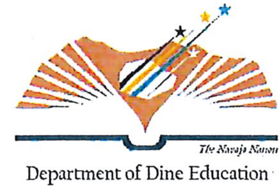
Winslow Residential Hall, Inc.



ALL STUDENTS **must** submit a complete application for **SY 2021/2022**. The following documents **must** be submitted with your application:

- Student Enrollment Application
  (*__NO__ faxed application will be accepted*)
- Legal Documents
  (*Power of Attorney, Restraining Order, School Suspension*)
- Consent for Release of Information
- Acceptance Letter from WHS & WJHS
- Certificate of Indian Blood (CIB)
- Current Immunization Record
- IEP and/or 504 Documentation, if applicable
- Boundary Map
- COVID-19 Wavier
- Application for Free & Reduced Meal
- Medical Insurance Information
- Physical Examination
- Birth Certificate
- Social Security Card
- Transcript/Report Card
- $50.00 Room Deposit (***Money Order only***)

In addition, the following information is what is required prior to enrollment and some of our expectations:

- Students must be enrolled full-time and provide a class schedule at Winslow High School or Winslow Junior High prior to the approval of residency.
- All student **must** have a 2.5 GPA cumulative or above. An official transcript must be attached to the enrollment application.
- The student **must** have an acceptable attendance at the residential hall and school. If a student fails to maintain their attendance, they can be released from Winslow Residential Hall, Inc.
- Students may enroll up to the age of twenty (20), however students with IEP may be accepted and will be subject to the same policies and procedures of Winslow Residential Hall, Inc. student handbook. Students enrolled at the age of eighteen (18) years of age or during the school year, must sign a wavier of consent.
- Students on juvenile probation **will not** be eligible. If a student is reported to be on juvenile probation, the student will be automatically withdrawn.
- Returning students who were on student contracts **must** be pre-approved by the Homeliving Supervisor and/or Residential Manager prior to enrollment.
- Students are **required** to be present at school and Winslow Residential Hall, Inc. for student count week.
- Students with special needs will be considered for enrollment upon review of their medical history. If enrolled, the staff must be aware of all medication and any condition that may arise in an emergency.

If you should have any questions or concerns regarding this application, please contact our office at (928) 289-4488.

Student Enrollment Application

Type of School: *Residential*
______ **Returning Student**
______ **New Student**

School Year: ______
Grade: ____ 7th ____ 10th
____ 8th ____ 11th
____ 9th ____ 12th

IDENTIFICATION

Student's Name: ______________________
Last, First, Middle

Gender: ____ Male ____ Female

Social Security No.: X X X - X X - ______

Home Address: ______________________

Date of Birth: ______ / ______ / ______
Month Date Year

P.O. Box: ______________________

City: ______________________

Student Mobile No.: ______________________

State: ________ **Zip Code:** ________

Tribal Affiliation: ______________________

Enrollment No.: ______________________

Religious Affiliation: ______________________

Degree (per CIB): 4/4 3/4 1/2 1/4

Language: Navajo Hopi English Other: ______________

Dominant Language spoken in the home (circle one)

Other: ______________________

Is your child eilgible for special needs service? NO YES

What is their disability? ______________________ NO YES

Does your child have a current Individual Education Plan (IEP)? NO YES

** Please attach a copy of your child's IEP.*

BACKGROUND INFORMATION

Has your child been arrested? NO YES

Is your child on probation? NO YES

Has your child ever had drug/alcohol treatment, aftercare services or counseling? NO YES

Has your child had treatment, hospitalized or counseled for other issues? NO YES

If you answered YES to any of the above questions, please explain: ______________________

____

____

EMERGENCY CONTACT *(other than parents/guardians)*

Contact Name: ______________________
Phone No.: ______________________
Address: ______________________
Relationship: ______________________

Contact Name: ______________________
Phone No.: ______________________
Address: ______________________
Relationship: ______________________

SCHOOL(s) PREVIOUSLY ATTENDED *(most recent first)*

School Name: ______________________ **Dates Attended:** ____________

Reason for Leaving: ______________________ **Grade:** ______

____

School Name: ______________________ **Dates Attended:** ____________

Reason for Leaving: ______________________ **Grade:** ______

PARENT INFORMATION

Student resides with (circle one): Parents Mother Father *Legal Guardian

*Grandparents Mother/Step-Father Father/Step-Mother

**Must present legal guardianship or power of attorney documents*

Mother's Name: ______________________ **Father's Name:** ______________________

Address: ______________________ **Address:** ______________________

City State Zip Code City State Zip Code

Tribal Affiliation: ______________________ **Tribal Affiliation:** ______________________

Census No.: ______________________ **Census No.:** ______________________

☐ Living ☐ Deceased ☐ Living ☐ Deceased

Occupation: ______________________ **Occupation:** ______________________

Employer: ______________________ **Employer:** ______________________

Mobile No.: ______________________ **Mobile No.:** ______________________

Work No.: ______________________ **Work No.:** ______________________

Email: ______________________ **Email:** ______________________

SILBING(s) INFORMATION

Name: ______________________ **Age:** ______ **School Attending:** ______________________

Name: ______________________ **Age:** ______ **School Attending:** ______________________

Name: ______________________ **Age:** ______ **School Attending:** ______________________

Name: ______________________ **Age:** ______ **School Attending:** ______________________

I am legally responsible for my child and hereby apply for his/her admission to Winslow Residential Hall, Inc. I understand that the residential hall may request additional information before my child is enrolled.

