



WHITESIDE SCHOOL DISTRICT 115

111 Warrior Way
Belleville, Illinois 62221

Telephone 618 239-0000
Middle School Fax 618 239-9240
Elementary School Fax 618 233-7931

<http://www.wssd115.org>

Mark L. Heuring
Superintendent

Monica Laurent
Middle School Principal

Jaime Cotto
Middle School Assistant Principal

Nathan Rakers
Elementary Principal

Kevin Johnson
Elementary Assistant Principal

SCHOOL FEES 2020-2021 School Year

The School Board may establish fees and charges to fund certain school activities. It is recognized that some students will be unable to pay these fees. Consequently, students shall not be denied educational services or academic credit due to the inability of parents or guardians to pay fees. **Whiteside School District's textbook & materials fee is currently \$65.00 per student for Kindergarten, 1st, 2nd, 3rd, 4th, and 5th Grades; and \$75.00 for 6th, 7th, and 8th Grades and should be paid at Registration in July/August. Textbook & materials fee for students (all grades) who qualify for reduced-price meals is \$25.00. All 3rd Graders will also be assessed a \$5.00 fee for the purchase of a recorder for Music class. All Middle School Band Students will be assessed a \$25.00 fee for Band. Fees MUST be paid in full by October 15, 2020. FEES NOT PAID BY THE DEADLINE WILL BE CHARGED A \$10.00 LATE FEE. Fees for students enrolling after the first day of school are due at the time of registration. ALL FEES ARE SUBJECT TO CHANGE.**

NOTE: Fees must be paid in full prior to Middle School Sports Try-outs.

Students whose parents are unable to afford student fees may receive a waiver of the fees based upon approval of a completed Fee Waiver Application. However, these students are not exempt from charges for lost and damaged books, locks, materials, supplies and equipment.

Applications and additional information for the fee waiver will be available in August.

Whiteside School District #115
Enrollment Form

Student's Name: _____ Male Female
(Last Name) (First Name) (Middle Name)

Address: _____ Phone: _____
(Street) (City) (Zip Code) (main contact number)

Student's Birthdate: _____ City / State of Birth: _____

Name of Mother or Legal Guardian: _____ Maiden Name: _____

Mother's Cell # () _____ Work # () _____ Home # () _____

E-mail address: _____ Employer: _____

Mother's home address (if different than Student): _____

Name of Father or Legal Guardian: _____

Father's Cell # () _____ Work # () _____ Home # () _____

E-mail address: _____ Employer: _____

Father's home address (if different than Student): _____

Student's ethnic or racial background:

American Indian / Alaskan Native Asian Black or African American Native Hawaiian or other Pacific Islander White

Must also check one box below:

Hispanic or Latino Not Hispanic or Latino

Is either Parent / Guardian Military (Active Duty / Reserves)?

Must check one box below:

Yes No

Military deployed or about to deploy?

Optional:

Yes No

Status of Parents (please check all that apply):

Married Separated Divorced Single Mother Deceased Father Deceased

Does a court order or decree prevent either parent from receiving student records or having limited or no access to the student?

Yes No *If yes, please provide a copy of the court document to the school.*

Child lives with (please check all that apply):

Parents Mother Father Legal Guardian Foster Homeless

Other (Give name: _____) Relationship to Student (_____)

Please complete back side

SCHOOL USE ONLY

Student ID _____ Teacher _____ Grade _____ Bus # _____ Bus Stop _____ Car / Walk _____

Start date: _____ IL Transfer _____ Out of State Transfer _____ Special Ed _____ Birth Cert _____

Waiver: _____ Registration approved by: _____

List the persons (other than Parent / Guardian to contact if you are unable to be reached. These people also have permission to pick up your child. List in preferred order of contact.

Name of person	Relationship to child	Cell #	Home / Work #

List NAMES and BIRTHDATES of student's brothers and sisters

School attended last year (Name of School / address) _____

Does your child receive special education services? Yes No

If yes, please indicate program: Speech L.D. Services Self-contained Other (specify) _____

Was your child in an intervention (RTI) program for reading? Yes No

Was your child in an intervention (RTI) program for math? Yes No

Was your child in a gifted / honors program? Yes No

What language(s) other than English, does your child speak? _____

Has your child ever attended Whiteside School District #115 before? Yes No

Health Information

Please Circle: None Asthma ADD/ADHD Seizures Diabetes Allergies

Other Explain _____

Preferred Hospital _____

The District has permission to allow the media to use my child's picture and/or place my child's picture on the website / social media or newspaper for special recognition purposes.

Yes No

Students will be given textbooks to use at the beginning of the school year. It is the students' responsibility to turn their book into the classroom teacher. If textbooks are not returned, or are returned damaged beyond normal wear and tear, the students account will be charged for the cost of replacement or repair. If not paid for the account will be turned over to a collection agency. Fee waivers do NOT cover lost, damaged or stolen textbooks. Parent Initials _____

My signature indicates that I will read a copy of the school's Student Handbook online at wssd115.org (under Information, click Student Handbook).

I voluntarily furnish the above information and hereby certify that the student listed above and I are legal residents of Whiteside School District #115 residing within the boundary lines of said district as mandated by the State of Illinois. I understand that I may be charged with a Class C misdemeanor and may be required to pay back tuition for providing false information.

Signature of parent / legal guardian

Date



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AUTHORIZATION TO RELEASE RECORDS

RE:

Name of Student

Grade this school year

Date of Birth

Sent to or receive records from:

School name

Street Address

City, State, Zip Code

I hereby consent to the release of the following information on the above child to the Whiteside School District #115, Belleville, IL.

1. Permanent Record Information (Identifying information, grades, attendance and health records).
2. Temporary Record Information (Ability and Achievement Test results and other pertinent information).
3. Special Education Records (including MDC and IEP), Individual Psychological Test and special testing information.
4. All School Record Information on file.

K-4 Records

Whiteside Elementary School
2028 Lebanon Ave
Belleville, IL 62221
Fax: 618-233-7931
E-mail: bridget.conley@wssd115.org

5-8 Records

Whiteside Middle School
111 Warrior Way
Belleville, IL 62221
Fax: 618-239-9240
E-mail: tami.muren@wssd115.org

I understand that the information thus obtained will be treated in a confidential manner.

Signed / Relationship to Student

Address

Date

Whiteside's mission is to help all learners reach their maximum potential so that they may become tomorrow's leaders.

