Check List to Receive an Admission Slip

Please read all items. Everything must be 100% complete to receive an admission slip.

❑ Signed Contract with School (Mrs. Ayelet Bortunk)

❑ One (per child) completed "Free and Reduced Meal Applications"

❑ One completed "Emergency Contact Form"

❑ Completed Physical and Immunization Health Forms (Per child) All Immunizations MUST be up to date including Hepatitis B, Varicella (Chicken Pox) and PneumoConju

❑ Yearly Enrichment Activities Fee * (Cash/Checks accepted. Credit cards accepted through our website lecfl.com)

Enrichment fee for 1st grade is **$100**

2020-2021

FREE AND REDUCED-PRICE SCHOOL MEALS FAMILY APPLICATION

PART 1. ALL HOUSEHOLD MEMBERS** **RETURN THIS APPLICATION TO YOUR CHILD'S SCHOOL****

Names of all household members (First, Middle Initial, Last)	Student ID	*Place a check in the box below if child is a foster, homeless, migrant, runaway, or Head Start child. If each child attending school is a foster, homeless, runaway, migrant or in Head Start, skip to part 4 to sign this form.*					*Place a check in the box if NO income*
		Foster	Homeless	Migrant	Runaway	Head Start	

PART 2. BENEFITS

IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVES **[State SNAP]**, **[FDPIR]** OR **[State TANF Assistance]**, PROVIDE THE NAME AND CASE NUMBER FOR THE PERSON WHO RECEIVES BENEFITS AND **SKIP TO PART 4. IF NO ONE RECEIVES THESE BENEFITS, SKIP TO PART 3.**

NAME:_____ PROGRAM NAME . CASE NUMBER: (NOT EBT CARD NUMBER)_____

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

1. NAME (LIST **ONLY** HOUSEHOLD MEMBERS WITH INCOME)	**2. GROSS INCOME** AND HOW OFTEN IT WAS RECEIVED																			
	Earnings from work before deductions.	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Social Security, SSI, VA, retirement benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All other income (such as Unemployment) benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly
(Example) Jane Smith	**$200**	X				**$150**		X			**$0**					**$0**				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				

PART 4. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 3 is completed, the adult signing the form also must list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted. I understand my child's eligibility status may be shared as allowed by law.

Signature: _____ Printed name:_____ Date:

Address:_____ Phone Number: _____

Email:_____ City:_____ State:_____ Zip Code:_____

Last four digits of Social Security Number: * * * - * * - __ __ __ __ ❑ I do not have a Social Security Number

The information contained within this application may be shared with other Federal/Local health programs for which your child(ren) may qualify, however your permission is required. This will not affect your eligibility for school meals. May school officials share the information within this application with other programs ☐ No ☐ Yes Child(ren) may also qualify for free or low-cost health and dental insurance with Florida KidCare. Apply at floridakidcare.org or call 1-888-540-5437.

PART 5. CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

Choose one ethnicity:	*Choose one or more (regardless of ethnicity):*
❑ Hispanic/Latino ❑ Not Hispanic/Latino	❑ Asian❑ American Indian or Alaska Native❑ Black or African American❑ White❑ Native Hawaiian or other Pacific Islander

B”h

YOUNG DIVISION EMERGENCY CONTACT FORM

Last Name: _____

Children’s name and age:

1) _____
2) _____
3) _____

Mother’s Name: _____

Father’s Name: _____

Home Phone: _____

Mother Cell Number: _____ Work_____

Father Cell Number: _____ Work_____

Other_____ Email: _____

Alternate Emergency Contact:

1) Name _____ Number _____

2) Name _____ Number _____

Relationship to child_____

Allergies or other medical concerns:

_____

_____