro-rated share of expenses), do not include them.

2. WHAT IF MY INCOME IS NOT ALWAYS THE SAME? List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only made $900, put down that you made $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

3. WE ARE IN THE MILITARY. DO WE INCLUDE OUR HOUSING ALLOWANCE AS INCOME? If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.

4. MY SPOUSE IS DEPLOYED TO A COMBAT ZONE. IS HIS/HER COMBAT PAY COUNTED AS INCOME? No, if the combat pay is received in addition to his/her basic pay because of his/her deployment and it wasn't received before s/he was deployed, combat pay is not counted as income. Contact your school for more information.

5. WHAT DOCUMENTS CAN I PROVIDE TO VERIFY MY INCOME? Individual Income Tax Form 1040, W-2 forms, pay stubs dated within the last month, written statements from employers, or documentation showing current status of recipients of public assistance.

If you have other questions or need help, call **606-473-7936.**

Sincerely,

Melissa Latimer

Preschool Director

INSTRUCTIONS FOR APPLYING

Part 1: All Household Members (**a household member is any child or adult living with you**): All applicants should complete this part. List the name of each household member, the name of the school each child attends, and the child's grade. If the child is a foster child, check the box for foster child. If a household member has no income, check the box for no income. All household members, including foster children, should be included here. If you need additional space, attach a separate piece of paper.

If your child is **HOMELESS, A MIGRANT OR A RUNAWAY**, follow these instructions.

Part 2: Check the appropriate category.
Part 3: Skip this part.
Part 4: Sign the form.

If you have **FOSTER CHILD(REN) ONLY**, follow these instructions. You do **not** need to fill out a separate form for each foster child in your household. (If there are both foster children and non-foster children in your household, follow the instructions below for All Other Households).

If all children in the household are marked as foster children in Part 1:
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Sign the form.

ALL OTHER HOUSEHOLDS, including WIC households, households with non-foster children and households with both foster children and non-foster children, follow these instructions:

Part 2: Skip this part.
Part 3: Follow these instructions to report total household income from **this month or last month.**

- **Section 1–Name:** List all household members who have income.
- **Section 2 –Gross Income and How Often It Was Received:** List the income for each household member. Check the box to tell us how often the person receives the income—weekly, every other week, twice a month, or monthly.
    - **Earnings from work**: List the **gross income,** not the take-home pay. Gross income is the amount earned *before* taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. Net income should *only* be reported for self-owned business, farm, or rental income.
    - **Welfare, Child Support, Alimony**: List the amount each person receives, and check the box to tell us how often.
    - **Pensions, Retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits**. List the amount each person receives, and check the box to tell us how often they receive it.
    - **All Other Income**: List Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income received weekly, every other week, twice a month, or monthly. Do not include income from KTAP, SNAP, WIC, federal education benefits and foster payments received by your family from the placing agency.
    - If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 4: An adult household member must sign the form. Please include your address and phone number in the event the Preschool Coordinator has a question about your information.

HOUSEHOLD AND INCOME FORM

The State-Funded Preschool Program is available to children who are 4 years old on or before August 1 and whose family income is 160% poverty or less; and, the program is available to children who are 3 or 4 years old with an identified disability. To determine income eligibility, please complete, sign and return this application to **Greenup County Schools.**

PART 1. ALL HOUSEHOLD MEMBERS

Names of <u>all</u> people living in your household (First, Middle Initial, Last)	School the child attends, or indicate "NA" if household member is not in school	Grade Level	*Check if a foster child (legal responsibility of welfare agency or court) If <u>all</u> children listed below are foster children, **skip to Part 4** to sign this form.*	*Check if NO income*
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

PART 2. HOMELESS, MIGRANT, RUNAWAY STATUS

If any child you are applying for is HOMELESS, MIGRANT, OR A RUNAWAY, check the appropriate box.

HOMELESS ☐ MIGRANT ☐ RUNAWAY ☐

PART 3. TOTAL HOUSEHOLD GROSS INCOME (before deductions). List all income on the same line as the person who receives it. Check the box for how often it is received. RECORD EACH INCOME ONLY ONCE.

1. NAME (List only household members with income)	**2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED**															
	Earnings from work before deductions.	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, Social Security, SSI, VA benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All Other Income (indicate frequency, such as "weekly" "every 2 weeks", "monthly")
(Example) Jane Smith	$200	☒	☐	☐	☐	$150	☐	☒	☐	☐	$0	☐	☐	☐	☐	$50 / monthly
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$ /

PART 4. SIGNATURE (ADULT HOUSEHOLD MEMBER MUST SIGN)

An adult household member must sign the form.

I certify (promise) that all information on this form is true and that all income is reported. I understand that the school will get state and federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my child(ren) may lose benefits.

Sign here: ______________________ Print name: ______________________ Date: ____________

Address: ______________________ City: ______________________ State: ________ Zip Code: ________

Phone Number: ______________________ Cell Phone Number: ______________________

Privacy Notice

The Kentucky Department of Education is requiring schools to collect the information on this form. You do not have to give this information, but if you do not, we cannot determine your child's eligibility for additional benefits under state and federal programs. We will hold the information you provide us as private and confidential to the extent required by law. However, we will share your socioeconomic status with various state and federal 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.

Non-Discrimination Statement: In accordance with Federal Law and U.S. Department of Education policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write U.S. Department of Education, Office for Civil Rights, The Wanamaker Building, 100 Penn Square East, Suite 515, Philadelphia, PA 19107-3323 or call (215) 656-8541 (Voice). Individuals who are hearing impaired or have speech disabilities may contact U.S. DOE through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). The U.S. Department of Education is an equal opportunity provider and employer.

CHECKLIST

- ☐ Have you included all your children as household members?
- ☐ For each household member receiving income, is the frequency checkbox checked?
- ☐ Have you signed the application?

DO NOT FILL OUT THIS PART. THIS IS FOR SCHOOL USE ONLY.

Annual Income Conversion: Weekly x 52; Every 2 Weeks x 26; Twice A Month x 24; Monthly x 12

Total Income: _____ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice A Month ☐ Month ☐ Year Household size: _____

Eligibility: 160% poverty ___ Special Education ___ Head Start ___ Over Income ___

Reason (160% poverty; Special Education; Head Start (if applicable); Over Income): _____

Preschool Coordinator: _____ Date: _____

Secondary Signature: _____ Date: _____