____

Print Name

______________________ ______________________

Signature of Parent/Guardian Date

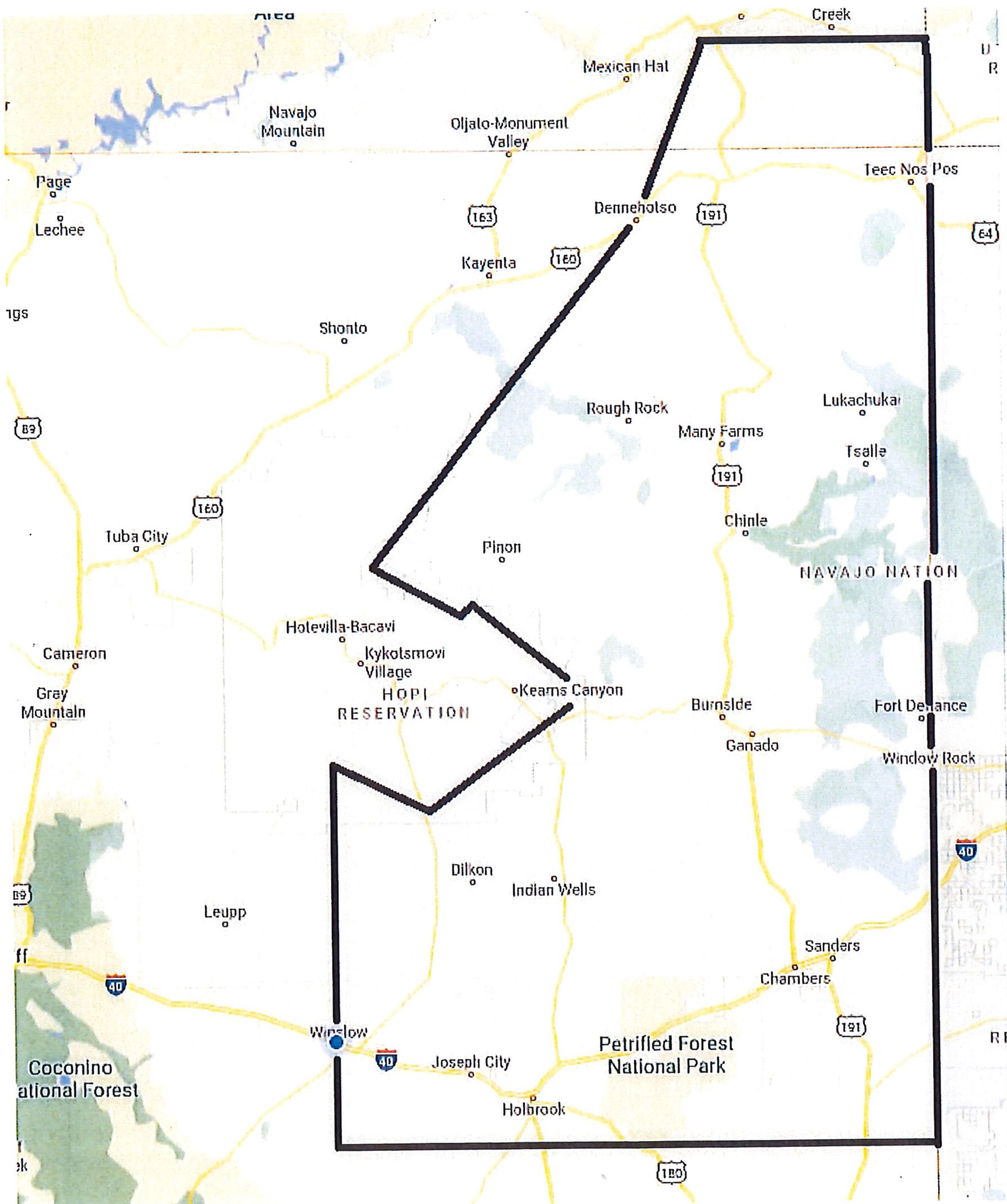
Acknowledge that all necessary is true and correct for ______________________________, I understand that this
Student Name

Information is being furnished for the receipt of federal funds that school officials may verify the information on the application, and that deliberate misrepresentation of any information may subject me to prosecution under applicable state and federal laws.

______________________________ ________________
Signature of Parent/Guardian Date

Physical Location: ______________________________ **School Year:** ________________

Please put an "X," where the student lives:



Student Name: ___________________________

Parent/Guardian Name: ___________________________

Date: _____________

Criteria for Winslow Residential Hall, Inc. – SY 2021-2022

Favorable action is recommended on this application and has to conform to the following criteria for all new residential students or out of boundary enrollment. Winslow Residential Hall, Inc., is an educational support services to WUSD that does not accept students who has social behavioral problems (*i.e., suspension or expulsion from school*).

Education Factors (*check all, if applicable*):

_____ Federal/public schools near student's home;

_____ Excessive distance to the releasing school from student's home and adverse road conditions;

_____ Receiving residency offers residential and academic support service needed by student to attend public school;

_____ Receiving residency offers academic support service needed to complete graduation requirements(s) for seniors;

_____ Receiving residency accepts student who has 2.5 GPA (*Grade Point Average*) or better.

Verification of Acceptance:

( ) Approved ( ) Disapproved

____________________________	____________________________	_______________
Official Signature	Title	Date

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047

Telephone: (928) 289-4488;2379 Fax: (928) 289-2821/2258

PARENTAL PERMISSION, ACKNOWLEDGEMENT OF HAZARDS, ASSUMPTION OF RISK AND WAIVER OF LIABILITY AGREEMENT

BY SIGNING AND RETURNING THIS DOCUMENT, YOU ARE GIVING UP SUBSTANTIAL LEGAL RIGHTS. THEREFORE, YOU ARE ADVISED TO READ THIS AGREEMENT CAREFULLY BEFORE SIGNING AND RETURNING IT.

DISCLOSURE

Our communities are facing a pandemic related to the outbreak of the 2019 novel coronavirus and Covid-19 ("Coronavirus"). Despite Federal, State, and Tribal governments taking measures to protect public health and slow the spread of Coronavirus, the virus remains a problem and threatens the health and well-being of our students, staff, and families, and can lead to illness, disability, and death. Winslow Residential Hall, Inc. ("WRHI") is striving to implement policies, procedures, and practices to prevent the spread of the virus. However, WRHI cannot guarantee that the virus does not exist or will not spread in our facilities and during our activities. In order to address this situation, WRHI is requiring students and their parents/guardians to follow certain procedures and acknowledge certain risks.