WHITESIDE SCHOOL DISTRICT #115
2020-2021 SCHOOL YEAR

STUDENT AUTHORIZATION FOR ELECTRONIC NETWORK ACCESS

STUDENT NAME: _____

Last, First (Please print)

Student Section

I understand and will abide by the Whiteside School District 115 *Student Acceptable Use Policy for Electronic Networks*. I understand that the district and/or its agents may access and monitor my use of the Internet, including e-mail and downloaded material, without prior notice to me. I further understand that should I commit any violation, my access privileges may be revoked, and school disciplinary action and/or appropriate legal action may be taken. In consideration for using the district's electronic network connection and having access to public networks, I hereby release the school district and its board members, employees, and agents from any claims and damages arising from my use, or inability to use the Internet.

USER SIGNATURE: _____ DATE: _____

Parent/Guardian Section

I have read the Whiteside School District 115 *Student Acceptable Use Policy for Electronic Networks*. I understand that access is designed for educational purposes and that the district has taken precautions to eliminate controversial material. However, I also recognize it is impossible for the district to restrict access to all controversial and inappropriate materials. I will hold harmless the district, its employees, agents, or board members for any harm caused by materials or software obtained via the network. I accept full responsibility for supervision if and when my child's use is not in a school setting. I have discussed this authorization with my child. I hereby request that my child be allowed access to the Whiteside School District 115 Electronic Network.

PARENT/GUARDIAN NAME *(Please print)*: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

AUTHORIZATION FOR USING A PHOTOGRAPH OR VIDEO OF A STUDENT

Parent/Guardian Section

I grant consent to Whiteside School District 115 to identify a picture of my child or ward, by full name and/or the school he or she attends, in any school-sponsored material, publication, video, or website. This consent is valid for the entire time my child or ward is enrolled in Whiteside School District 115. I may revoke this consent at any time by notifying the Building Principal in writing.

I deny consent to Whiteside School District 115 to include a photo of my child in any school-sponsored material, publication, video, or website, even if my child is not identified by name

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Pictures of students taken by non-school agencies: While the school limits access to school buildings by outside photographers, it has no control over news media or other entities that may publish a picture of a named or unnamed student. School staff members will not, however, identify a student for an outside photographer.

HANDBOOK RECEIPT

_____ (parent/guardian initials) I have received the Student & Parent Handbook/Agenda and understand that my child and I are responsible for following the rules and policies as stated in the handbook. Note: The handbook may be updated throughout the school year. Notice of handbook amendments will be sent to parents through Skyward and will be published in the monthly Smoke Signals Newsletter.

MOVIE PERMISSION FORM

_____ I give permission for my child to watch "G" and "PG" rated movies as might pertain to the curriculum.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

E-Learning Survey

Student Name: _____ Grade: _____

1. Does your student have the ability to access an internet-connected device for E-Learning?
 Yes No

2. Please mark a yes/no next to the device(s) that your child will use for future E-Learning.

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Desktop Computer
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Laptop Computer
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Chromebook
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Ipad/Tablet
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Cell Phone
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	My student does NOT have a device

3. Do you have internet service at your residence? Yes No

4. Is your internet service provided by an internet company (ie: Charter, AT&T, etc.)?
 Yes No

5. Is your internet service provided through your cell phone company as a hotspot?
 Yes No

6. Would you need a Chromebook or E-Device, if provided, to allow for E-Learning?
 Yes No

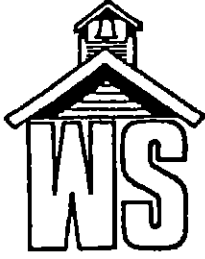
7. If an E-Learning Device is provided, will you be able to provide internet services for your student(s)?
 Yes No

8. If an E-Learning Device is provided, do you need access to be provided for internet service?
 Yes No

9. If a remote hotspot (internet) is provided within the school district at different remote locations would you be able to transport your student(s) to access the internet?
 Yes No

10. If you answered yes to the previous question, please select the amount of time you would be able to stay at the remote location and allow your student(s) to work on E-Learning?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Less than 30 minutes
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	30-60 minutes
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	More than 60 minutes



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All students must be up to date with physical and immunizations by the start of school.

Students will NOT be able to attend school until ALL required health information is on file.

It is not too early to begin scheduling physical and immunization appointments.

- Physical The Health History portion is a requirement and must be completed by parent or guardian.
- Immunizations
- Dental
- Vision

Requirements by Grade:

Preschool Students

- Physical Exam on Illinois Form
- Complete Immunization Record
- (4) DTaP, (3) Polio, (4) Hib, (3) Hep B, (1) MMR, (1) C.pox, (4) Pneumococcal
-

Kindergarten Students

- **New** Physical Exam on Illinois Form (Preschool Exam cannot be used for Kindergarten)
- Complete Immunization Record
- (5) DTaP, (4) Polio, (4) Hib, (3) Hep B, (2) MMR, (2) C.pox, (4) Pneumococcal
- Dental Exam on Illinois Form
- Eye Exam on Illinois Form
-

Second Grade Students

- Dental Exam on Illinois Form

Sixth Grade Students

- **New** Physical Exam (dated 8/1/19 or later) on Illinois Form.
- Complete Immunization Record
- (1) Tdap, (3) Hep B, (2) MMR, (2) C.pox, (1) **Meningitis-(on or after 11 birthday)**
- Dental Exam on Illinois Form

Ninth Grade Students

- **NEW** Physical Exam on Illinois Form
- Complete Immunization Record Including
- (1) Tdap, (3) Hep B., (2) C.pox, (1) Meningitis
- Dental Exam on Illinois Form

Religious Exemption

- **A New Religious Exemption Certificate** is required for children entering Kindergarten, sixth, or ninth grade.

Whiteside's mission is to help all learners reach their maximum potential so that they may become tomorrow's leaders.



State of Illinois Certificate of Child Health Examination

Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#						
Last	First	Middle	Month/Day/Year									
Address			Parent/Guardian	Telephone # Home	Work							
Street City Zip Code												
IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <i>every</i> dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.												
REQUIRED Vaccine / Dose	DOSE 1		DOSE 2		DOSE 3		DOSE 4		DOSE 5		DOSE 6	
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP												
Tdap, Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV	
Hib Haemophilus influenza type b												
Pneumococcal Conjugate												
Hepatitis B												
MMR Measles Mumps Rubella							Comments: * indicates invalid dose					
Varicella (Chickenpox)												
Meningococcal conjugate (MCV4)												
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose												
Hepatitis A												
HPV												
Influenza												
Other: Specify Immunization Administered/Dates												
Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.												
Signature				Title				Date				
Signature				Title				Date				
ALTERNATIVE PROOF OF IMMUNITY												
1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR												
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease. Date of Disease Signature Title												
3. Laboratory Evidence of Immunity (check one) <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella Attach copy of lab result. *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.												
Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____ Physician Statements of Immunity MUST be submitted to IDPH for review.												

