MUSTANGS

Eldon Upper Elementary School

409 E. 15th St. Eldon, MO 65026 Phone: 573-392-6364 Fax: 573-392-6820
Cody Kliethermes, Principal Kari Duncan, Assistant to the Principal

Student Record Release Permission Form

Date: _____

Student Full Name: _____ Grade: _____

Date of Birth: _____

New Enrollments in other Buildings: _____

Name of Last School Attended: _____

Address: _____

Phone: _____ Fax: _____

To enable us to complete our records, please send the following information:

1. Record of Scholastic Achievement
2. Health and Immunization Record
3. Testing Scores (MAP)
4. Diagnostic Summary and IEP, if applicable
5. Discipline and Attendance Records

Parent/Guardian Signature: _____

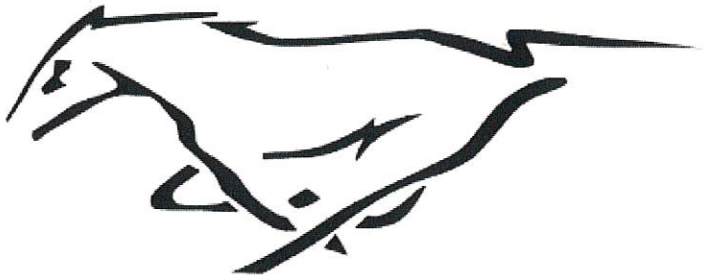
Please return records to haley.wood@eldonmustangs.org

The Family Rights and Privacy Act, Buckley Amendment. Section 99.30, Paragraph (B) states that schools where a student intends to enroll DO NOT need to have consent form signed for transfer of school records.

Important

If you have had a change of address since the 2023-2024 school year you must provide a new Proof of Residency.

Thank you!



ELDON R-I SCHOOLS ENROLLMENT INFORMATION

Date_____ Grade_____

Student's Name: _____ **Birthdate:**_____ **Age:**_____

Address: _____ **City**_____ **ZipCode**_____

IF PO BOX is used, please list actual street address above: PO BOX #_____

Home Phone #: _____ **Cell:** _____ **E-mail address:**_____

Grade _____ **Social Security #:** _____ **Male**___**Female** ____

RACE: (please check) White___Black___Hispanic___Indian___Asian___Other_____

Parent/Guardian (in home) or whom you are living with: **Are you a registered voter? YES NO**

Parent One Name: _____ **Marital Status: M W D S**

Relationship to Student:_____ **Cell #:** _____

Parent/guardian E-mail Address:_____

Employer: _____ **Work #:** _____

Parent/Guardian 2 information_____ **Marital Status: M W D S**

Relationship to Student:_____ **Cell #:** _____

Parent/guardian E-mail Address:_____

Employer: _____ **Work #:** _____

Please list all siblings in Eldon Schools and their ages:_____

Are there currently any court orders dealing with custody or visitation? YES NO

IF YES, please provide the school with a copy. We CANNOT honor without documentation.

Emergency Contacts:

1.Name_____ **Relation:**_____ **Phone #:** _____ **Cell:** _____

2.Name_____ **Relation:** _____ **Phone #:** _____ **Cell:** _____

3.Name_____ **Relation:** _____ **Phone #:** _____ **Cell:** _____

4.Name_____ **Relation:** _____ **Phone #:** _____ **Cell:** _____

Name of Parent out of the home (if applicable):_____ **Relationship:** _____

Address: _____

Cell#: _____ Employer: _____ Work #: _____

Spouse: _____ Cell #: _____

Would this parent like a grade card sent to them? YES NO

Continued on back.....

Previous school attended (name of school in what State):_____

Previous school address:_____ Phone #:_____

Circle the county in which you live: MILLER MORGAN MONITEAU

Circle the district in which you live: ELDON R-I HIGH POINT OTHER

Does the student use a language other than English? YES NO If YES, what language?_____

Is a language other than English used in the home? YES NO If YES, what language?_____

Are you or an immediate family member in the Military? (circle one) Active Duty National Guard or Reserve Unknown

Are you currently living in a temporary residence due to loss of permanent housing (e.g. motel, hotel, car, shelter)? YES NO

Has your family moved within the past 3 years to seek or obtain temporary or seasonal agricultural or food processing work? YES NO

Is child involved in (check all that apply):

Special Ed. classes_____ Speech_____ Title I Reading_____ Gifted_____ 504 Plan_____

I VERIFY THAT ALL ENROLLMENT INFORMATION IS CORRECT.

Parent Signature_____

Title One Home-School Compact

Upper Elementary School is a school-wide Title 1 building; therefore, all students have the opportunity for additional assistance in learning.

Students of Upper Elementary School are encouraged to be responsible for their own success. To aid in this success they can make the following commitments:

1. Attending school on time every day.
2. Doing their best in class and completing homework on time.
3. Respecting others and themselves, making good choices and being a cooperative learner.
4. Keeping parents informed about progress in school and asking for help when needed.
5. Using time wisely at home and at school.

Parents are encouraged to be involved in their child's education in an effort to help with his/her achievement, attitude and behavior. To aid in this effort parents can make the following commitments:

1. Sending child to school every day, well rested and ready for the day.
2. Providing appropriate learning supplies and a place and time for learning.
3. Letting child know how much they care about their learning.
4. Checking child's homework and their graded schoolwork.
5. Making sure communication flows two ways, both from school to home and from home to school.

As educators at Upper Elementary School, we understand the importance of the educational experience for every student and our role as the teacher and role model. Therefore, in order to insure learning that takes place for every student we are committed to the following:

1. Maintain high expectations for every child to learn and achieve.
2. Provide a safe, positive and respectful learning environment.
3. Recognize and adapt for each students' needs and encourage individual talents.
4. Communicate with parents and students on a regular basis concerning student progress.
5. Help parents to support learning and positive behavior and encourage interaction at school.

By signing this compact, I acknowledge that I have access to a printed and online version of the Student/Parent Handbook and understand the terms and conditions. Together, students, parents, and educators become partners to enable the child to know success and a lifelong love of learning.