PERMISSION, ACKNOWLEDGEMENT, ASSUMPTION OF RISK AND WAIVER

In consideration for permitting my child ______________________________ ("the Student") to attend and reside at WRHI and participate in all WRHI-related activities (collectively "the Activity") and other good and valuable consideration the receipt and sufficiency of which are hereby acknowledged, I hereby agree to the following on behalf of myself, the Student, my spouse, heirs, executors, administrators, representatives, and/or assigns (collectively "Releasors"):

______ 1. I am familiar with Coronavirus, including its contagious nature, symptoms, health risks, and means by which it is spread and contracted by humans. I am also familiar with the Activity and understand that participation in the Activity might result in exposure to Coronavirus. Nonetheless, I give permission for Student to participate in the Activity.

______ 2. I acknowledge that the risk of exposure to and contracting Coronavirus cannot be eliminated or even substantially reduced without jeopardizing the essential qualities of the Activity. Nevertheless, I accept those risks and assume full responsibility for the health, safety, and well-being of the Releasors.

______ 3. The Releasors, including the Student, agree to abide by all instructions and protocols implemented by WRHI representatives pertaining to Coronavirus, including but not limited to rules and regulations regarding personal protective equipment such as masks and face shields, hygiene, social distancing, temperature checks, and physical examinations. The Releasors further agree to report to the WRHI Homeliving Supervisor any activity that is contrary to such instructions or is potentially or actually dangerous because it promotes the spread of Coronavirus. I understand that any person, including Student, may be precluded from the Activity if it is determined that the person is not following instructions, protocols, rules, regulations, and best practices designed to slow the spread of Coronavirus.

______ 4. I certify that Student is in good health and fully capable of participating in the Activity. I certify further that Student has not tested positive for COVID-19, has not exhibited any symptoms of COVID-19 (including without limitation fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle

or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and/or diarrhea), and to the best of my knowledge, does not have COVID-19 and has not been exposed to anyone who has COVID-19 or symptoms of COVID-19 within the past 14 calendar days.

______ 5. I agree to check Student for symptoms of COVID-19 each week before weekly check-in to WRHI. I agree further that if Student exhibits symptoms of COVID-19 or is exposed to anyone who has COVID-19 or symptoms of COVID-19, I will have Student tested for COVID-19.

______ 6. I agree that if Student contracts COVID-19, tests positive for COVID-19, or exhibits symptoms of COVID-19, or is exposed to anyone who has COVID-19 or symptoms of COVID-19, I will (a) voluntarily, fully, and honestly notify the WRHI Homeliving Supervisor and (2) voluntarily keep Student out of WRHI and the Activity until it is medically determined that Student does not have COVID-19.

______ 7. I agree that WRHI may take reasonable measures, including temperature checks and physical examinations, to check Student for symptoms of COVID-19.

______ 8. I understand that any person, including Student, may be precluded from WRHI and the Activity if it is determined that the person is showing symptoms of COVID-19, has COVID-19, has tested positive for COVID-19, and/or has been exposed to a person showing symptoms of COVID-19 or who has COVID-19. The person may be permitted to return to the Activity after it is medically confirmed that the person does not have COVID-19.

______ 9. I, on behalf of the Releasors, hereby voluntarily release, forever discharge, agree to hold harmless and indemnify, and agree not to sue WRHI, its Board Members, employees, volunteers, agents, attorneys, and all other persons and entities (collectively "Releasees") from and for any and all liability, claims, demands, actions, or rights of action, which are related to, arise out of, or are in any way connected with Coronavirus, including without limitation claims arising out of Student's exposure to or contracting of Coronavirus and claims arising from Releasee's negligent acts or omissions.

______ 10. If any provision of this document is declared void or unenforceable, such provision shall be deemed severed from this document which shall otherwise remain in full force and effect. This document shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, assigns and successors-in-interest. This document contains the entire understanding between and among the parties and supersedes any prior understandings and agreements among them respecting the subject matter of this document.

______ 11. I have carefully read this document and fully understand its content. I am aware that this document is a parental permission, acknowledgment of hazards, assumption of risks, waiver of liability, an agreement not to sue, and a contract between me and the School. I sign this document voluntarily, knowingly, and intelligently.

______________________________ ______________________________

Parent/Guardian Print Name Parent/Guardian Signature Date

Phone: ______________

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047

Telephone: (928) 289-4488;2379 Fax: (928) 289-2821/2258

STUDENT AGREEMENT

I, ______________________________, agree that while attending and residing at Winslow Residential Hall, Inc. and participating in Winslow Residential Hall, Inc. activities, I will follow all instructions and protocols regarding Coronavirus, including rules and regulations regarding personal protective equipment such as masks and face shields, hygiene, social distancing, temperature checks, and physical examinations.

____

Student Signature

Date: ________________

INTERNET USE AGREEMENT

Student's Name: ______________________________ **Grade:** ________

Last First Middle

I understand and will abide by the provisions and conditions indicated. I understand that any violations of the internet use policy may result in disciplinary actions and the revocations of my use of the IT system at Winslow Residential Hall Inc.

Print Name: ______________________ **Date:** ______________

Student Name

Signature: ______________________

* *The user agreement of a student who is a minor must also have the signature of a parent/guardian who has read and will uphold this agreement.*

Parent/Guardian Consent

As the parent/guardian of the above-named student, I have read the Winslow Residential Hall Inc., Internet Use and Agreement policy and understand it. I understand that its impossible for Winslow Residential Hall Inc., to restrict access to all controversial materials, however I will not hold Winslow Residential Hall, Inc., responsible for materials by use of the IT system. I also agree to report any misuse of the IT system to a Winslow Residential Hall Inc., administrator.

I accept full responsbility and hereby give my permission to have my child use Winslow Residential Hall Inc., IT system.