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last			First			Middle			Birth Date Month/Day/ Year			Sex	School			Grade Level/ ID					
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER																					
ALLERGIES (Food, drug, insect, other)						Yes	No	List:			MEDICATION (Prescribed or taken on a regular basis.)						Yes	No	List:		
Diagnosis of asthma?						Yes	No				Loss of function of one of paired organs? (eye/ear/kidney/testicle)						Yes	No			
Child wakes during night coughing?						Yes	No				Hospitalizations? When? What for?						Yes	No			
Birth defects?						Yes	No				Surgery? (List all) When? What for?						Yes	No			
Developmental delay?						Yes	No				Serious injury or illness?						Yes	No			
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.						Yes	No				TB skin test positive (past/present)?						Yes*	No	*If yes, refer to local health department.		
Diabetes?						Yes	No				TB disease (past or present)?						Yes*	No			
Head injury/Concussion/Passed out?						Yes	No				Tobacco use (type, frequency)?						Yes	No			
Seizures? What are they like?						Yes	No				Alcohol/Drug use?						Yes	No			
Heart problem/Shortness of breath?						Yes	No				Family history of sudden death before age 50? (Cause?)						Yes	No			
Heart murmur/High blood pressure?						Yes	No				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other										
Dizziness or chest pain with exercise?						Yes	No				Information may be shared with appropriate personnel for health and educational purposes.										
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____												Parent/Guardian Signature						Date			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)																					
Ear/Hearing problems?						Yes	No														
Bone/Joint problem/injury/scoliosis?						Yes	No														
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA																					
HEAD CIRCUMFERENCE if < 2-3 years old						HEIGHT			WEIGHT			BMI			BMI PERCENTILE			B/P			
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMD>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>																					
LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.) Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ Result _____ TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm . No test needed <input type="checkbox"/> Test performed <input type="checkbox"/> Skin Test: Date Read _____ Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____ Blood Test: Date Reported _____ Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Value _____																					
LAB TESTS (Recommended)				Date		Results				Date		Results									
Hemoglobin or Hematocrit						Sickle Cell (when indicated)															
Urinalysis						Developmental Screening Tool															
SYSTEM REVIEW		Normal	Comments/Follow-up/Needs						Normal		Comments/Follow-up/Needs										
Skin									Endocrine												
Ears			Screening Result:						Gastrointestinal												
Eyes			Screening Result:						Genito-Urinary		LMP										
Nose									Neurological												
Throat									Musculoskeletal												
Mouth/Dental									Spinal Exam												
Cardiovascular/HTN									Nutritional status												
Respiratory			<input type="checkbox"/> Diagnosis of Asthma						Mental Health												
Currently Prescribed Asthma Medication:									Other												
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																					
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																					
NEEDS/MODIFICATIONS required in the school setting								DIETARY Needs/Restrictions													
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup																					
MENTAL HEALTH/OTHER Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal																					
EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.																					
On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.) PHYSICAL EDUCATION Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> INTERSCHOLASTIC SPORTS Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>																					
Print Name						(MD,DO, APN, PA) Signature						Date									
Address												Phone									



State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
 _____ (Last) _____ (First) _____ (Middle Initial)
 Birth Date _____ Gender _____ Grade _____
 _____ (Month/Day/Year)
 Parent or Guardian _____
 _____ (Last) _____ (First)
 Phone _____
 _____ (Area Code)
 Address _____
 _____ (Number) _____ (Street) _____ (City) _____ (ZIP Code)
 County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____
 Ocular history: Normal or Positive for _____
 Medical history: Normal or Positive for _____
 Drug allergies: NKDA or Allergic to _____
 Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? Yes No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other _____



State of Illinois Eye Examination Report

Recommendations

1. Corrective lenses: No Yes, glasses or contacts should be worn for:
 Constant wear Near vision Far vision
 May be removed for physical education
2. Preferential seating recommended: No Yes

Comments _____

3. Recommend re-examination: 3 months 6 months 12 months
 Other _____

4. _____

5. _____

Print name _____
Optometrist or physician (such as an ophthalmologist)
who provided the eye examination MD OD DO

License Number _____

Address _____

Phone _____

Consent of Parent or Guardian
 I agree to release the above information on my child
 or ward to appropriate school or health authorities.

 (Parent or Guardian's Signature)

 (Date)

Signature _____

Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)



PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City		ZIP Code
Name of School:	ZIP Code		Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Last Name		First Name	
Student's Race/Ethnicity:				
<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				

To be completed by dentist:

Date of Most Recent Examination: _____ (Check all services provided at this examination date)
 Dental Cleaning Sealant Fluoride treatment Restoration of teeth due to caries

Oral Health Status (check all that apply)

- Yes No **Dental Sealants Present on Permanent Molars**
- Yes No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.
- Yes No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.
- Yes No **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

- Restorative Care** — amalgams, composites, crowns, etc. Appointment Date: _____
- Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date: _____
- Pediatric Dentist Referral Recommended** Treatment Completion Date: _____

Additional comments: _____

Signature of Dentist _____ License #: _____ Date: _____





State of Illinois
Illinois Department of Public Health

DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City		ZIP Code
Name of School:	ZIP Code		Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Last Name	First Name		
Student's Race/Ethnicity:				
<input type="checkbox"/> White	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian	
<input type="checkbox"/> Native American	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Multi-racial	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other _____				

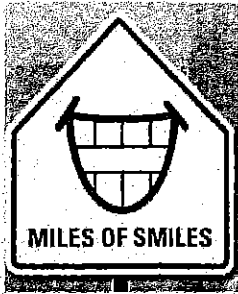
I am unable to obtain the required dental examination because:

- My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid / All Kids).
- My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid / All Kids).
- My child is enrolled Medicaid / All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid / All Kids.
- My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Parent or Guardian Signature _____ Date: _____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov





Miles of Smiles, Ltd.

ATTENTION PARENTS!!!!!!

Miles of Smiles, Ltd. is providing preventive dental services at your school to eligible children in **all grades**.

Services may include exam, cleaning, fluoride varnish, and sealants if needed.

This also satisfies the dental requirement mandated by the State of Illinois for school children (Kindergarten, 2nd, 6th, and 9th).

