

STERLING SCHOOLS AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY PHYSICIAN/DENTIST/PROVIDER

<u>Name of Medication</u>	<u>Dosage</u>	<u>Route</u>	<u>Time of Day</u>

If given prn specify the length of time between doses _____

Inhalers: _____

Indicate if student must carry on his/her person (above 6th grade) Yes _____ No _____
(Parents are recommended to maintain a backup inhaler in the office for an emergency)

It is safe for unlicensed staff provide this student this medication Yes _____ No _____

Emergency procedure in case of serious side effects _____

I request and authorize that the above-named student be administered/provided the above identified medication in accordance with the instructions indicated above from _____ to _____ (not to exceed the current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

Date of Signature

Physician/Dentist/Provider Signature

Telephone Number

Name: _____
(Print or Type)

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, route, and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to give medication to my student in accordance with the health care provider's instructions written above. I understand that unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication.

Permission to carry inhaler Yes _____ No _____ Contract Signed Yes _____ No _____

Date

Parent/Guardian Caretaker Signature

Phone # _____
Home _____ Work _____

Free and Reduced Price School Meals Family Application

Attachment C: 2010-11

Part 1: Children in School (Must fill out a separate application for each foster child.)

Names of all Children in School (First, Middle Initial, Last)	Name of School	Grade

Part 1a: SNAP, TANF or FDIPIR Benefits

Enter **MASTER CASE NUMBER** if household qualifies for SNAP, TANF or FDIPIR:

(Social Security numbers, Medicaid numbers and EBT numbers are not accepted.) Skip to Part 4.

Part 2: Foster Child/Institutionalized Child

Check this box if application is for a foster child or a child who is residing in an institution. List the amount of the child's personal use monthly income: \$ _____. If there is no income, record "0". Skip to Part 4.

Part 3: Total Household Gross Income - You must tell us how much and how often.

1. Name List everyone in household and the income each earns or check the box at the right if they have no income	2. Gross Income and how often it was received								3. Check if NO income	
	Earnings from Work before deductions		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		All Other Income (Self Employment)			
	Income	How often	Income	How often	Income	How often	Income	How often		
										<input type="checkbox"/>
										<input type="checkbox"/>
										<input type="checkbox"/>
										<input type="checkbox"/>
										<input type="checkbox"/>
										<input type="checkbox"/>
										<input type="checkbox"/>
										<input type="checkbox"/>
										<input type="checkbox"/>

Part 4: Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 3 is completed, the adult signing the form must also list his/her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on page 2)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get 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 children may lose meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Address: _____ Zip: _____ Phone Number: _____

Social Security Number: _____ I do not have a Social Security Number

Part 5: Children's Racial and Ethnic identities (optional)

Mark one Ethnic Identity: -- and -- Mark one or more Racial Identities:

- | | | | |
|---|--------------------------------|---|--|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Asian | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> White | <input type="checkbox"/> American Indian or Alaska Native | |

Do not fill out this part. For school use only.

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

Total Household Size _____ Free Temporary Approval for Zero Income Until: _____

Total Income \$ _____ per _____ Reduced Results of Follow-up (45 days or less): _____

Year Month 2 X Mo. Every 2 Wks Week SNAP (formerly Food Stamps)/FDPIR/TANF Denied Reason for Denial: _____ Follow-up Signature _____ Date: _____

Foster/Institutionalized Child Income too high Incomplete App. Date Withdrawn from School: _____

Signature of Determining Official _____ Date Approved: _____

Signature of Confirming Official (Verification only) _____ Date Confirmed: _____