_____

Parent Signature

_____

Student Signature

Access to Devices/Internet

Please provide as much information as possible

Student Name: _____ Grade: _____

Teacher Name: _____

Please check all that apply:

- Does your student have internet access? Yes ____ No____
- Does your student have access to a computer during school hours? Yes____ No____

Please check all that apply:

- My student has access to the following devices during school hours:
- Computer/Chromebook _____
- Tablet/I-Pad _____
- Phone _____
- My student does not have access to any of the devices listed above. _____

What internet provider do you have access to? _____

Email address to best reach you: _____

Thank you ☺

Media Permission

Dear Parents/Guardians,

On certain occasions, media will be taking pictures of students in the classroom or participating in special events on and off campus. We believe this is a wonderful opportunity for the community to see what great students and staff we have. It provides an outlet for the community to see and hear about the wonderful things we have going on at Upper Elementary.

Student Name_____ Teacher_____

☐ Yes, I give permission for my student's picture to be published.

☐ No, I **DO NOT** give permission for my student's picture to be published.

_____ _____

Parent/Guardian Date

Thanks for all you do! When families and schools work together, great things can happen.

ELDON SCHOOL DISTRICT

Home of the Mustangs

For NEW Parent Portal Users ONLY

***Please only fill out if you are a new portal user or your email address has changed.**

Through this web-based system, Parent Portal, parents will be able to view their child's attendance history, schedule, grades based on three week progress reports, and lunch account balances.

Information for your child is available only with a password. All passwords are distributed through email. It will be your responsibility to keep this password private. We cannot issue any passwords via phone conversation. Passwords will not be issued to the student. You must have an email address to view your child's records in PARENT LINK.

Please provide the email address that you would like used for student information notifications. You may use only one email address, for example, home or work, but email cannot be sent to both. Please fill in the correct email address on the line provided. This form must be submitted each school year for you to have access.

____ I would like to be able to access my student's information over the Internet by using a password.

____ I do not want access to my student's information available over the Internet.

PLEASE PRINT BELOW

Student Name _____

_____ _____

Parent Name Email Address

_____ _____

Parent Name Email Address

I understand that it is my responsibility to protect my PARENT LINK password. I should not share my password with my children. I understand that the PARENT LINK system may not be available 24 hours a day due to maintenance on the school network, weather related interruptions, etc.

Date: _____

Parent Signature Parent Printed Name

Eldon R-1 School District – Health Services
Student Health Information 2023-2024

Student Name _____ **Grade** _____

Regular or Emergency Medications Your Child Is Taking

(at home) _____

(at school) _____

I request that you give over the counter medication to my child during the school year in accordance with the Board Policy. I authorize the school nurse or designee to give my child medication. I will not hold the school staff responsible for any undesired reaction that may occur from the medication. (Examples of non-prescription medication to be given with parent permission are: non-aspirin pain relievers including Acetaminophen, Ibuprofen, Tylenol, sore throat spray, antacid, antibiotic ointment, hydrocortisone cream, calamine lotion, throat lozenges, topical anti-sting treatments and generic substitutes.

Please initial below for over the counter medications:

_____ Yes

_____ No

I hereby give my permission for the Eldon Schools to obtain or send my students immunization record to Physician of choice.

Please initial below:

_____ Yes

_____ No

Please mark below if your child has any of the following:

___ Asthma
___ Diabetes
___ Seizures
___ Severe Allergies
___ Heart Condition

___ ADHD
___ ADD
___ Hearing problem
___ Vision problem
___ Seasonal Allergies

___ Other Medical Condition EXPLAIN
_____
_____
_____
_____

List **All** Child's **Medication Allergies** _____

List **All** Child's **Food Allergies and provide Doctors note:**

_____

Students Physician _____

1. Any medication that is sent to school with a student must be in the original container with the student's name on it.
2. Medication sent to school with a student must be accompanied by a signed and dated note from the parent/guardian requesting the medication to be given.
3. It is recommended that a small container of medication be sent to school.
4. All medications must be given to the school nurse as soon as the student arrives at school.
5. Please make sure the medication is age appropriate.

It is my understanding that my signature allows all of the above information and treatment as well as yearly vision, hearing, height and weight screenings to be administered to my student.

Parent Cell Phone _____

Parent Signature _____ **Date** _____

MUSTANGS

Upper Elementary Transportation Confirmation Form

***Please note that your student should have a transportation plan marked for each day of the week.**

- Please specify days of the week that your student will be picked up at regular dismissal time. **(Pick-Up/Walker Dismissal Authorization MUST be filled out.)**

Please indicate:
Pick Up = P
Walker = W

_____ Monday - **3:20pm**
_____ Tuesday - **3:20pm**
_____ Wednesday - **2:20pm**
_____ Thursday - **3:20pm**
_____ Friday - **3:20pm**
_____ **Call Only**

- Please specify days of the week that your student needs to ride a bus at regular dismissal time. **(Bus Transportation form MUST be filled out.)**

_____ Monday - 3:20pm
_____ Tuesday - 3:20pm
_____ Wednesday - 2:20pm
_____ Thursday - 3:20pm
_____ Friday - 3:20pm
_____ **Call Only**

- Please specify days of the week that your student will attend PM LEAP or LEAP of Faith **(LEAP or LEAP of Faith form must be filled out.)**

_____ Monday - **PM LEAP**
_____ Tuesday - **PM LEAP**
_____ Wednesday - **LEAP of Faith**
_____ Thursday - **PM LEAP**
_____ Friday - **PM LEAP**

Parent/Guardian _____ **Date** _____

BUS TRANSPORTATION

Dear Parents/Guardians:

1. **All requests must be completed and given to the student's Building Official for review prior to their approval. *THREE SCHOOL DAYS NOTICE IS REQUIRED BEFORE A REQUEST MAY BE GRANTED.***
2. **Final approval of request must be made by the Transportation Department prior to the student being placed on a transfer bus to ensure that all parties involved (parent/guardian, teacher, building official, Transportation Department and bus driver) are informed and the student's safe transportation is assured.**
3. **Transfer students must present a bus pass to the driver, given to them by the Principal's Office, to ride their new bus to their new location. The transfer stop should be written on the bus pass given to the new driver.**

Please complete this form and return to the Building Office.

