



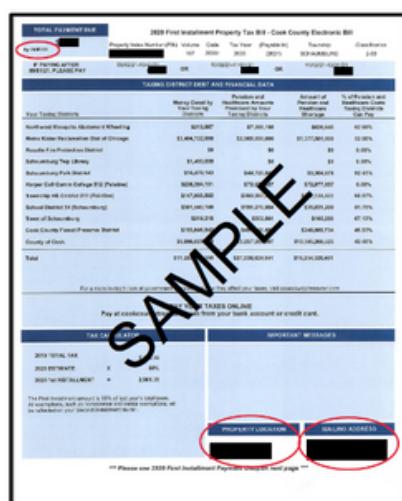
શાળા જિલ્લા ૫૧ માં આપનું સ્વાગત છે

તમારા બાળકને શાળામાં નોંધણી કરાવવા માટે તમારે કયા દસ્તાવેજોની જરૂર પડશે?

1

રહેઠાણનો પુરાવો **

નીચેના દસ્તાવેજોમાંથી એક પ્રદાન કરો:

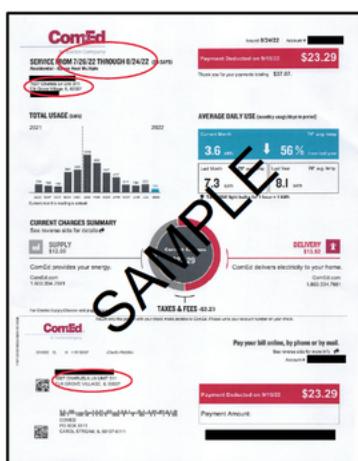


લીજ

આ દસ્તાવેજમાં લીજ ધારક અને ભાડૂતનું નામ, સરનામું, શરૂઆત અને સમાપ્તિ તારીખો હોવી આવશ્યક છે

આ દસ્તાવેજમાં મિલકતના માલિકનું નામ, સરનામું અને નિવેદનની તારીખ હોવી આવશ્યક છે

તમારે નીચેનામાંથી બે દસ્તાવેજોની પણ જરૂર પડશે



વીજળી અથવા ગેસ બિલ (Utility Bill)

બિલમાં નિવાસીનું નામ અને વર્તમાન સરનામું હોવું આવશ્યક છે

આ દસ્તાવેજમાં નિવાસીનું નામ અને વર્તમાન સરનામું હોવું આવશ્યક છે

**જો તમે જિલ્લાના રહેવાસી સાથે રહેતા હો, તો "લીઝના બદલામાં પત્ર" પૂર્ણ કરવાની જરૂર છે. રહેઠાણ સાબિત કરવા માટે ઘરના માલિકે ઉપર સૂચિબદ્ધ દસ્તાવેજો પ્રદાન કરવાની જરૂર પડશે. માતા-પિતા/વાલીએ પણ તેઓ રહેઠાણ પર રહે છે તે સાબિત કરવા માટે દસ્તાવેજો આપવા પડશે.



ડ્રાઇવરનું લાઇસન્સ અથવા રાજ્ય ID

લીગ ફોર્મને બદલે

માતાપિતા અથવા વાલી એક ફોર્મ ભરે છે અને ઘર માલિક આગળનું ફોર્મ ભરે છે. ઘરના માલિક રહેઠાણ સાબિત કરવા માટે દસ્તાવેજો પણ આપવાના રહેશે. માતાપિતા/વાલીએ તેઓ સરનામા પર રહે છે તે સાબિત કરવા માટે દસ્તાવેજો પણ પ્રદાન કરવા આવશ્યક છે (યુટિલિટી બિલ્સ અને/અથવા ડ્રાઇવરનું લાઈસન્સ).

2

વિદ્યાર્થીનું જન્મ પ્રમાણપત્ર અથવા પાસપોર્ટ



3

નવા વિદ્યાર્થીઓ માટેના ફોર્મ (ઓનલાઈન અથવા પેપર ફોર્મ) (Registration packet)