Please sign up your child today to receive this wonderful service.

There is ***no cost*** to the family or school.

After the services are performed, the following entities will be billed where applicable:
IL Medicaid program, public/private grants, or private dental insurance.
Miles of Smiles, Ltd. will accept any reimbursement as the final payment (even if the claim is denied). The families and the schools are never billed for any co-payments, deductibles, or balances.

There is never any cost to the school or to the families.

*****If you see a dentist regularly,
please continue for routine exams and x-rays!*****

All Kids online application & forms:
<https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/application.aspx>
All Kids Hotline: 1-866-ALL-KIDS (1-866-255-5437)

2424 N. 8TH St., Pekin, IL 61554 * Office: 309-382-6404 * Fax: 309-382-6405

ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

Rev 06/17

PLEASE PRINT IN INK

DENTAL EXAM

Services Rendered By:

MUST BE RETURNED TOMORROW (ONLY IF YOU WANT THESE SERVICES)



Miles of Smiles, Ltd.

NAME OF SCHOOL: _____

2424 N 8th St

TEACHER: _____

GRADE: _____

Pekin, IL 61554-1547

COUNTY: _____

309-382-6404

DO YOU HAVE A DENTIST? YES / NO

DENTIST'S NAME: _____

EXAM DATE: _____

 PROVIDE THE FOLLOWING INFORMATION ONLY IF YOU WANT THESE DENTAL SERVICES

to be rendered by Miles of Smiles, Ltd at school.

Dear Parent or Guardian,

Miles of Smiles, Ltd. and The Illinois Department of Healthcare and Family Services have arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, hygienists, and assistants will come to your child's school with portable equipment. In order for your child to receive these services, you must **PROVIDE ALL THE INFORMATION REQUESTED BELOW AND SIGN IN THE AREA INDICATED.**

YOUR CHILD'S LEGAL NAME: _____

BIRTH DATE: ____/____/____

ADDRESS: _____

GENDER: M / F

CITY/ZIP: _____

HOME PHONE: _____

DOES YOUR CHILD QUALIFY FOR FREE OR REDUCED MEALS: YES / NO

MCO COMPANY NAME (circle one): Aetna, BCBS,

IS YOUR CHILD ENROLLED IN THE 'Medicaid/All Kids' PROGRAM: YES / NO

Cigna, CommunityCare, CountyCare, Family Health Network,

MCO COMPANY NAME (if not listed): _____

Harmony, Humana, IlliniCare, Meridian, Molina

IF YES, INCLUDE YOUR CHILD'S RECIPIENT ID NUMBER: _____

Medicaid/All Kids will be billed

(9 DIGIT ID NUMBER ON BACK OF MEDI-PLAN CARD)

IS YOUR CHILD COVERED BY PRIVATE DENTAL INSURANCE: YES / NO

(If incomplete, only grades K, 2nd, & 6th may be eligible for an exam)

IF YES, please fill out ALL the insurance information below: **(DENTAL INSURANCE COMPANY WILL BE BILLED)**

Name of Dental Insurance Company: _____

Dental Insurance Company Address: _____

Member's (employee) ID or SS #: _____

Dental Insurance plan or group number: _____

Member's name: _____

Member's Birth Date: _____

Member's Address (if different than child's): _____

Member's Phone Number (if different than child's): _____

Employer: _____

Has your child had any history of, or conditions related to, any of the following: (Please circle)

Anemia:	YES / NO	Chronic Sinusitis:	YES / NO	Growth problems:	YES / NO	Seizures:	YES / NO
Asthma:	YES / NO	Diabetes:	YES / NO	Hearing:	YES / NO	Thyroid:	YES / NO
Bleeding disorders:	YES / NO	Ear aches:	YES / NO	Heart Disease:	YES / NO	Tobacco / drug use:	YES / NO
Cancer:	YES / NO	Epilepsy:	YES / NO	Latex allergy**:	YES / NO	Allergies:	
Cerebral Palsy:	YES / NO	Fainting:	YES / NO	Pregnancy (teens):	YES / NO	Other:	

Is your child taking any prescription and/or over the counter medications at this time? YES / NO

If yes, please list: _____

Does your child have any known heart condition? YES / NO DESCRIBE: _____

Does your child have any artificial joints: YES / NO IF YES, WHEN & WHAT JOINT: _____

Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatment? YES / NO

IF YES, WHAT: _____

IMPORTANT: PARENT/GUARDIAN SIGNATURE REQUIRED (ONLY IF YOU WANT THESE SERVICES)

I am a custodial parent or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment described, and allow the school nurse/ school representative and dental provider access to child's dental record.

This will also give permission for the Illinois Department of Public Health to provide Quality Assurance Audits by evaluation of your child's sealants that were placed at the school. Upon determination, this permission will also allow for the sealants to be replaced by the provider if indicated.

To the extent permitted by law, I consent to the use and disclosure of the minor child's protected health information to carry out payment activities in connection with this claim. I hereby authorize and direct payment of the dental benefits directly to Miles of Smiles, Ltd.

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

IF YOU HAVE A DENTIST, SEEK DENTAL CARE THERE!

DDS INITIALS _____

RDH INITIALS _____

Child's Name: _____ Date of Birth: _____ Grade: _____

"DO NOT WRITE BELOW THIS LINE"

ALL KIDS SCHOOL-BASED DENTAL PROGRAM DENTAL RECORD

(BELOW TO BE COMPLETED BY MILES OF SMILES, LTD. DENTIST)

PRIOR TREATMENT

Restorations:	Sealants:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

TREATMENT NEEDED

Restorative:	Sealants: ✓	Sealants: ✓
_____	_____ S _____ S	_____ S _____ S
_____	_____ S _____ S	_____ S _____ S
_____	_____ S _____ S	_____ S _____ S
_____	_____ S _____ S	_____ S _____ S
_____	_____ S _____ S	_____ S _____ S
_____	_____ S _____ S	_____ S _____ S

(Check off sealants placed today; occlusal is assumed)

ORAL HYGIENE STATUS:	_____ Good	_____ Fair	_____ Poor
PERIODONTAL STATUS:	_____ Good	_____ Fair	_____ Poor
MALOCCLUSION:	I	II	III

(Circle one) ORAL HEALTH ASSESSMENT RATING & SCORE:



3	<u>URGENT</u> Treatment:	5+ carious lesions, gross caries, root tips, caries likely to involve pulpal tx, abscess, soft tissue pathology, pain from disease or foreign object.
2	<u>RESTORATIVE</u> Care:	4 or less cavitated, occlusal, or incipient caries. Caries not close proximity to pulpal tissue.
1	<u>PREVENTIVE</u> Care: (services rendered today)	There is no visual evidence of caries activity or periodontal pathology.