Print Name: ______________________ **Date:** ______________

Parent/Guardian Name

Signature: ______________________

PHOTO AUTHORIZATION

Student's Name: ______________________________
Last First Middle

Grade: ________

I, ______________________ parent/guardian of ______________________ hereby
Parent/Guardian Name Student Name

grant permission to Winslow Residential Hall Inc., to take and/or use photos of my child to use in news release and/or educational material.

I agree that my child's name and identity may be reavealed in descriptive text or commentary in connection with the image(s) and I authorize the use of these images without compensation to Winslow Residential Hall Inc. All negatives, prints, digital reproductions shall be property of Winslow Residential Hall Inc.

______________________ ______________
Student Signature Date

______________________ ______________
Parent/Guardian Signature Date

☐ I do not grant permission to Winslow Residential Hall Inc., to take/or use photos of my child in any Winslow Residential Hall Inc., sponsored news release and/or educational material.

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047 I Telphone: (928) 289-4488 Fax: (928) 289-2821

WINSLOW RESIDENTIAL HALL, INC.
INTERNET USE AND AGREEMENT POLICY

Before a student, parent and/or employee may access the Winslow Residential Hall, Inc's (WRHI) technology resources, the individual must have a signed and dated user agreement on file. The user agreement of a student ***who is a minor*** must also have the signature of a parent or guardian who has read and will uphold this agreement.

PURPOSE:

Winslow Residential Hall, Inc. is pleased to continue offering access to the internet to their students, employees, and parents. The internet is provided to support access to global information to increase career development, research, homework assistance, and communication.

The WRHI has the right to set reasonable restrictions on any material a student can access or post. This policy is set forth to protect the students, parents, and staff of WRHI. Inappropriate use can increase the risks of virus attacks, endangers the network systems and service, legal copyright violation, student privacy and unacceptable risks to students.

SCOPE:

This policy will be relevant and applied to all the students, parents, and employees using the Information Technology (IT) system at WRHI. This policy also applies to all equipment owned or leased by WRHI and all related equipment. The internet users accepts the responsibilities of adhering to high standards of conduct and the terms and conditions set forth in all parts of this policy.

TERMS OF USE:

Only the authorized users who have signed the user agreement shall have computer access, the agreement shall remain in effect for the remainder of the school year.

TERMS AND CONDITIONS:

1. All internet, tablet, or computer equipment use shall be consistent with the purpose, goals, policies and rules of the WRHI. It is imperative that users of the IT system conduct themselves in a responsible, ethical, moral, and polite manner, as well as following all rules for behavior and communications.
2. The users agree to abide by the general accepted rules of the WRHI Student Handbook as approved by the Governing Board. Furthermore, WRHI is governed by the BIE policies located at http://enan.bia.edu/site_res_view_folder.aspx?id=71dd2af0-a19a-4ceb-a11d-e2dad6ceace2
3. Accessing or transmitting of immoral, obscene, pornographic, profane, lewd, vulgar, rude, defaming, harassing, threatening, disrespectful, or otherwise inappropriate images or information is strictly prohibited.
4. Any attempt to bypass school internet security (e.g. bypassing proxies or "hacking" servers or work stations), and/or installing of any type of software is forbidden.
5. Any destruction, defacement, theft, authorized altering of WRHI's computer system, attempting illegal access to or from WRHI computer systems, and intentional spreading of a computer virus or similar programs is unacceptable, and will not be tolerated.

6. The users agree to abide by all patent, trademark, trade name, and copyright laws. Plagiarism in any form will not be tolerated. All sources must be cited.
7. ***The users will not access any chat rooms, instant messaging, and websites such as: Facebook, You Tube, Twitter, and/or any other similar websites, as these sites have inappropriate content that violates this policy. In addition, users are prohibited from downloading music to their IPOD or to any other devices.***
8. Users are prohibited from providing information about themselves or others over the internet including social security number, credit card information, passwords, usernames, and/or other personal information.
9. All users agree NOT to use any computing resources for commercial purposes, product advertising, political lobbying, or political campaigning.

PRIVILEGE:

The use of the IT system within the WRHI is a ***privilege, not a right.*** The information produced from internet access, tablet, or computer use shall be deemed the property of WRHI. All users agree and consent to allow WRHI staff to review any and all files, data and messages to ensure that users are using the system responsibly at any time with or without notice.

SECURITY:

Internet users may encounter materials that are controversial or inappropriate or offensive. WRHI has taken precautions to restrict access to inappropriate materials through a filtering and monitoring system. However, it is impossible on a global Internet to control access to all data which a user may discover. It is the user's responsibility not to initiate access to such material, and any site or material that is deemed controversial. These activities shall be reported immediately to the appropriate administrator. WRHI expressly disclaims any obligation to discover all violations of inappropriate Internet access.

PENALITIES FOR IMPROPER USE:

1. Unacceptable use or violations of this policy may result in restricting Internet use or use of any or all computers. WRHI administrators may refuse to reinstate privileges to use the IT system for the remainder of the student's enrollment at WRHI.
2. The WRHI may also take other disciplinary actions in certain circumstances. In some instances inappropriate computer and internet use violates state and/or federal laws and my result in criminal prosecution or juvenile court action.

DISCLAIMER OF ALL WARRANTIES:

WRHI makes no warranties of any kind, whether expressed or implied, for the services provided in connection with use of the internet or computer equipment. WRHI will not assume the responsibility or liability for any loss of data resulting from delays, non-deliveries or service interruptions caused by negligence or errors indirectly or directly. WRHI specifically denies any responsibility for the accuracy of quality of information obtained through its services.

AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Name: ______________________________
Last First Middle

Grade: __________

I, ______________________________ here by authorize a release of information between Winslow
Parent/Guardian Name

Residential Hall, Inc., (WRHI) and Winslow Unified School District (WUSD) concerning my child's student records information as followed: transcripts, grades, scholastic, assestments, counseling and health records, truancy, and behavior, and attendance to WRHI. I understand that only WRHI personnel and their authorized agents will have access to my child's student records.