Grade: _____ **Current Teacher:** _____

Student's name _____

Address: _____

My student will load the bus in the *morning* at the following *designated* bus stop:

_____ **AM Bus#:** _____

My student will ride the bus in the *afternoon* to the following *designated* bus stop:

_____ **PM Bus#:** _____

My child does *NOT* require bus transportation: _____

My child is enrolled in the afternoon LEAP program: YES ____ NO____

No Bus Discipline Warnings: If a student does not follow the bus driver's rules, they will lose their bus privilege immediately. The bus driver will document discipline issues and submit them to the transportation director promptly. Immediate action will take place. The six bus rules must be followed at all times in order to keep not only all students safe, but also the other motorists on the road.

Discipline Guidelines for Buses

1. Obey the driver promptly
2. Stay seated until the bus comes to a complete stop
3. Keep hands, feet and items to yourself at all times and no throwing objects
4. No offensive language or disruptive behavior
5. No food, candy, gum, or beverages on the bus
6. No large equipment, animals, skateboards or other equipment on the bus

_____

Parent/Guardian Signature **Phone Number** **Date**

****

(OFFICE USE ONLY)

Bldg Approval: _____ Date: _____ (Must be approved prior to request from transportation)

****

(TRANSPORTATION DEPARTMENT)

AM Bus # _____ AM Bus Stop _____ AM P/U Time: _____

PM Bus # _____ PM Bus Stop _____ PM D/O Time: _____

Effective Date: : _____ Date (Parent/Guardian/Teacher) notified: _____

School Safety Alert: District's Bus Transfer Requests Policies and Procedures

BUS TRANSFER REQUESTS

The Eldon School District continuously strives to maintain and improve its operation as a Safe School District for all students and staff. One area that the District needs continued parent cooperation is in following the District's procedures and policies for requesting bus transfers for students because of childcare and related reasons.

Please note that all bus transportation requests are to be in writing on the correct form and they are to be made in advance, at least three (3) school days prior to the requested transfer start date. The time is necessary to ensure that the transfer is consistent with Board policy and that all parties (Building Official, Homeroom Teacher, Bus Driver, and Transportation Office) are informed in a timely manner. Please provide an updated copy of your new address any time that you move and need to make a change to your child's transportation.

BUS STOP POLICIES AND PROCEDURES

The District needs continued parent cooperation in drop-off procedures. It has been the District's practice to drop-off students at their regular bus stop with a parent or guardian present. If a responsible adult is not present at the bus stop for an individual student, the student will be taken back to their school and the parent(s) or guardian will be called using the emergency phone numbers listed in the student's file. Parent(s) or guardians will be expected to pick-up their child at the school within 30 to 60 minutes for being notified before local police or Children and Youth Services is called. Persistent lack of parental or guardian presence at the student's assigned stop for the student's return home trip may result in a suspension of bus riding privileges.

The above procedures are being restated with the intent of requesting the assistance of all District parents to help the District maintain a safe student transportation system for ALL of our children.

Contact the Eldon R-1 transportation dept if you have any questions or need assistance with the above bus procedures and policies.

CENTRAL OZARKS MEDICAL CENTER

COMC

ELDON SCHOOL CLINIC

Child's Name: _____

Dear Parent/Guardian:

Central Ozarks Medical Centers (COMC) is excited to announce we have partnered with the Eldon School District to provide Medical, Dental and Behavioral Health Services during the 2024-25 academic year! This partnership will allow COMC to expand access to convenient care to ensure your child stays healthy throughout the school year. COMC is a local, non-profit organization that has worked to meet the healthcare needs of your community and surrounding areas since 1979.

Open all year, even during the summer and school breaks, COMC's School-Based Clinic offers many services. Jillynn and her Medical Team provide school and sports physicals, care for colds, flu, immunizations, rapid labs, treatment for health problems like asthma, diabetes, and many other health concerns. Dr. Currey and her Dental Team provide access to students, staff, faculty, and the Eldon community for all dental needs. The Dental Clinic is located across the hallway from Medical Services.

In addition to Medical and Dental Services, our Behavioral Health Staff can work with your child to provide access to Counseling Services for issues such as depression, body image, peer pressure and any other challenges that your child may be experiencing. Students served by our School-Based Therapists have direct access in a convenient and confidential setting while they are at school. This limits absences from the classroom, ensures appointments are kept and creates a less intimidating environment for the student.

COMC's School-Based Services are available to any child who completes registration information and makes financial arrangements. COMC accepts Medicaid, Private Medical and Dental Insurance. We also offer a Sliding Fee Scale based on household size and income. We have dedicated staff to assist in eligibility for our Slide Scale and to identify if your student is eligible for the Missouri Medicaid Program. If your child is insured, please attach a copy of the front and back of their insurance card to the completed packet or email a copy of the front and back of the insurance card to: comc.clinic@eldonmustangs.org.

We look forward to working with you to provide the best healthcare experience for your child. If you have questions or concerns, please call: (573)392-8056 for Medical, (573)557-4220 for Dental, or send us an email to: comc.clinic@eldonmustangs.org.

If you would like for your child to be seen by COMC, please complete the attached registration packet and return it to school at your earliest convenience.

Indicate below, which services you would like for us to provide your child:

□ Medical □ Dental □ Behavioral Health

Sincerely,

Kelly Miller, CEO

Your Health... Our Mission

CENTRAL OZARKS MEDICAL CENTER
COMC
ELDON SCHOOL CLINIC

Central Ozarks Medical Centers
School Based Healthcare Services
Patient Registration

Grade: _____

Teacher: _____

If you have questions or need assistance filling out any of these forms, please call: (877) 406-2662

PATIENT INFORMATION (Please Print)

Patient's First Name:	Middle Initial:	Last Name:	Gender at Birth: ❑ Male ❑ Female	Social Security Number: (optional)	Birth Date: / /

Street Address:	City:	State:	Zip Code:

Mailing Address: ❑ Same as above	Home Phone Number where messages can be left: ( )
Email Address:	Cell Phone Number where messages can be left: ( )

Preferred Pharmacy:	Preferred Pharmacy City & Street:,

Does the patient have any problems with: ❑Vision ❑Hearing ❑Reading ❑Speaking Explain:

PARENT/LEGAL GUARDIAN/GUARANTOR INFORMATION

Name:	DOB:	Phone Number:	Relationship Type: ❑ Mother ❑ Father ❑ Guarantor ❑ Guardian (Specify): _____
Name:	DOB:	Phone Number:	Relationship Type: ❑ Mother ❑ Father ❑ Guarantor ❑ Guardian (Specify): _____

PERSON(S) WHO MAY BE NOTIFIED IN CASES OF EMERGENCY OTHER THAN PARENT/LEGAL GUARDIAN

Name:	Phone Number:	Relationship to Patient :
Name:	Phone Number:	Relationship to Patient :

PROTECTED HEALTH INFORMATION

Person(s) who may obtain medical and/or dental health information. This may include verbal and/or copies of records unless specified by you. I also give consent for the following individuals to attend and give consent for services received by COMC and to make treatment decisions for my child in my absence. (This does not include psychiatry or behavioral health records)

Name:	Phone Number:	Relationship type:
Name:	Phone Number:	Relationship type:

If your student is uninsured, a Community Health Worker will be reaching out to you to discuss obtaining insurance for your family and Sliding Fee options

Please provide the best contact number: _____

_____ (Initial) ***Medicare Recipients Only*** I request payment of authorized medical benefits be made to Central Ozarks Medical Center, and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

_____ (Initial) The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Central Ozarks Medical Center. I understand that I am financially responsible for any balance. I also authorize COMC or my insurance company to release any information required to process my claims.

Signature:_____ **Date:** _____

****MEDICIAL INSURANCE INFORMATION**

Insurance Carrier: _____

Full billing address on back of card: _____

Group Number: _____ Plan Number: _____

Participant's ID Number: _____

Subscriber Name (if different than patient): _____

Relationship to Patient: □ Spouse □ Parent □ Step-Parent

Subscriber's Birthdate: _____ Subscriber's Phone#: _____

Subscriber's Social Security Number: _____

Subscriber's Address: _____

****FAILURE TO PROVIDE INSURANCE/SLIDING FEE INFORMATION WILL RESULT IN BEING BILLED FULL PRICE FOR SERVICES RENDERED****

PLEASE EMAIL A COPY OF FRONT AND BACK OF INSURANCE CARDS TO: COMC.CLINIC@ELDONMUSTANGS.ORG

****Dental Insurance Information**

Insurance Carrier: _____

Full billing address on back of card: _____

Group Number: _____ Plan Number: _____

Participant's ID Number: _____

Subscriber Name (if different than patient): _____

Relationship to Patient: □ Spouse □ Parent □ Step-Parent

Subscriber's Birthdate: _____ Subscriber's Phone#: _____

Subscriber's Social Security Number: _____

Subscriber's Address: _____

Due to our participation in Federal Programs, we are required to request the following information

Household Size: _____

Household Income: _____

Sex Assigned at Birth:
- □ Male
- □ Female

Race:
(Select ALL that Apply)
- □ American Indian/Alaska Native
- □ Asian
- □ Asian Indian
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Vietnamese
- □ Other Asian
- □ Black/African American
- □ Native Hawaiian
- □ Other Pacific Islander
- □ Guamanian or Chamorro
- □ Samoan
- □ White

Primary Language:
- □ English
- □ Spanish
- □ Russian
- □ Ukrainian
- □ Other: _____

Sexual Orientation:
- □ Lesbian or Gay
- □ Heterosexual (stralght)
- □ Bisexual
- □ Other
- □ Don't Know
- □ Chose Not to Disclose
- □ Unknown

Ethnicity:
- □ Hispanic or Latino
- □ Mexican/Mexican American/ Chicano
- □ Puerto Rican
- □ Other Hispanic, Latino or Spanish Origin
- □ Non-Hispanic or Latino

Gender Identity:
- □ Male
- □ Female
- □ Transgender Man
- □ Transgender Woman
- □ Unknown
- □ Other
- □ Chose Not to Disclose

Have you ever served in the Military or Armed Forces? (This includes: Air Force, Army, Coast Guard, Marines, Navy, National Guard, or Reserves)
- □ Yes □ No

Employment Status:
- □ Full-Time □ Part-Time
- □ Migrant Worker
- □ Seasonal Migrant Worker
- □ Currently Unemployed

Education:
Current Student: □ Yes □ No

Highest Level of Education:
- □ Not yet in School
- □ Pre-School / Kindergarten
- □ Grade School
- □ Middle School
- □ High School
- □ High School Degree / GED
- □ Didn't complete High School
- □ Technical / Trade School
- □ Some College
- □ College Graduate

Housing Status:
Are you currently:
- □ Homeless Shelter
- □ Transitional Housing
- □ Doubling Up
- □ Street
- □ Permanent Supportive Housing
- □ Other (Own / Rent)
- □ Unknown

CENTRAL OZARKS MEDICAL CENTER

COMC

ELDON SCHOOL CLINIC

Patient Medical History

Allergies: ☐ **NKDA (No Known Drug Allergies)**

Medications: ☐ **I do not take any medications**

Have you ever had an adverse reaction to Anesthesia? ☐ **Yes** ☐ **No**
If yes, please explain:

Do you, or have you ever taken Bisphosphonate (medication used for bone loss)? ☐ **Yes** ☐ **No**
If yes, which one?