TREATMENT COMPLETED TODAY: (Check-off)

EXAM
 PROPHYLAXIS
 FLUORIDE TREATMENT VARNISH / GEL
 SEALANTS (tooth #s listed above)

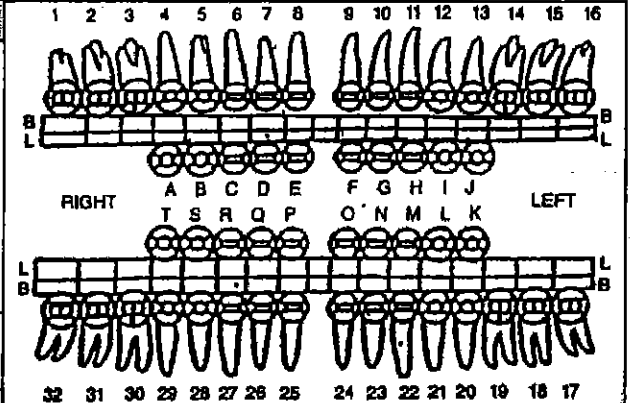
Total # sealants placed today: _____

Treatment Date: _____

Dentist's Signature: _____

Hygienist's Initials: _____

<input type="checkbox"/> NO TX	<input type="checkbox"/> MOS yellow	<input type="checkbox"/> CCHC green	OTHER DR: <input type="checkbox"/> Haarman purple	<input type="checkbox"/> Dietz blue	<input type="checkbox"/> REFER red
--------------------------------	-------------------------------------	-------------------------------------	---	-------------------------------------	------------------------------------



Charting: BLUE-existing restorations; RED-treatment needed

NOTES:

(Revised 06/17)

WHITESIDE SCHOOL DISTRICT 115

111 Warrior Way
Belleville, Illinois 62221

Telephone 618 239-0000
Middle School Fax 618 239-9240
Elementary School Fax 618 233-7931



Nurse's office phone- x2313 (E), x3366 (M)

WHITESIDE SCHOOL MEDICATION PERMIT FORM

TO BE COMPLETED BY HEALTHCARE PROVIDER:

GRADE: _____

STUDENT'S NAME: _____ DATE OF BIRTH _____

MEDICATION/ HEALTH CARE TREATMENT: _____

ROUTE: _____ DOSAGE: _____ FREQUENCY OR TIME TO BE ADMINISTERED: _____

EXPECTED OR POSSIBLE SIDE EFFECTS: _____

ADDITIONAL INSTRUCTIONS: _____

DISCONTINUE * RE-EVALUATE * FOLLOW- UP:(CIRCLE ONE) DATE: _____

PRESCRIBER'S NAME (PRINT) _____

PRESCRIBER'S SIGNATURE: _____ DATE: _____

CONTACT PHONE # _____

PARENT/GUARDIAN AUTHORIZATION:

I hereby authorize Whiteside School District 115 and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of Whiteside School District 115) lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

CONTACT PHONE# _____

Whiteside School Medication Policy:

All medicines to be given at school require a medication permit signed by a healthcare provider. The ONLY exception is for the use of an asthma inhaler.

All medicine must be in a pharmacy labeled container or original package, properly labeled.

Controlled medicine can only be brought in or picked up by an adult.

All medication permits must be filled out- one for each medicine and a new permit completed every school year.

ANY changes in the medication administration must be in writing and will require a new permit from the healthcare provider.

Whiteside's mission is to help all learners reach their maximum potential so that they may become tomorrow's leaders.

Grade: _____

2020-2021

Hour: _____

Whiteside P.E. Uniform

(\$15.00 per set)

Students Name _____

Date _____

Shirt Size: Small Medium Large Ex-Large
(Circle One)

Short Size: Small Medium Large Ex-Large
(Circle One)

No. of Uniforms _____ Amount _____ Collected by _____

Uniform(s) issued by _____

Date _____

Grade: _____

2020-2021

Hour: _____

Whiteside P.E. Uniform

(\$15.00 per set)

Students Name _____

Date _____

Shirt Size: Small Medium Large Ex-Large
(Circle One)

Short Size: Small Medium Large Ex-Large
(Circle One)

No. of Uniforms _____ Amount _____ Collected by _____

Uniform(s) issued by _____

Date _____

WHITESIDE SCHOOL 2020-2021 SUPPLY LIST

GRADE 1:

- Fiskars scissors (metal blade) - mark with name
- 20 Elmer's glue sticks
- 3 boxes Crayola Markers: thick tip, classic colors
- 3 boxes Crayola Crayons (24 ct.)
- 40 plain yellow #2 sharpened pencils
- 2 pink erasers
- 2 boxes Kleenex 200 ct.
- 3 spiral single subject notebooks (wide rule)
- 2 2-pocket folders -Five Star Brand (plastic coated cardboard)
- 1 Spacemaker School box (plastic cigar box size) - mark with name
- 1 large roll paper towels
- 1 package of baby wipes
- 1 box Ziploc storage bags (Quart size) - Girls Only
- 1 box Ziploc storage bags (Gallon size) - Boys Only
- 4 Dry Erase Markers
- 1 bottle Germ-X
- 2 red plastic 3-prong folders
- 1 bottle Elmer's liquid school glue
- Ear Buds (cheap)

GRADE 2

- 60 plain yellow #2 pencils - sharpened
- 3 boxes Crayola Crayons (24 ct.) leave in original box (1 for Library)
- 1 10 ct. box Crayola Markers (classic colors, thick tip) leave in original box
- 1 pair Fiskars pointed school scissors (student size)
- 3 boxes Kleenex tissue 200 ct.
- 1 large roll paper towels or napkins
- 4 pink eraser
- 1 12" ruler (inches & centimeters)
- 10 Large Elmer's glue sticks
- 6 2-pocket paper folders
- 2 spiral (wide rule) notebooks
- 1 roll Scotch tape (girls)
- 1 Zipper Pencil Bag
- 2 boxes unscented wipes (1 box goes to computers)
- 2 boxes Ziploc bags (snack size-girls, quart size-boys, gallon size-everyone)
- 1 Crayola Watercolor paints (Art)
- 2 Sharpie highlighters
- 1 package of white paper plates (boys)
- 3x3 Post-It notes (girls)
- 1" 3-ring binder (Mrs. Lay's Class)
- Ear Buds or Headphones