____
Parent/Guardian Print Name

______________________________ ____________________
Parent/Guardian Signature Date

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047 / Telphone: (928) 289-4488 Fax: (928) 289-2821

STUDENT CHECK-OUT POLICY

Student's Name: ______________________________
Last First Middle

Grade: ________

WEEKLY CHECK-OUT POLICY

Student attendance is very important to us, therefore we discourage parents/guardians and family members from checking out your child(ren) during school hours unless prior arrangements have been made with the residential hall.

You're expected to pick up your child no later than 6:00pm (MST) on Friday, unless prior and specific arragements have been made with the residential. In the event you are unable to be on time, you are required to call and inform the residential hall of the projected time of arrival.

Please remember that all authorized adults that check out your child(ren) **must** be a blood relative and over the age of twenty-five (25).

On Fridays, we ask that you **not** check-out your child(ren) until school is dismissed after 2:30pm. Any questions regarding this policy should be addressed to the administration office for clarification.

______________________________ ______________
Student Signature Date

______________________________ ______________
Parent/Guardian Signature Date

GUIDANCE COUNSELING SERVICES

Student's Name: ______________________________ **D. O. B.:** ____/____/____
Last First Middle Month Date Year

Grade: __________ **Gender:** Female Male

Phone No.: ______________

Dear Parent/Guardian,

The counseling and guidance services that will be provided by Winslow Residential Hall Inc., Cousnelor are designed to supplement the counseling servies of the Winslow Unified School District counseling staff. Winslow Residential Hall Inc., Counselor is certified to provide services in the area of career readiness, academic, social and planning skills, decsion-making skills, and consequences and behavior management.

Winslow Residential Hall Inc., Counselor will be the contact person with Winslow Indian Health Care Center and other related agencies if there are referral needs for additional counseling services for your child. Winslow Residential Hall Inc., Counselor training and responsbilities are tied to academic success. Winslow Residential Hall Inc., Counselor is not a psychologist or therapist.

☐ I, **DO** give consent for my child to participate in counseling services provided by Winslow Residential Hall Inc.

☐ I, **DO NOT** give consent for my child to participate in the counseling services provided by Winslow Residential Hall Inc.

According to the Bureau of Indian Affairs (BIA) ***25 CFR Subpart 36.91:*** *parents/guardians may opt out of any non-emergency behavioral health services by* ***submitting a written request****.*

If you **DO NOT** give Winslow Residential Hall Inc., consent for counseling, please provide a reason:

____

____

____

____

______________________________ ______________________
Parent/Guardian Signature Date

STUDENT ASSISTANCE PROGRAM CONSENT

Student's Name: ______________________________
Last First Middle

Grade: ________

Dear Parent/Guardian,

The counseling department at Winslow Residential Hall Inc., will be inviting all students to participate in a peer support group. This is a **voluntary support group** that is part of our Student Assistance Program (SAP).

The goal of these groups are to increase students' self esteem, decision-making, life skills, communication skills, problem solving strategies, building self-worth and confidence, and help promote and encourage healthy lifestyles. It is our belief that building these personal skills help students prepare and effectively cope with peer pressure and school related stresses and other isses they may be facing.

Peer support groups meet weekly and are scheduled in the evenings while students are on campus and last not longer than one (1) hour. Facilitators are specially trained residential advisors and staff. The training model is used by Winslow Unified School District.

If you would like further information or have any questions, please contact the Winslow Residential Counseling Department at (928) 289-4488/2379.

______________________________ ____________________
Student Signature Date

______________________________ ____________________
Parent/Guardian Signature Date

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047 | Telphone: (928) 289-4488 Fax: (928) 289-2821

MEDICAL INFORMATION

Student's Name: ______________________________ **Grade:** ________

Last First Middle

Which of the following conditions is your child currently being treated or have been treated for in the past (please check all that apply):

- ☐ Heart Disease/Murmur/Angina
- ☐ High Blood Pressure
- ☐ Heartburn (Relfux)
- ☐ Swollen Ankles
- ☐ Lung Problems/Cough/Asthma
- ☐ Sinus Problems
- ☐ Tonsillitis
- ☐ Eye disorder/Glaucoma
- ☐ Stroke
- ☐ Neurological Problems
- ☐ Psychiatric Care
- ☐ Kidney/Bladder Problems
- ☐ Arthritis
- ☐ Ulcers/Collitis
- ☐ High Cholesterol
- ☐ Low Blood Pressure
- ☐ Anemia/Blood Problems
- ☐ Shortness of Breath
- ☐ Thyroid Problems
- ☐ Seasonal Allergies
- ☐ Ear/Hearing Problems
- ☐ Seizures
- ☐ Headaches/Migraines
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Liver Problems/Hepatitis
- ☐ Cancer

Please describe any current or past medical treatment not listed above:

____

____

____

Please list your child's past surgeries:

____

____

____

Allergies:

____

____

Is your child allergic to penicillin or any other drugs? **Yes** **No**

Please list:

____

____

____

Name of Insurance | Name of Policy Holder | Policy No.

____

Insurance Phone No. | Policy Holder Signature | Date

WINSLOW INDIAN HEALTH CARE CENTER

DATABASE

NAME (LAST, FIRST, MIDDLE)	OTHER NAMES USED(MAIDEN NAME)	WIHCC NO.	SEX M F
BIRTH DATE	PLACE OF BIRTH (CITY, STATE)	SOCIAL-SECURITY NO.	MARITAL STATUS	INTERNET Y N Email Address:

CURRENT COMMUNITY	DATE MOVED	LOCATION OF HOME (DIRECTIONS TO YOUR HOME, ETC. PLEASE BE SPECIFIC.)