Heart & Circulatory Problems	Yes	No
Heart Inflammation		
Artificial Heart Valve		
Heart Murmur		
Heart Trouble		
Heart Attack		
Stroke		
High Blood Pressure		
Other Health Concerns		
Liver Problems		
Kidney Problems		
Thyroid Problems		

Bleeding Disorders	Yes	No
Anemia		
Bleeding Disorder		
Neurological Disorders		
Seizures		
ADHD		
Autism		
Alzheimer's / Dementia		
Diabetes		
Mental Health		
Immune System		

Infectious Diseases	Yes	No
Hepatitis A, B, C		
AIDS		
HIV Infection		
Tuberculosis / TB		
Muscle & Joint		
Hip / Knee Replacement		
Arthritis		
Cancer		
Pregnant		
Breastfeeding		
Taking Phentermine		

If you answered yes to any of the above, please explain:

Do you have any pertinent family medical history? (i.e.. Cancer, Autoimmune Disorder, etc.):

CENTRAL OZARKS MEDICAL CENTER
COMC
EUDON SCHOOL CLINIC

(Printed Name of Minor)

Patient Name: _____ **DOB:** _____

Central Ozarks Medical Centers Policies and Consents

Consent to Treat:

I, _____, consent for the treatment of _____.
(Printed Name of Parent/Guardian) (Printed Name of Minor)

I attest that I have legal responsibility for this patient and the legal right to direct the medical treatment of this patient. I give permission for Central Ozarks Medical Centers (COMC) to provide healthcare services to my child - WITHOUT a parent or legal guardian present. However, Medical Services will be PROVIDED ONLY AFTER attempting to reach a parent/guardian. COMC's Behavioral Health Services WILL NOT begin until an intake is completed with a parent/guardian. This consent allows for treatment today and all future appointments. I understand this record may be given to other providers within COMC to treat this minor as needed. I understand that I will be contacted for treatment plans or any changes in treatment. I understand that the information in my child's health record is confidential and will not be released to any unauthorized person or agency without my consent. I authorize COMC to only disclose any portion of my child's health record to school personnel only as it relates to my child's academic success, including scheduling treatment and confirmation that my child is receiving services. I authorize COMC to have access to my child's school records only to assist in providing necessary care to my child.

Consent for Services:

I agree to my child receiving the below School Based Services while at school. Initial all that apply:

_____**Medical Services**
(Initial)

_____**Dental Services**
(Initial)

_____**Behavioral Health Services**
(Initial)

Telehealth:

COMC offers its patients Telehealth services as a method to expand access to care. I understand I may be offered a Telehealth appointment at COMC. I consent to receive services via COMC's Telehealth equipment and understand and/or agree to the following:

- I understand I have the right to refuse to participate or revoke consent for services delivered via Telehealth at any time by informing any COMC staff member.
- I understand that my provider will document in my medical chart as if the visit were conducted in person with only the additional information required for Telehealth billing.
- I understand the healthcare provider performing the service will not be physically in the same room as me and will be performing the service at a different location, therefore, if parts of my care and treatment require physical examination they may be conducted by other COMC providers and staff under the direction of my Telehealth provider or I may need to be re-scheduled for a face-to-face visit which could result in a delay in service and the potential need to travel for the face-to-face visit.
- I understand there are potential drawbacks of participating in a Telehealth visit versus a face-to-face visit.
- I understand that no part of the Telehealth visit will be recorded by my provider and agree not to record any part of the visit myself.
- I understand my visit will be conducted via technology and COMC cannot guarantee technology will always work.
- I understand that if there is an equipment failure I may need to be rescheduled for a face-to-face visit.
- I understand COMC utilizes HIPAA compliant, encrypted software to conduct its Telehealth services.
- I understand I have the right to ask any questions regarding the Telehealth equipment, technology, etc. at any time.
- I understand I will be informed and made aware of the role of the Telehealth provider at the distant site, as well as qualified professional staff at the COMC location who are going to be responsible for follow-up or ongoing care, and the location of the distant site as well as be informed of all parties who will be present at each end of the Telehealth transmission; and consent to have COMC staff in the exam room to operate Telehealth equipment, if needed.
- I understand I have the right to have appropriately trained staff immediately available to me while receiving the Telehealth service to attend to emergencies or other needs. I understand this is not possible if conducting a Telehealth visit from my place of residence located within the state of Missouri or other temporary location within or outside the state of Missouri.
- I understand that mandated reporting laws will be followed by my provider during telehealth visits
- I understand that certain situations including emergencies are inappropriate for telehealth services. If I have an emergency, I should immediately call 911 or go to the nearest hospital.
- I understand that I or my insurance will be billed as authorized by my insurance and/or sliding fee plan.

Notice of Privacy Practices:

We are committed to protecting your personal health information in compliance with the law. Our Notice of Privacy Practices detail the following:

- Our obligation under the law with respect to your personal health information
- How we may use and disclose the health information we keep about you
- Your rights relating to your personal health information
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in this notice

To receive a copy of our Notice of Privacy Practices, please visit: www.centralozarks.org or send an email to: info@centralozarks.org

CENTRAL OZARKS MEDICAL CENTER
COMC
ELDON SCHOOL CLINIC

Patient Name: _____ **DOB:** _____

Central Ozarks Medical Centers Policies and Consents

Finance Policy/Release of Billing Information/Assignment of Benefits:

COMC serves all patients whether they are covered by insurance or not. When you use our services, you are responsible for the cost of those services. If you have insurance: You are responsible for understanding the limitations of your insurance coverage and are responsible for any co-pays, cost shares, and deductibles, or non-covered services at the time service is provided. As a courtesy, we will bill your insurance for you. If requested, payment plans are available. If you do not have insurance: We offer a sliding fee scale based on household size and income. You may apply for a discount at the front desk. We can also assist you with obtaining insurance c overage. I authorize COMC and its representatives to release any information they obtain, including medical information to my insurance company or their representatives to process claims for payment. As applicable, I authorize my insurance provider to pay COMC for services rendered.

Notice of Health Information Exchange Participation:

COMC may participate in one or more health information exchanges (HIEs) and may electronically share your medical information for treatment, payment, healthcare operations, and other authorized purposes, to the extent permitted by law, with other participants in the HIEs. HIEs allow your health care providers, health plan, and other authorized recipients to efficiently access medical information necessary for your treatment, payment for your care, and other lawful purposes. The types of medical information that may be shared through HIEs, includes, but is not limited to: diagnoses, medications, allergies, lab test results, radiology reports, health plan enrollment and eligibility. Such information may also include health information that may be considered particularly sensitive to you, including: mental health information; HIV/AIDs information, genetic information, STD treatment, test results, and family planning information. The inclusion of your medical information in an HIE is voluntary and subject to your right to opt-out. If you do not opt-out, we may provide your medical information in accordance with applicable law to the HIEs in which we participate. More information on any HIE in which we participate and how you can exercise your right to opt-out can be found at: www.mhc-hie.org or you may call us at (877) 406-2662. If you choose to opt-out of data-sharing through HIEs, your information will no longer be shared through an HIE, including in a medical emergency; however, your opt-out will not modify how your information is otherwise accessed and released to authorized individuals in accordance with the law, including being transmitted through other secure mechanisms (i.e., by fax or an equivalent technology).