Grade 3

- 1 box Crayola crayons (24 ct. only)
- 1 pair Friskars pointed school scissors (student size)
- 4 boxes Kleenex 200 ct.
- 8 Elmer's glue sticks
- 1 package Regular - lined loose leaf paper - wide rule NO college rule or narrow lines - Girls to bring
- 2 pink erasers
- 5 dozen #2 pencils - **SHARPENED please!!**
- 1 Spacemaker pencil box (no larger than 9" x 5")
- 3 Dry Erase Markers
- 2 highlighter pens
- 1 box Crayola markers
- 1 box Crayola colored pencils
- 1 12" wooden ruler (inches & centimeters)

- 2 spiral notebooks (Wide Ruled)
- 3 double-pocket plastic folders that are 3 hole punched
- 1 large roll paper towels- Boys to bring
- 1 container of Clorox wipes
- Pencil and folder for Music
- 1 box 12 count pencils (Library)
- 1 box Gallon size Ziploc Freezer Bags-Boys to bring
- 1 box Quart size Ziploc Freezer Bags-Girls to bring
- Ear Buds (cheap)
- \$5.00 for Recorder (**Purchased at school**) **NO DOLLAR TREE OR WALMART RECORDERS.**

GRADE 4

- 3 Dry Erase Markers (Expo)
- 48 #2 pencils -**SHARPENED**
- 1 pink eraser
- 1 hand held pencil sharpener
- 1 box Crayola crayons (24 ct.)
- 1 box Crayola markers - classic colors (water colors - not permanent)
- 2 boxes Crayola colored pencils, 12 count
- 1 pair Fiskars pointed school scissors
- 8 Elmer's glue sticks
- 7 folders with prongs & pockets (must have red, green, blue, orange, purple, black and yellow)Plastic preferred
- 1 non-flexible ruler (Inches & centimeters)
- 2 rolls Scotch tape
- 3 boxes Kleenex 200 ct. and 2 large roll paper towels
- 1 small Space Maker pencil box or zipper case
- 2 highlighter pens
- 1 1" diameter 3-ring binder with 2 side pockets (not zippered)
- 1 unopened set of at least 5 tabbed dividers for 3 ring binder
- 2 packages Wide ruled notebook paper - unopened
- 1 composition notebook
- 4 1 subject Wide ruled, SPIRAL notebooks
- 1 Black Sharpie
- 1 box Quart size Ziploc Freezer bags (Girls to bring)
- 1 box Gallon size Ziploc Freezer bags (Boys to bring)
- 1 package antibacterial wipes
- 1 plastic protractor
- NO rolling backpacks (do not fit in all lockers)
- 1 package 3 x 3 Post-It Notes & 1 pkg. lined 3 x 5 index cards
- Ear Buds (cheap)
- \$5.00 for Recorder (**Purchased at school**) **NO DOLLAR TREE OR WALMART RECORDERS.**
- 1 bottle white Elmer's school glue

ART ROOM NEEDS:

- Glue Sticks, Paper Towels, Kleenex, Gallon and Sandwich size Ziploc Bags

Please put names on all supplies including book bag, lunch box, jackets, hats, or anything that could get lost. ALL GRADE LEVELS MUST HAVE CLEAN TENNIS SHOES WITH SHOESTRINGS FOR P.E. Additional items may be required by grade level.

WHITESIDE SCHOOL 2020-2021 SUPPLY LIST

****NO Birthday treats are to be sent to school to be handed out in the classrooms or the lunchroom****

GRADE 5

- 4 large boxes of Kleenex (3-Homeroom/1-Specials)
- 2 rolls of paper towels
- 2 packages loose leaf paper (wide rule)
- 9 spiral notebooks-wide rule (orange, yellow, green, red, blue, Purple, + 3 more any color – DO NOT LABEL)
- 1 composition notebook (any color)
- 2 packages note cards
- 1 pair of scissors (blunt-tip)
- 10 2-pocket 3-pronged folders (orange, yellow, green, red, blue, purple, + 4 more any color) DO NOT LABEL
- 1 1-1/2" 3-ring binder w/pockets
- 2 black sharpies (fine point)
- 6 dozen #2 pencils
- 1 pink eraser & 1 pkg. eraser heads
- 2 pkgs. red pens
- 1 box of crayons
- 1 box of markers
- 1 package colored pencils
- 2 highlighters
- 4 dry erase markers
- 4 glue sticks
- 6 Scotch tape
- 1 dictionary (Webster's paperback)
- 1 book bag
- 1 zippered pencil bag
- 1 package post-it notes
- 1 see-through 12" ruler (inches & cm.)
- Recorder (purchase in the office for \$5.00)
- 2 Hand held pencil sharpeners w/cover (manual)
- 3 Pkgs. Disinfecting wipes
- 1 bottle of hand sanitizer
- 2 pr. Ear Buds with traditional jack (no Bluetooth) – 1 for classroom & 1 for computers

GRADE 6

- 5 boxes of Kleenex (3-Homeroom/2-P.E.-Specials)
- 1 rolls of paper towels (for Art)
- Clorox Wipes
- Hand sanitizer
- 1 trapper keeper with dividers
- 2 single subject spiral notebooks
- 3 Composition notebooks (Composition, Literature & Math)
- 4 packages loose leaf paper (1 for Library)
- 7 2-pocket folders (1 for Library & 1 for Literature))
- 3 pkg. 3" x 5" index cards (Science, Composition, & SS)
- 5 dry erase markers (3 Math & 2 SS)
- 1 pencil bag
- 20+ Pencils with erasers
- 1 pkg. ballpoint pens (at least 1 red)
- 1 pkg. multi-colored highlighters
- 1 pkg. colored pencils
- 1 pkg. markers/crayons
- 4 glue sticks (2 for Math)
- 1 bottle liquid glue (Literature)
- 1 8-1/2x11" spiral sketchbook (Art Students Only – No Band)
- 2 pr. Ear Buds with traditional jack (no Bluetooth) – 1 for classroom & 1 for computers