MAILING ADDRESS	CITY/STATE	ZIP CODE

HOME PHONE NUMBER	MESSAGE PHONE NUMBER	WORK PHONE NUMBER

INDIAN BLOOD QUANTUM	TRIBE	DEGREE	CENSUS NUMBER	CIB Y N
	OTHER TRIBE	DEGREE	RELIGION	

FATHER'S NAME	CITY OF BIRTH	STATE OF BIRTH
MOTHER'S MAIDEN NAME	CITY OF BIRTH	STATE OF BIRTH

EMPLOYER(IF APPLICABLE)	SPOUSE'S EMPLOYER(IF APPLICABLE)
EMPLOYER'S ADDRESS	SPOUSE'S EMPLOYER'S ADDRESS
EMPLOYER PHONE NUMBER	SPOUSE'S EMPLOYER PHONE NUMBER

IF YOU ARE UNEMPLOYED, PLEASE GIVE SOURCE OF INCOME

___UNEMPLOYMENT ___RETIREMENT ___SSI ___SSB WELFARE____________________ OTHER____________________

NAME OF EMPLOYER (FATHER)18 & UNDER	EMPLOYER ADDRESS	EMPLOYER TELEPHONE NUMBER
NAME OF EMPLOYER (MOTHER)18 & UNDER	EMPLOYER ADDRESS	EMPLOYER TELEPHONE NUMBER

EMERGENCY CONTACT PERSON		NEXT OF KIN CONTACT PERSON	
RELATIONSHIP	PHONE NUMBER	RELATIONSHIP	PHONE NUMBER
ADDRESS		ADDRESS	

HEALTH INSURANCE INFORMATION

DO YOU HAVE MEDICARE COVERAGE?	YES	NO	DO YOU HAVE RAILROAD RETIREMENT COVERAGE?	YES	NO
DO YOU HAVE AHCCCS (MEDICAID)?	YES	NO	DO YOU HAVE PRIVATE INSURANCE COVERAGE?	YES	NO

MILITARY SERVICE?	YES	NO	BRANCH	CLAIM NUMBER	ENTRY DATE	SEPARATION DATE

VIETNAM VETERAN?	YES	NO	SERVICE CONNECTED?	YES	NO

HOUSEHOLD INFORMATION: How many family members in your household – including children?

PLEASE READ AND SIGN CAREFULLY

I authorize Winslow Indian Health Care Center to release any medical information or records necessary to process my Medicare, Medicaid or other insurance claims. I authorize my insurance company to pay medical benefits directly to Winslow Indian Health Care Center. If I am a non-beneficiary, I understand co-payments and deductibles will be requested at the time of service. I understand that I will be responsible for all costs if my account should be turned over to collections.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN	DATE

AUTHORIZATION

Student's Name: ______________________________
Last First Middle

Grade: ________

STUDENT TRAVEL

I authorize for my child to travel on trips that are sponsored and endorsed by Winslow Residential Hall, Inc., using Winslow Residential Hall Inc., transportation.

______________________________ ______________
Parent/Guardian Signature Date

MEDICAL

In case of an emergency or illness of my child, and I cannot be contacted immediately, I authorize Winslow Residential Hall Inc., staff to transport my child to the nearest Indian Health clinic, non-profit hospital or private hospital for medical treatment.

____
Designated Hospital No. Name of Insurance Policy No.

My child (does) or (does not) have special medical condition(s):

____

____

My child is being treated for: ______________ by ______________
(Type of Medical Condition) (Physician's Name)

at ______________
(Location of Treatment)

Other information: ______________________________

____

____

______________________________ ______________
Parent/Guardian Signature Date

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047 | Telphone: (928) 289-4488 Fax: (928) 289-2821

500 North Indiana Avenue
Winslow, Arizona 86047

PARENTAL/GUARDIAN CONSENT FOR SCHOOL HEALTH SERVICES

Full Name of Student____**DOB**_____________________

__

Name of School ____ **School Year**____________________

I, ____, authorize Winslow Indian Health Care Center (WIHCC) to arrange for/ or to provide the following health services for my child while he/she is attending school and/or the dormitory:

1. **The school will work with WIHCC Public Health Nursing on immunization tracking and record updating based on verified sources like Resource Patient Management System (RPMS), immunization registries, or health department records. There will be release of immunization information between WIHCC and the school.**

   ☐ **I hereby give consent for all of the above services.**

   ☐ **Exceptions or Special Instructions:** ____

2. **The school will work with WIHCC Community Health Division on health screenings including the following: fitness grams, acanthosis nigricans, and blood pressure assessments. Students at risk for diabetes and other chronic diseases will be identified. Students will be referred to the Youth Wellness Program as needed.**

   ☐ **I hereby give consent for all of the above services.**

   ☐ **Exceptions or Special Instructions:** ____

I, as the parent/guardian, also agree to:

1. **Submit my child's immunization record to the school at admission to the school.**
2. **Submit a WIHCC Data Base Form if my child is a new student.**
3. **Take my child to a health care facility for an immunization update, in a timely manner, if any immunizations are deemed missing.**
4. **Take my child for medical follow-up, in a timely manner, to be evaluated for any failed screenings, such as hearing or vision screenings, or for any concerns identified from other health screenings.**

Print Name ___________________________________**Signature** _____________________________________

Relationship ______________**Address** ____

Phone Number_______________________________________

PLEASE RETURN THIS FORM TO THE SCHOOL PRINCIPAL

White Copy--Medical Records **Yellow Copy--School** **Pink Copy--Parent/Guardian** **(Revised 6/2021)**

MEDICATION ADMINISTRATION RECORD

Student Name: ______________________ **Allergies?** ______________________

Grade: __________ ______________________

D.O.B. ______________ ______________________

Date	Time	Description of Medication	Temp.	Doses	AMT.	Staff Initial
	AM PM					
	AM PM					
	AM PM					
	AM PM					
	AM PM					
	AM PM					
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	AM PM					

Winslow Residential Hall, Inc.