તબીબી માહિતી

 <p>State of Hawaii Bureau Department of Public Health</p>		<p align="center">PROOF OF SCHOOL DENTAL EXAMINATION FORM</p> <p>Dental law (Hawaii Health Care Commission Title 7) & 11-18. Code 500-503 states of children or teenagers, school, staff, and math grades of any public, private, or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to 1st day of the school year. This form is to be used by the Bureau of Oral Health for the purpose of tracking dental examinations and generation of forms. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.</p> <p>This important examination will let you know if there are any dental problems that require attention by a dentist. Children need good oral health to learn and do well in school. Good dental health can help your child succeed in school, make friends, and have a positive self-image, a close personal relationship, and less missed time in the classroom. For this reason, we thank you for making the contribution to the health and well-being of your child.</p>																											
<p>To be completed by the parent or guardian (please print)</p> <table border="1"> <tr> <td>Student's Name _____</td> <td>Last _____</td> <td>First _____</td> <td>Middle _____</td> <td>Birth Date _____/_____/_____</td> </tr> <tr> <td>Address _____</td> <td>Street _____</td> <td>City _____</td> <td colspan="2">ZIP Code _____</td> </tr> <tr> <td>Name of School _____</td> <td>ZIP Code _____</td> <td colspan="3">Grade Level _____</td> </tr> <tr> <td>Parent or Guardian _____</td> <td>Last Name _____</td> <td colspan="3">First Name _____</td> </tr> <tr> <td colspan="5"> <p>Select from the below general dental categories which most clearly reflects the education of his or her community or with which the student most identifies.</p> <p><input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Two or More Races</p> </td> </tr> </table> <hr/> <p>To be completed by dentist</p> <p>Date of Most Recent Examination: _____ (Check all services provided at this examination date) <input type="checkbox"/> Dental Cleaning <input type="checkbox"/> Exam <input type="checkbox"/> Possible Treatment <input type="checkbox"/> Resolution of teeth due to caries</p> <p>One or More Teeth _____ all that apply</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Caries Experience / Restoration History: A tooth is temporary/permanent OR a tooth that is missing because it was extracted as a result of decay (OR missing primary teeth for infants).</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Unrestored Caries: Missing 5 or more tooth surfaces at the enamel surface. Given to dark brown coloration of the tooth. If a tooth has a cavity, it is considered unrestored. If a tooth has a cavity and the cavity has been filled, it is considered restored. Note: If a tooth has a cavity and the cavity has been filled with temporary filling, it is considered unrestored. If a tooth has a cavity and the cavity has been filled with permanent filling, it is also present.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Urgent Treatment: Treatment that requires immediate, advanced treatment, signs or symptoms that include pain, infection, or bleeding.</p> <p>Treatment Needs (check all that apply): Please list additional date or date of most recent treatment complete date, treatment provider name, and address.</p> <p><input type="checkbox"/> Emergency Treatment _____ <input type="checkbox"/> Preventive Care - restorative, fluoride treatments, prophylaxis _____ <input type="checkbox"/> Pediatric Dentist Referral Recommended _____</p> <p>Appointment Date _____ Treatment Complete Date _____</p> <hr/> <p>Dental Office Address _____ Office phone number _____</p> <hr/> <p>Signature of Dentist _____ Date _____</p> <p align="center">Hawaii Department of Public Health, Division of Oral Health 217-768-8999 - TTY (Deaf/Hearing Impaired only) 800-567-1000 - www.dph.hawaii.gov/oralhealth Previous, Authority of the Bureau of Oral Health</p> <p align="right">DRC</p>					Student's Name _____	Last _____	First _____	Middle _____	Birth Date _____/_____/_____	Address _____	Street _____	City _____	ZIP Code _____		Name of School _____	ZIP Code _____	Grade Level _____			Parent or Guardian _____	Last Name _____	First Name _____			<p>Select from the below general dental categories which most clearly reflects the education of his or her community or with which the student most identifies.</p> <p><input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Two or More Races</p>				
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State of Illinois		Eye Examination Report																																																				
 State of Illinois Illinois Department of Public Health																																																						
<p>Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provided 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 district. This report must be completed within one year prior to the first day of the school year. If the child enters the Illinois schools for the first time, the parent of any child who is unable to obtain an examination must submit a waiver form to the school.</p>																																																						
Student Name _____ Birth Date _____ (Month/Year) Gender _____ Grade _____ Parent or Guardian _____ (Name) _____ Phone _____ (Area Code) _____ Address _____ (Street) _____ City _____ State _____ Zip _____ County _____ To Be Completed By Examining Doctor																																																						
Case History Date of exam _____ Ocular history: <input checked="" type="checkbox"/> Normal or Positive for _____ Medical history: <input checked="" type="checkbox"/> Normal or Positive for _____ Drug allergies: <input checked="" type="checkbox"/> NADA or Allergic to _____ Other information: _____																																																						
Examination <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th>Distance</th> <th>Up</th> <th>Down</th> <th>Left</th> <th>Right</th> <th>Both</th> </tr> </thead> <tbody> <tr> <td>Uncorrected visual acuity</td> <td>20'</td> <td>20'</td> <td>20'</td> <td>20'</td> <td>20'</td> <td>20'</td> </tr> <tr> <td>BEST CORRECTED VISUAL ACUITY</td> <td>20'</td> <td>20'</td> <td>20'</td> <td>20'</td> <td>20'</td> <td>20'</td> </tr> </tbody> </table> Was refraction performed with dilation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						Distance	Up	Down	Left	Right	Both	Uncorrected visual acuity	20'	20'	20'	20'	20'	20'	BEST CORRECTED VISUAL ACUITY	20'	20'	20'	20'	20'	20'																													
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Other _____	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____																																																		
<small>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.</small>																																																						
Diagnosis <input checked="" type="checkbox"/> Myopia <input type="checkbox"/> Hyperopia <input type="checkbox"/> Astigmatism <input type="checkbox"/> Strabismus <input type="checkbox"/> Amblyopia Other _____																																																						
Page 1			Continued on back																																																			