**** NO Birthday treats are to be sent to school to be handed out in the classrooms or the lunchroom****

GRADE 7

- 4 boxes of Kleenex
- 3 rolls of paper towels (Science)
- Clorox/Lysol wipes or hand sanitizer
- 1 zippered trapper keeper
- 1 pkg. dividers with pockets for trapper keeper
- 4 100-page wide ruled composition notebooks (2 Science & 2 Comp)
- 1 pkg. loose leaf paper
- 1 spiral notebooks (Math)
- 1-300ct. pkg. 3" x 5" index cards (S, C, Library)
- 6 pocket folders (S, C, M, SS, L, & Library)
- 1 pencil bag
- 1 pkg. pens (at least 1 red pen)
- 20+ Pencils with erasers + extra lead for mechanicals
- 1 pkg. colored pencils
- Hand held pencil sharpener
- 1 protractor
- Simple 4 function calculator (non-scientific)
- 1 pr. safety scissors
- 8 glue sticks (4 are for Science)
- 2 rolls of scotch tape
- 4 Sharpie markers (Sci & PE)
- 4 dry erase markers (PE)
- 2 pr. Ear Buds with traditional jack (no Bluetooth) – 1 for classroom & 1 for computers
- NEW STUDENTS ONLY: 8-1/2" x 11" spiral sketchbook (Art)

GRADE 8

- 4 boxes of tissues for homeroom
- 1 Clorox wipes
- 3 rolls of paper towels (Science)
- 3 packages loose leaf paper- college rule
- 2 composition notebooks - college rule (Science)
- 1 binders, 1-1/2" size (Composition)
- 4 2-pocket folders
- 4 divider tabs for binder (Composition)
- 1 pkg. graph paper (Science, Math)
- 4 packs 3x5" index cards
- 1 bottle of Elmer's White glue (Science)
- 1 solar scientific calculator with fraction capability (TI-30XA or equivalent)
- 1 pkg. Colored pencils (Science)
- Fine tip markers (Literature)
- Black and Blue pens
- Mechanical pencils with extra lead
- Highlighters
- 2 dry erase markers (Math)
- Erasers
- 6 glue sticks (Science)
- 2 pr. Ear Buds with traditional jack (no Bluetooth) – 1 for classroom & 1 for computers
- NEW STUDENTS ONLY – 8-1/2" x11" spiral sketchbook (Art)
- Not required, but helpful: pencil bag and Binder/Trapper Keeper for organization

STUDENTS IN 6TH, 7TH, & 8TH GRADE **MUST** PURCHASE A P.E. UNIFORM FROM WHITESIDE SCHOOL AT A COST OF \$15.00 PER UNIFORM. THEY MUST ALSO HAVE A PAIR OF WHITE SOCKS AND TENNIS SHOES FOR P.E. CLASS. STUDENTS WILL PUT THEIR NAMES ON THEIR CLOTHES WITH PERMANENT MARKER THE FIRST WEEK OF SCHOOL. BLACK SWEATPANTS AND A GREY SWEATSHIRT MAY BE WORN AS WEATHER CONDITIONS WARRANT.

Please put names on all supplies including book bag, lunch box, jackets, hats, or anything that could get lost. ALL GRADE LEVELS MUST HAVE CLEAN TENNIS SHOES WITH SHOESTRINGS FOR P.E. Additional items may be required by grade level.

Dear Parent/Guardian:

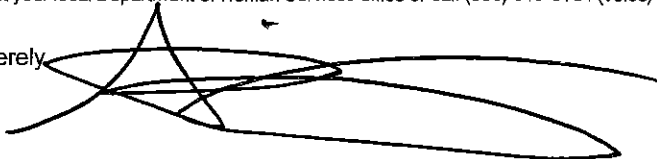
Children need healthy meals to learn. Whiteside School District #115 offers healthy meals every school day. Breakfast costs **\$1.35**; lunch costs **\$2.45**. Your children may qualify for free meals or for reduced price meals. Reduced price is **\$0.30** for breakfast and **\$0.40** for lunch. To apply for free or reduced-price meals, use the Household Eligibility Application, which is enclosed. We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to Jamie Wolfe in Superintendent's office.

Your child(ren) may qualify for free or reduced price meals if your household income falls at or below the limits on this chart.

Federal Income Eligibility Guidelines (Effective from July 1, 2020 to June 30, 2021)						
Household Size	Reduced-Price Meals (100% Federal Poverty Guidelines)					
	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly	
1	23,606	1,968	984	908	454	
2	31,894	2,658	1,329	1,227	614	
3	40,182	3,349	1,675	1,546	773	
4	48,470	4,040	2,020	1,865	933	
5	56,758	4,730	2,365	2,183	1,092	
6	65,046	5,421	2,711	2,502	1,251	
7	73,334	6,112	3,056	2,821	1,411	
8	81,622	6,802	3,401	3,140	1,570	
For each additional family member add:	8,288	691	346	319	160	

1. DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD? No. Complete the application to apply for free or reduced price meals. Use *one Household Eligibility Application* for all students in your household per district. We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to the school.
2. WHO CAN GET FREE MEALS? All children in households receiving benefits from Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and/or are foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals regardless of your income. Also, your children can get free meals if your household's gross income is within the free limits on the Federal Income Eligibility Guidelines. Children who meet the definition of homeless, runaway, or migrant also qualify for free meals. If you haven't been told your children will get free meals, please contact your school to see if your child(ren) qualifies.
3. WHO CAN GET REDUCED PRICE MEALS? Your children can get low cost meals if your household income is within the reduced price limits on the Federal Eligibility Income Chart, shown above.
4. A MEMBER OF MY HOUSEHOLD RECEIVED SNAP OR TANF BENEFITS. THE SCHOOL SENT A LETTER STATING THAT MY CHILD IS AUTOMATICALLY APPROVED FOR FREE MEALS BASED ON DIRECT CERTIFICATION. DO I NEED TO DO ANYTHING MORE TO ENSURE THAT MY CHILD RECEIVES FREE MEALS? No. You do not need to do anything more to receive free meals for your child. If you have students not listed on the letter, contact the school immediately. If you do not wish to receive the free meals, you should follow the steps outlined in the letter from the school to notify school personnel immediately.
5. 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 contact your school.
6. MY CHILD'S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT ANOTHER 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.
7. I GET WIC. CAN MY CHILD(REN) GET FREE MEALS? Children in households participating in WIC may be eligible for free or reduced price meals. Please fill out the enclosed application.
8. WILL THE INFORMATION I GIVE BE CHECKED? Yes. We may also ask you to send written proof.
9. 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.
10. 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 the person listed above.
11. MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN? Yes. You or your child(ren) do not have to be U.S. citizens to qualify for free or reduced price meals.
12. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD? You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro-rated share of expenses), do not include them.
13. 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.
14. 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 mean to do so.
15. 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, 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.
16. MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR? To find out how to apply for SNAP, TANF or other assistance benefits, contact your local Department of Human Services office or call (800) 843-8154 (voice) or (800) 447-6404 (TTY).