600 N. Alfred Ave., Winslow, AZ 86047 I Telphone: (928) 289-4488 Fax: (928) 289-2821

ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 N. 18TH ST., PHOENIX, ARIZONA 85020-5552
PHONE: (602) 385-3810

NextCare® URGENT CARE
The Preferred Urgent Care of the Arizona Interscholastic Association

2021-22 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete) Exam Date: ____________

Name: ____________
Home Address: ____________
Phone: ____________
Date of Birth: ____________
Age: ____________
Gender: ____________
Grade: ____________
School: ____________
Sport(s): ____________
Personal Physician: ____________
Hospital Preference: ____________

In case of emergency contact:
Name: ____________
Relationship: ____________
Phone (Home): ____________
Phone (Work): ____________
Phone (Cell): ____________

Name: ____________
Relationship: ____________
Phone (Home): ____________
Phone (Work): ____________
Phone (Cell): ____________

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

	Y	N
1) Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2) Do you have an ongoing medical conditional (like diabetes or asthma)?	☐	☐
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): ____________	☐	☐
4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify): ____________	☐	☐
5) Does your heart race or skip beats during exercise?	☐	☐
6) Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ A Heart Infection		
7) Have you ever spent the night in a hospital?	☐	☐
8) Have you ever had surgery?	☐	☐
9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11)	☐	☐
10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11):	☐	☐
11) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below):	☐	☐

☐ Head	☐ Neck	☐ Shoulder	☐ Upper Arm	☐ Elbow	☐ Forearm
☐ Hand/Fingers	☐ Chest	☐ Upper Back	☐ Lower Back	☐ Hip	☐ Thigh
☐ Knee	☐ Calf/Shin	☐ Ankle	☐ Foot/Toes		

 NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.

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	Y	N
12) Have you ever had a stress fracture?	☐	☐
13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	☐	☐
14) Do you regularly use a brace or assistive device?	☐	☐
15) Has a doctor told you that you have asthma or allergies?	☐	☐
16) Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
17) Is there anyone in your family who has asthma?	☐	☐
18) Have you ever used an inhaler or taken asthma medication?	☐	☐
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?	☐	☐
20) Have you had infectious mononucleosis (mono) within the last month?	☐	☐
21) Do you have any rashes, pressure sores or other skin problems?	☐	☐
22) Have you had a herpes skin infection?	☐	☐
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	☐	☐
24) Have you ever had a seizure?	☐	☐
25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	☐	☐
26) While exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
28) Have you ever been tested for sickle cell trait?	☐	☐
29) Have you had any problems with your eyes or vision?	☐	☐
30) Do you wear glasses or contact lenses?	☐	☐
31) Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
32) Are you happy with your weight?	☐	☐
33) Are you trying to gain or lose weight?	☐	☐
34) Has anyone recommended you change your weight or eating habits?	☐	☐
35) Do you limit or carefully control what you eat?	☐	☐
36) Do you have any concerns that you would like to discuss with a doctor?	☐	☐

Females Only

	Y	N
37) Have you ever had a menstrual period?	☐	☐
38) How old were you when you had your first menstrual period?	______	
39) How many periods have you had in the last year?	______	

Explain "Yes" Answers Here

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NextCare® URGENT CARE The Preferred Urgent Care of the Arizona Interscholastic Association

2021-22 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: ______________________ Date of Birth: ______________

Patient History Questions: Please Tell Me About Your Child...

	Y	N
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	☐	☐
2) Has your child ever had extreme shortness of breath during exercise?	☐	☐
3) Has your child had extreme fatigue associated with exercise (different from other children)?	☐	☐
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	☐	☐
5) Has a doctor ever ordered a test for your child's heart?	☐	☐
6) Has your child ever been diagnosed with an unexplained seizure disorder?	☐	☐
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	☐	☐

Explain "Yes" Answers Here

COVID-19...

	Y	N
1) Has your child been diagnosed with COVID-19?	☐	☐
1a) If yes, is your child still having symptoms from their COVID-19 infection?	☐	☐
2) Was your child hospitalized as a result for complications of COVID-19?	☐	☐
3) Has your child been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)?	☐	☐
4) Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist) to be cleared to return to sports?	☐	☐
5) Has your child returned back to full participation in sports?	☐	☐
6) Has your child had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?	☐	☐
6a) Was your child tested for COVID-19?	☐	☐
7) Did your child receive the COVID-19 vaccine?	☐	☐

7a) What was the manufacturer of the vaccine? ______________________

7b) Date of vaccination(s) ______________

Explain "Yes" Answers Here

 NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.

Family History Questions: Please Tell Me About Any Of The Following In Your Family...

	Question	Y	N
1)	Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowning or near drowning)	☐	☐
2)	Are there any family members who died suddenly of "heart problems" before age 50?	☐	☐
3)	Are there any family members who have unexplained fainting or seizures?	☐	☐
4)	Are there any relatives with certain conditions, such as:		

Condition	Y	N	Condition	Y	N
Enlarged Heart	☐	☐	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	☐	☐
Hypertrophic Cardiomyopathy (HCM)	☐	☐	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	☐	☐
Dilated Cardiomyopathy (DCM)	☐	☐	Marfan Syndrome (Aortic Rupture)	☐	☐
Heart Rhythm Problems	☐	☐	Heart Attack, Age 50 or Younger	☐	☐
Long QT Syndrome (LQTS)	☐	☐	Pacemaker or Implanted Defibrillator	☐	☐
Short QT Syndrome	☐	☐	Deaf at Birth	☐	☐
Brugada Syndrome	☐	☐			

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of Student-Athlete ____________ Signature of Parent/Guardian ____________ Date ____________

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP ____________ Date ____________

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2021-22 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name: ______________________ Date of Birth: ______________________
Age: ______________________ Sex: ______________________
Height: ______________________ Weight: ______________________
% Body Fat (optional): ______________________ Pulse: ______________________
BP: ____ / ____ (____ / ____, ____ / ____)
Vision: R20/____ L20/____ Corrected: Y◯ N◯
Pupils: Equal◯ Unequal◯

	Normal	Abnormal Findings	Initials *
Medical			
Appearance			
Eyes/Ears/Throat/Nose			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary &			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hands/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

* - Multi-examiner set-up only
& - Having a third party present is recommended for the genitourinary examination

NOTES:

☐ Cleared Without Restriction
☐ Cleared With Following Restriction: ______________________
☐ Not Cleared For: ☐ All Sports ☐ Certain Sports: ______________ Reason: ______________
Recommendations: ______________________

Name of Physician (Print/Type): ______________________ Exam Date: ______________
Address: ______________________ Phone: ______________
Signature of Physician: ______________________, MD/DO/ND/NMD/NP/PA-C/CCSP

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AIA ARIZONA INTERSCHOLASTIC ASSOCIATION™

OUR STUDENTS, OUR TEAMS . . . OUR FUTURE.