શારીરિક પરીક્ષણ ફોર્મ અને રસીકરણ

ੴ-ਟਲ ਟੇਸਟ

ੴ ਪਰੀਕਸਾ

5

વધારાનું ફોર્મ: મફત લંચ એપ્લિકેશન (જો તેઓ લાયક હોય તો)

- પરિવારના તમામ સભ્યોના પગાર સ્ટબનો સમાવેશ કરો.

Schaumburg Community Consolidated School District 54
 524 East Schaumburg Road, Schaumburg, IL 60194
 Application for Illinois Free Lunch Program 2022-2023 School Year

To apply for free meals/lunch, complete this application, sign and return the application to the school.
 If you need assistance, please call 847-567-6021

APPENDIX A: FREE MEALS/LUNCH.—Complete One Application Per Household Pre School/District Household Income.

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

NAME(S) OF ALL HOUSEHOLD MEMBERS
 FLSI: 6000-6000-L000

Relationship
 Adult Householder

EMPLOYED/EMPLOYED/EMPLOYED
 EMPLOYEE NUMBER
 Last Name First Name Middle Initial
 Last Name First Name Middle Initial
 Last Name First Name Middle Initial

EMPLOYEE NUMBER
 Last Name First Name Middle Initial
 Last Name First Name Middle Initial
 Last Name First Name Middle Initial

Household Income	Amount	Household Size	Amount
1	\$0-\$10,000	1	\$0-\$10,000
2	\$10,000-\$19,999	2	\$10,000-\$19,999
3	\$20,000-\$29,999	3	\$20,000-\$29,999
4	\$30,000-\$39,999	4	\$30,000-\$39,999
5	\$40,000-\$49,999	5	\$40,000-\$49,999
6	\$50,000-\$59,999	6	\$50,000-\$59,999
7	\$60,000-\$69,999	7	\$60,000-\$69,999
8	\$70,000-\$79,999	8	\$70,000-\$79,999
9	\$80,000-\$89,999	9	\$80,000-\$89,999
10	\$90,000-\$99,999	10	\$90,000-\$99,999
11	\$100,000 or more	11	\$100,000 or more

*A letter which the legal responsibility who applies agency or school

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

Household Migrant Runaway Head Start

DISABILITY STATUS (check all that apply)
 I am disabled
 I am blind

Date _____

3. Total Household Gross Income Before Deductions* You must tell us how much and how often.

*Household gross income before deductions includes W-2 income, Social Security, SSI, AFDC, child support, alimony, dividends, interest, capital gains, self-employed income, etc. (Deductibles such as child support, alimony, etc. will be deducted from gross income.)

A. INSTALLMENT LOANS AND MEMBERSHIP IN CREDIT UNIONS

NAME	Gross Income	G. Payment, Child Support Received		H. Payments Received		I. Worker's Comp., Unemployment Compensation, etc.	
		amount	new amount	amount	new amount	amount	new amount
I.	\$	\$	\$	\$	\$	\$	\$
II.	\$	\$	\$	\$	\$	\$	\$
III.	\$	\$	\$	\$	\$	\$	\$
IV.	\$	\$	\$	\$	\$	\$	\$
V.	\$	\$	\$	\$	\$	\$	\$

4.5 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part II is completed, the adult signing the form must also sign the Part II, right side of the form. If her social security number is listed, she must sign the application. _____

X X X - X X - _____ I do not have a social security number

(Please provide additional information on this application to avoid income suspension. Documentation of all factors required for food stamp or food deduction income suspension. Underlined school officials may verify income for the following: _____) I understand if I inaccurately give false information, my children's free meal benefits and I may be prosecuted.

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

5. Contact Information:

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 Identity (Optional)

Mark one box only
 Hispanic/Latino
 Not Hispanic/Latino
 Mark one or more racial identities:
 White
 Black/African American
 American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander

08-02 School Year 2022-2023 REB 1/17/2022