Sincerely,



INSTRUCTIONS FOR APPLYING – COMPLETE ONE APPLICATION PER HOUSEHOLD PER SCHOOL DISTRICT

IF YOUR HOUSEHOLD RECEIVES SNAP OR TANF BENEFITS, FOLLOW THESE INSTRUCTIONS AND RETURN THE COMPLETED FORM TO YOUR SCHOOL:

Part 1: List all household members, school and grade for each student, and a SNAP or TANF case number for any household member including adults receiving such benefits. (Attach another sheet of paper if necessary.)

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Sign the form. (The last four digits of a Social Security Number are not necessary.)

Part 5 & 6: Contact Information, and Children's Racial and Ethnic Identities: Answer these questions if you choose to. (Optional)

IF NO ONE IN YOUR HOUSEHOLD GETS SNAP OR TANF BENEFITS AND IF ANY CHILD IN YOUR HOUSEHOLD IS HOMELESS, A MIGRANT OR RUNAWAY OR HEAD START/EVEN START, FOLLOW THESE INSTRUCTION AND RETURN THE COMPLETE FORM TO YOUR SCHOOL:

Part 1: List all household members and the name of school for each child.

Part 2: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your school.

Part 3: Complete only if a child in your household isn't eligible under Part 2. See instructions for All Other Households.

Part 4: Sign the form. Only if part 3 is completed, please include the last four digits of a Social Security Number. (or mark the box if s/he doesn't have one).

Part 5 & 6: Contact Information, and Children's Racial and Ethnic Identities: Answer these questions if you choose to. (Optional)

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS AND RETURN THE COMPLETED FORM TO YOUR SCHOOL:

If all children in the household are foster children that are the legal responsibility of a foster care agency or court:

Part 1: List all foster children and the school name for each child. Check the "Foster Child" box for each foster child.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Sign the form. The last four digits of a Social Security Number are not necessary.

Part 5 & 6: Contact Information, and Children's Racial and Ethnic Identities: Answer these questions if you choose to. (Optional)

If some of the children in the household are foster children that are the legal responsibility of a foster care agency or court:

Part 1: List all household members and the name of school for each child. Check the "Foster Child" box for each foster child.

Part 2: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your school.

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

- **Box 1—Name:** List all household members with income.
- **Box 2—Gross Income and How Often it Was Received:** For each household member, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month or monthly. For earnings, be sure to list the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. For other income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits. Under All Other Income, list Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from SNAP, FDIPIR, WIC, Federal education benefits and foster payments received by the family from the placing agency. For ONLY the self-employed, under Earnings from Work, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 4: Adult household member must sign the form and list the last four digits of their Social Security Number (or mark the box if s/he doesn't have one).

Part 5 & 6: Contact Information, and Children's Racial and Ethnic Identities: Answer these questions if you choose to. (Optional)

ALL OTHER HOUSEHOLDS INCLUDING MEDICAID AND WIC HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: List all household members and the name of school for each child.

Part 2: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your school.

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

- **Box 1—Name:** List all household members with income.
- **Box 2—Gross Income and How Often it Was Received:** For each household member, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month or monthly. For earnings, be sure to list the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. For other income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits. Under All Other Income, list Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include income from SNAP, FDIPIR, WIC, Federal education benefits and foster payments received by the family from the placing agency. For ONLY the self-employed, under Earnings from Work, report income after expenses. This is for your business, farm, or rental property. Do not include income from SNAP, FDIPIR, WIC or Federal education benefits. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 4: Adult household member must sign the form and list the last four digits of their Social Security Number (or mark the box if s/he doesn't have one).

Part 5 & 6: Contact Information, and Children's Racial and Ethnic Identities: Answer these questions if you choose to. (Optional)

Privacy Act Statement: This explains how we will use the information you give us. 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 FDIPIR 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.

SCHOOL USE ONLY

Check if Error Prone Application

1. All Household Members (Attach another sheet of paper if necessary.)

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	(for Student only) School Name	(for Student only) Grade	SNAP OR TANF CASE NUMBER ONLY Skip to Part 4 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below. If you receive Medicaid and were not directly certified for free meals, you MUST apply based on household size and income.						Check if Foster Child*
									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>

* A foster child is the legal responsibility of a welfare agency or court.

2. Homeless, Migrant, Runaway, or Head Start (Categorically eligible)

- Homeless Migrant Runaway Head Start

Signature of Your School Homeless Liaison, Migrant Coordinator, or Head Start Director _____ Date _____

3. Total Household Gross Income (before deductions) You must tell us how much and how often.

A. NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: \$100/month; \$100 twice a month; \$100/every other week; \$100/week)							
	B. Earnings From Work (Before Deductions)		C. Welfare, Child Support, Alimony		D. Pensions, Retirement, Social Security		E. Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	\$		\$		\$		\$	
ii.	\$		\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

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 the last four digits of his or her social security number or mark the I do not have a social security number box. X X X - X X - I do not have a social security number.

I certify (promise) all information on this application is true and all income is reported. I understand the school will get Federal funds based on the information I give. I understand school officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits and I may be prosecuted.

Date _____ Printed Name of Adult Household Member _____ Signature of Adult Household Member _____

5. Contact Information (Optional)

Work Telephone Number (include Area Code) _____ Home Telephone Number (include Area Code) _____ Home Address (Number, Street, City, State, Zip Code) _____

6. Children's Racial and Ethnic Identities (Optional)

- Mark one ethnic identity: Mark one or more racial identities:
- Hispanic/Latino Asian Black or African American Native Hawaiian or Other Pacific Islander
- Not Hispanic/Latino White American Indian or Alaska Native

THE FOLLOWING SECTIONS ARE FOR SCHOOL USE ONLY

INITIAL DETERMINATION

TOTAL INCOME \$ _____ Per: Week Every 2 Weeks Twice a Month Month Year NUMBER IN HOUSEHOLD: _____ CHANGE IN STATUS: _____ Date _____

LEAs must annualize income only when multiple incomes, at varying frequencies, are reported.
Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12

- Free based on:
- homeless
 - migrant
 - runaway
 - Head Start
- SNAP or TANF
- household's income
- Reduced based on: Denied—Reason:
- household's income
 - income too high
 - incomplete application
 - Non-qualifying SNAP/TANF

Date Withdrawn: _____
Date: _____

Signature of Determining Official _____