Arizona Interscholastic Association, Inc.
Mild Traumatic Brain Injury (MTBI) / Concussion
Annual Statement and Acknowledgement Form

I, ___________________________ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the school staff (e.g., coaches, team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the CDC Concussion fact sheet (http://www.cdc.gov/concussion/HeadsUp/youth.html) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spiritline and wrestling.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:
Print Name: ___________________________ Signature: ___________________________ Date: __________

Parent or legal guardian must print and sign name below and indicate date signed:
Print Name: ___________________________ Signature: ___________________________ Date: __________

FORM 15.7-C 06/2015

2021-2022 Application for Free and Reduced Price School Meals

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

STEP 1 List ALL infants, children, and students up to and including grade 12 in your household (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member:** "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Child's First Name	MI	Child's Last Name	School Name	Foster Child	Homeless, Migrant, Runaway
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Check all that apply

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR? Circle one: Yes / No

If you answered **NO** > Complete STEP 3. **If you answered YES** > Write a case number here then go to STEP 4 (Do not complete STEP 3) **Case Number:**

Write only one case number in this space.

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

Are you unsure what income to include here?

Flip to the back of this application and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income Section.

The "Sources of Income for Adults" chart will help you with the Adult Household Members Income Section.

A. Child Income

Sometimes children in the household earn income. Please include the TOTAL GROSS income earned by all Children Household Members listed in STEP 1 here.

Child GROSS income	How often? Weekly	Bi-Weekly	2x Month	Monthly
$	○	○	○	○

B. All Adult Household Members (including yourself)

List only the Adult Household Members (including yourself) **even if they do not receive income.** For each Household Member listed, if they do receive income, report total GROSS income (amount before taxes and deductions) for each source in whole dollars 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 no income to report.

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

C. Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X - X X - _ _ _ _ Check if no SSN ☐

STEP 4 Contact information and adult signature

Mail Completed Form to: INSERT SCHOOL/DISTRICT MAILING ADDRESS

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of adult completing the form | Today's date

Printed name of adult completing the form | Daytime Phone and Email (optional)

Street Address (if available) | Apt # | City | State | Zip

OFFICE USE ONLY

❑**Error Prone**

Eligibility: Free___ Reduced___ Denied___

Determining Official's Signature: ________ **Date:** ________

❑**Case # Application** ❑**Foster Application** ❑**Directly Certified: Date of Disregard:** ________

❑**Income Application**

Household Size: ______

Total Income: ______ Per: ❑Week ❑Bi-Weekly (Every 2 Weeks) ❑2x Month ❑Monthly ❑Annual

❑ **Selected For Verification:** Confirming Official's Signature: ________ Date: ______

Follow-Up Official's Signature: ________ Date: ______

INSTRUCTIONS Sources of Income

Sources of Income for Children

Type of Income	Examples
Earnings from work	A child has a job where they earn a salary or wages.
Social Security -Disability payments -Survivor Benefits	A child is blind or disabled and receives Social Security benefits. A parent is disabled, retired, or deceased and their child receives social security benefits.
Income from persons *outside* the household	A friend or extended family member *regularly* gives a child spending money.
Income from any other source	A child receives income from a private pension fund, annuity or trust.

Sources of Income for Adults

Earnings from Work	Public Assistance/ Alimony/Child Support	Pensions/Retirement/All Other Income
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) **If you are in the U.S. Military:** - Basic pay and cash bonuses *(do not include combat pay, FSSA, or privatized housing allowances)* -Allowances for off-base housing, food and clothing	- Unemployment benefits - Workers Compensation - Supplemental Security Income (SSI) - Cash Assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private Pensions or disability - Regular income from trusts or estates - Annuities - Investment Income - Earned Interest - Rental Income - Regular cash payments from outside household

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one):

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more):

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

---

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

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

CONSENT FOR SHARING INFORMATION WITH OTHER PROGRAMS

Dear Parent/Guardian:

The information you gave on your Free and Reduced-Price School Meals Application may be shared with other programs for which your children may qualify. For the following programs, we must have your permission to share your information. Sending in this form will not change whether your children get free or reduced-price meals.

☐ No! I **DO NOT** want information from my Free and Reduced-Price School Meals Application shared with any of these programs.

☐ Yes! I **DO** want school officials to share information from my Free and Reduced-Price School Meals Application with **Arizona Department of Education**.

☐ Yes! I **DO** want school officials to share information from my Free and Reduced-Price School Meals Application with **Nutrikids (POS system)**.

If you checked yes to any or all the boxes above, fill out the form below. Your information will be shared only with the programs you checked.

Child's Name: ______________________________ School: __________________________

Child's Name: ______________________________ School: __________________________

Child's Name: ______________________________ School: __________________________

Child's Name: ______________________________ School: __________________________

Signature of Parent/Guardian: ______________________________ Date: ___________________

Printed Name: _____________________________________

Address: ____

____

For more information, you may call **Marilyn June** at **928-289-4488 ext 107 or e-mail at mjune@wrhinc.org.**

Please return this form with your school meal application: **600 N Alfred Ave., Winslow, Az. 86047** by **July 29, 2021.**

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