Consent for Patient Portal:

Be proactive in the management of your healthcare!

COMC's Patient Portal is a secure, web-based, self-service portal that provides on-line interaction between our patients and our practice. Our Patient Portal allows you to submit requests for refills, referrals, view lab results, send messages to your care team, view current and past statements, and much more!

Email address: _____ **Phone:** _____ **Text:** □ **Yes** □ **No**

My Signature Means:

- I have reviewed and completed the Protected Health Information section. I understand that when I designate another person to authorize a treatment decision, Central Ozarks Medical Centers may disclose Protected Health Information to the authorized person(s).
- I have reviewed Central Ozarks Medical Center's Consent for Treatment; Finance Policy/Release of Billing Information/Assignment of Benefits; Notice of Health Information Exchange; Notice of Privacy Practices and Telehealth Policy.
- I have been given the opportunity to ask questions and all of my questions have been answered fully and satisfactorily.
- I understand that my consent will remain in effect for one year unless I notify COMC in writing. I understand that I may revoke my consent at any time.

By signing below, I am acknowledging that I have completed the information in this packet to the best of my knowledge.
By signing below and initialing on the above lines, I am acknowledging that I have read and understand the above information.

SIGNATURE: _____ **DATE:** _____

Printed Name of Person Signing: _____

Relationship to Patient: _____

CENTRAL OZARKS MEDICAL CENTER
COMC
EUDORA SCHOOL CLINIC

Introducing COMC's Healthy Tooth Club

Each child with a perfect exam (no cavities) will be added to the Healthy Tooth Club

- Entry in our monthly giveaway
- COMC "Healthy Tooth Club" T-Shirt
- Certificate of Achievement for Healthy Teeth

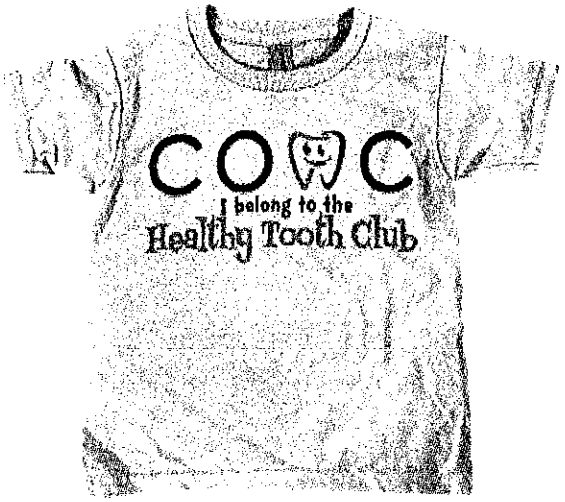


Photo Release Form

Student's Name: _____ School: _____

Parent(s) Name: _____ Phone#: _____

Address: _____ Email: _____

_____ (Initial) I DO give permission for my child's picture to be used by COMC on their Facebook account or any other publication in conjunction with Central Ozarks Medical Centers, with the understanding that his/her name will not be used with the photo nor will he/she be identified in any other way.

_____ (Initial) I DO NOT give permission for my child's picture to be used by COMC

_____ Parent/Legal Guardian Name (print)

_____ Parent/Legal Guardian Signature

_____ Date

LETTER TO PARENTS
FREQUENTLY ASKED QUESTIONS ABOUT FREE AND REDUCED PRICE SCHOOL MEALS

Dear Parent/Guardian:

Children need healthy meals to learn. **Eldon Upper Elementary School** offers healthy meals every school day. Breakfast is FREE to all students; lunch costs $2.05. **Your children may qualify for free meals or for reduced price meals.** Reduced price for lunch is $.40. This packet includes an application for free or reduced price meal benefits, and a set of detailed instructions. Below are some common questions and answers to help you with the application process.

1. WHO CAN GET FREE OR REDUCED PRICE MEALS?
   - All children in households receiving benefits from **the Food Stamp Program/Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR)** or **Temporary Assistance/Temporary Assistance for Needy Families (TANF)**, are eligible for free meals.
   - **Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals.**
   - **Children participating in their school's Head Start program are eligible for free meals.**
   - Children who meet the definition of homeless, runaway, or migrant are eligible for free meals.
   - Children may receive free or reduced price meals if your household's income is within the limits on the Federal Income Eligibility Guidelines. Your children may qualify for free or reduced price meals if your household income falls at or below the limits on this chart.

Household Size	Annually	Monthly	Weekly
1	$27,861	$2,322	$536
2	37,814	3,152	728
3	47,767	3,981	919
4	57,720	4,810	1,110
5	67,673	5,640	1,302
6	77,626	6,469	1,493
7	87,579	7,299	1,685
8	97,532	8,128	1,876
For each add'l person add	+9,953	+830	+192

2. HOW DO I KNOW IF MY CHILDREN QUALIFY AS HOMELESS, MIGRANT, OR RUNAWAY? Do the members of your household lack a permanent address? Are you staying together in a shelter, hotel, or other temporary housing arrangement? Does your family relocate on a seasonal basis? Are any children living with you who have chosen to leave their prior family or household? If you believe children in your household meet these descriptions and haven't been told your children will get free meals, please call or e-mail **Aaron Berendzen** aaron.berendzen@eldonmustangs.org **573 392-8010.**

3. DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD? No. *Use one Free and Reduced Price School Meals Application for all students in your household.* We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: **Eldon Upper Elementary School , 409 E. 14th St. Eldon, MO 65026 573 392-6364.**

4. SHOULD I FILL OUT AN APPLICATION IF I RECEIVED A LETTER THIS SCHOOL YEAR SAYING MY CHILDREN ARE ALREADY APPROVED FOR FREE MEALS? No, but please read the letter you got carefully and follow the instructions. If any children in your household were missing from your eligibility notification, contact **Eldon Upper Elementary School, 573 392-6364** immediately.

5. MY CHILD'S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT A NEW ONE? Yes. Your child's application is only good for that school year and for the first few days of this school year. You must send in a new application unless the school told you that your child is eligible for the new school year.

6. I GET WIC. CAN MY CHILDREN GET FREE MEALS? Children in households participating in WIC may be eligible for free or reduced price meals. Please send in an application.

7. WILL THE INFORMATION I GIVE BE CHECKED? Yes. We may also ask you to send written proof of the household income you report.

8. IF I DON'T QUALIFY NOW, MAY I APPLY LATER? Yes, you may apply at any time during the school year. For example, children with a parent or guardian who becomes unemployed may become eligible for free and reduced price meals if the household income drops below the income limit.

9. WHAT IF I DISAGREE WITH THE SCHOOL'S DECISION ABOUT MY APPLICATION? You should talk to school officials. You also may ask for a hearing by calling or writing to: **Shawndra Taylor, 112 S. Pine St. Eldon, MO 65026 573 392-8000,** Shawndra.taylor@eldonmustangs.org

10. MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN? Yes. You, your children, or other household members do not have to be U.S. citizens to apply for free or reduced price meals.

11. 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.

12. WHAT IF SOME HOUSEHOLD MEMBERS HAVE NO INCOME TO REPORT? Household members may not receive some types of income we ask you to report on the application, or may not receive income at all. Whenever this happens, please write a 0 in the field. However, if any income fields are left empty or blank, those will also be counted as zeroes. Please be careful when leaving income fields blank, as we will assume you meant to do so.

13. WE ARE IN THE MILITARY. DO WE REPORT OUR INCOME DIFFERENTLY? Your basic pay and cash bonuses must be reported as income. If you get any cash value allowances for off-base housing, food, or clothing, or receive Family Subsistence Supplemental Allowance payments, it must also be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income. Any additional combat pay resulting from deployment is also excluded from income.

14. WHAT IF THERE ISN'T ENOUGH SPACE ON THE APPLICATION FOR MY FAMILY? List any additional household members on a separate piece of paper, and attach it to your application. Contact **Eldon Upper Elementary School, 573 392-6364** to receive a second application.

15. MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR? To find out how to apply for the Food Stamp Program/SNAP or other assistance benefits, contact your local assistance office or call 1-855-373-4636.

If you have other questions or need help, call **Shawndra Taylor, 573 392-8000.**
Sincerely,

Shawndra Taylor, Food Service Director

USDA Non-discrimination 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/ad-3027.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

This institution is an equal opportunity provider.

HOW TO APPLY FOR FREE AND REDUCED PRICE SCHOOL MEALS

Please use these instructions to help you fill out the application for free or reduced price school meals. You only need to submit one application per household, even if your children attend more than one school in the Eldon School District. The application must be filled out completely to determine the eligibility your child(ren) for free or reduced price school meals. Please follow these instructions in order! Each step of the instructions is the same as the steps on your application. If at any time you are not sure what to do next, please contact your childrens school or Shawndra Taylor, 573 392-8000.

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

STEP 1: LIST ALL CHILDREN, INFANTS, AND STUDENTS UP TO AND INCLUDING GRADE 12

Tell us how many infants/toddlers, children not in school, and elementary/middle/high 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 formal foster arrangement through a court or state/local agency, or qualify as homeless, migrant, or runaway youth;
- Students attending Eldon School District, regardless of age.

A) List each child's name.	B) Building name/Grade.	C) Do you have any foster children?	D) Are any children homeless, migrant, or runaway?
Print each child's name. Use one line of the application for each child. When printing names, write one letter in each box. Stop if you run out of space. If there are more children present than lines on the application, attach a second piece of paper (or a second application if completing electronically) with all required information for the additional children. This also applies to adults in Step 3. "MI" is short for middle initial. Print the first letter of each child's middle name in the box.	If child is a student, list building name and grade.	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. Note: Adopted children are not considered foster children. A foster child is a minor child who has been taken into state custody and placed with a state-licensed adult, who cares for the child in place of their parent or guardian.	If you believe any child listed in this section meets this description, mark the "Homeless, Migrant, Runaway" box next to the child's name and complete all steps of the application. Homeless, Migrant, Runaway status must be confirmed with the appropriate program staff. If the school district cannot confirm your student's homeless, migrant, or runaway status, then the school district will contact you to complete and income-based application. You may choose to provide income information now in order to prevent the school district from potentially needing to contact you later.

STEP 2: DO ANY HOUSEHOLD MEMBERS CURRENTLY PARTICIPATE IN SNAP, TANF, 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)
- Temporary Assistance for Needy Families (TANF)
- The Food Distribution Program on Indian Reservations (FDPIR)

If no one in your household participates in any of the above listed programs:	If anyone in your household participates in any of the above listed programs:
• Check "No" in **STEP 2** and go to **STEP 3**.	• Write a case number for SNAP, TANF, or FDPIR. You only need to provide one case number. If you participate in one of these programs and do not know your case number, contact: State number 1-855-373-4636 . • Go to **STEP 4**.

STEP 3: LIST ALL HOUSEHOLD MEMBERS AND INCOME FOR EACH MEMBER

How do I report my income?

- Use the litsts titled "**Sources of Income for Adults**" & "**Sources of Income for Children**," printed on the back side of the application form to determine if your household has income to report.
- Report all amounts in GROSS INCOME ONLY. Report all income in whole dollars. Do not include cents.
  - Gross income is the total income received **before** taxes and deductions.
  - Many people think of income as the amount they "take home" and not the total, "gross" amount. Make sure that the income you report on this application has NOT been reduced to pay for taxes, insurance premiums, or any other amounts taken from your pay.

Write a "0" in any fields where there is no income to report. Any income fields left empty or blank will 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 suspect 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.

(Information follows on the reverse side.)

3.A. REPORT INCOME EARNED BY ADULTS

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 they are 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.
  - Infants, Children and students already listed in **STEP 1.**

1) List adult household members' names. Print the name of each household member in the boxes marked "Names of Adult Household Members (First and Last)." Include college students, unless they are declared independently on taxes (all college students are considered adults). Do not list any household members you listed in STEP 1.	**2) List earnings from work.** List all total gross income from work in the "Earnings from Work" field on the application. total gross income from work in the "Earnings from Work" field on the application. This is usually the money received from working at jobs. If you are a self-employed business or farm owner, you will report your net income. ***What if I am self-employed?*** Report income from that work as a net amount. This is calculated by subtracting the total operating expenses of your business from its gross receipts or revenue.	**3) List income from public assistance/child support/alimony.** List all income that applies in the "Public Assistance/Child Support/Alimony" field on the application. Do not report the cash value of any 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.
4) List income from pensions/retirement/all other income. List all income that applies in the "Pensions/Retirement/ All Other Income" field on the application.	**5) List 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.	**6) 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. 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 Social Security Number."

3.B. LIST INCOME EARNED BY CHILDREN

List all income earned or received by children. List 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 together with the rest of your household.

- ***What is Child Income?*** Child income is money received from outside your household that is paid DIRECTLY to your children. Many households do not have any child income.

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 statements on the back of the application.

Provide your contact information. Write your current mailing address in the fields provided if this information is available. If you have no permanent address, that is okay. Sharing a phone number, email address, or both is optional, but helps us reach you quickly if we need to contact you.	**Print and sign your name and write today's date.** Print the name of the adult signing the application and that person signs in the box "Signature of adult."	**Mail Completed Application to:** **Eldon School District, 112 S. Pine St. Eldon, MO 65026**

OPTIONAL

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. This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application, and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

Please return the application directly to your child's SCHOOL. DO NOT mail, fax, or email completed applications or questions about applications to the USDA Office of the Assistant Secretary for Civil Rights or your child's eligibility for free or reduced-price meals will be delayed.

2024-25 Application for Free and Reduced Price School Meals

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

APPLY ONLINE:
RETURN TO Eldon School District
Your child's School Office

Attachment E

Date Received by LEA (LEA use only): _____

STEP 1 List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

Child's First Name	MI	Child's Last Name	Building Name	Grade	Check all that apply: Foster Child	Homeless, Migrant, Runaway
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.

STEP 2 Do any household members (including you) participate in: SNAP, TANF, or FDPIR?

○ NO → Go to STEP 3. ○ YES → Write case number here and proceed to STEP 4. **CASE NUMBER (NOT EBT NUMBER):** _____ Write only one case number in this space.

STEP 3 List ALL household members and income for each member (before taxes and deductions)

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.)

List all Adult Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and 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 (promising) that there is not income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often received? Weekly / Every 2 Weeks / 2x Month / Monthly / Annual	Public Assistance, Child Support, Alimony	How often received? Weekly / Every 2 Weeks / 2x Month / Monthly	Pensions, Retirement, Social Security, SSI, VA Benefits, All Other Income	How often received? Weekly / Every 2 Weeks / 2x Month / Monthly
	$	○ ○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
	$	○ ○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
	$	○ ○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○

Total Household Members (Children and Adults): ☐☐

Last four numbers of Social Security Number (SSN) of primary wage earner or other adult household member (If Applicable): X X X X X ☐☐☐☐

Check if no Social Security Number ☐

Please see back of application for list of income sources.

B. Child Income

Sometimes children in the household earn or receive income.
Include the TOTAL income (before taxes and deductions) received by ALL children listed in STEP 1 here.

Child Income $ ☐☐☐☐☐

How often received? Weekly / Every 2 Weeks / 2x Month / Monthly / Annual ○ ○ ○ ○ ○

STEP 4 Contact information and adult signature. RETURN COMPLETED FORM TO YOUR CHILD'S SCHOOL: Eldon School District, 112 S. Pine St. Eldon, MO 65026 Attn: Shawndra Taylor

"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 (confirm) 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."

Print Name of Adult Signing the Form _____ Signature of Adult _____ Today's Date _____

Mailing Address (if Available) _____ City _____ State _____ Zip _____ Daytime Phone and Email (optional) _____

DO NOT FILL OUT THIS SECTION. 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 (USE ONLY IF MULTIPLE FREQUENCY)

☐Food Stamps/Temporary Assistance Household size: _____ Total income: _____ Per: ☐Week ☐Every 2 Weeks ☐Twice a Month ☐Month ☐Year

Eligibility: ☐Free ☐Reduced ☐Denied Reason: _____ Date withdrawn: _____

Error Prone Application: ☐Yes ☐No *(Optional – See FAQs)* Determining Official's Signature: _____ Date Approved/Denied: _____

Confirming Official's Signature (For Verification purposes only): _____ Date: _____

SOURCES AND EXAMPLES OF INCOME

For additional information on income, please refer to the instructions that accompany this application.

Sources of Income			Examples of Income for Children
Earning from Work	**Public Assistance/Alimony/Child Support**	**Pensions/Retirement/ All other sources of income**	
• Salary, wages, cash bonuses, tips, commissions • 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 • Workers' compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans' benefits • Strike benefits	• Social Security/Disability (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household	• A child has a regular full or part-time job where they earn a salary or wages • 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 • A child has a regular full or part-time job where they earn a salary or wages • A child has a regular full or part-time job where they earn a salary or wages

OPTIONAL

Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

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 (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ❑ Not Hispanic or Latino

Race (check one or more): ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White

Return this completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights.

Use of Information Statement

The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met.

Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, 'Check if no Social Security Number'. Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number.

Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

Return completed form to your child's school.

The contact information below is solely to file a complaint of discrimination

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:

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

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: Program.Intake@usda.gov

*** Do not mail applications to this address, only complaints of discrimination.**

This institution is an equal opportunity provider.

REQUEST FOR INFORMATION

(Complete one form per family)

Please answer the question below by checking the appropriate box. The following information is a request adopted by the General Assembly in 2010 requiring school districts to determine whether or not all children in a family have health insurance.

Does each child in your family have healthcare insurance?

☐ YES

☐ NO

MO HealthNet (Medicaid) is considered healthcare insurance.

If NO is checked the school district will provide the Does Your Child Need Healthcare Coverage form for the family.

Completion of this form is not a condition of determining meal eligibility. The Free and Reduced Price Meals Family Application will be reviewed regardless of your response to this Request for Information.

Submit this request with your Free and Reduced Price School Meals Family Application or return to your school/school district.

Printed name of parent/guardian: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____