

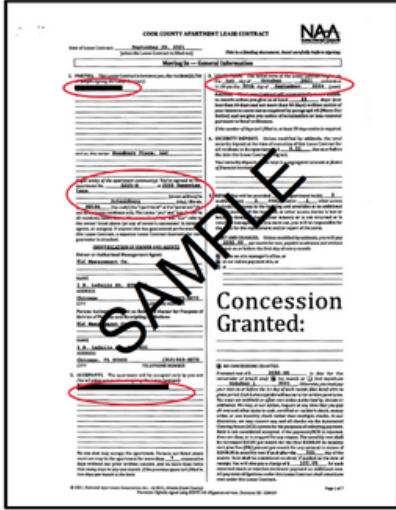


શાળા જિલ્લા 54 માં આપનું સ્વાગત છે

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

1 રહેઠાણનો પુરાવો **

નીચેના દસ્તાવેજોમાંથી એક પ્રદાન કરો:



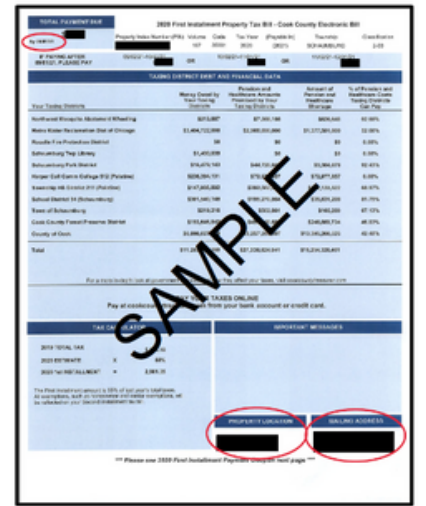
લીઝ

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



મોર્ટગેજ પેપર

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



ટેક્સ બિલ

આ દસ્તાવેજમાં મિલકતના માલિકનું નામ, સરનામું અને બિલની 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



ડ્રાઇવરનું લાઇસન્સ અથવા રાજ્ય ID

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.

લીઝ ફોર્મને બદલે

This form is for use by the parent/guardian of a child who is a resident of Cook County, Illinois, and is required to provide proof of residence when the child is enrolled in a public school. It includes fields for child's name, date of birth, and parent/guardian information.

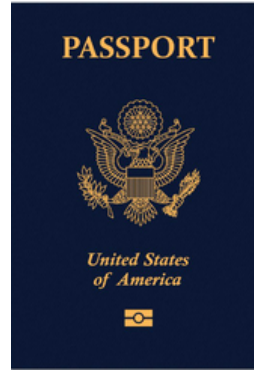
This is the updated form for the Child Early Affidavit of Residency. It features a more structured layout with clear sections for child information, parent/guardian details, and a declaration of residency.

માતાપિતા અથવા વાલી એક ફોર્મ ભરે છે અને ઘર માલિક આગળનું ફોર્મ ભરે છે. ઘરના માલિકે 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 લાઇસન્સ).

2

વિદ્યાર્થીનું જન્મ પ્રમાણપત્ર અથવા પાસપોર્ટ

A sample Certificate of Live Birth form from Cook County, Illinois. It contains fields for child's name, sex, date of birth, and parents' names. A large 'SAMPLE' watermark is overlaid on the form.



3

નવા વિદ્યાર્થીઓ માટેના ફોર્મ (Registration packet)

A screenshot of the 'Infinite Campus' online registration portal. It displays a welcome message and a 'Begin Registration' button. The registration year is set to 19-20.

State of Illinois Certificate of Child Health Examination

Student's Name: _____ Birth Date: _____ Sex: _____ Race/Ethnicity: _____ School Grade Level: _____

PHYSICIAN SIGNATURE: To be completed by health care provider. The provider for young children is required to sign and provide a medical certificate and complete a written statement to be sent to the health care provider responsible for completing the health examination certificate for the parent/guardian for the examination.

DATE OF EXAMINATION: _____

EXAMINATION RESULTS:

System	Examined	Normal	Abnormal	Notes
General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Head/Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Parent/Guardian Signature: _____

DATE: _____

शारीरिक परीक्षा झोर्म अने रसीकरण

State of Illinois Proof of School Dental Examination Form

Student's Name: _____ Birth Date: _____ Sex: _____ Race/Ethnicity: _____

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Student's Name: _____ Birth Date: _____ Sex: _____ Race/Ethnicity: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Name of School: _____ School Address: _____ City: _____ State: _____ ZIP Code: _____

Parent or Guardian: Last Name _____ First Name _____

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

Student's Name: _____ Birth Date: _____ Sex: _____ Race/Ethnicity: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Name of School: _____ School Address: _____ City: _____ State: _____ ZIP Code: _____

Parent or Guardian: Last Name _____ First Name _____

To be completed by dentist:

Date of Most Recent Examination: _____ (Check all services provided at the examination date)

Complete Checkup Filling Periodic Treatment Restoration of Teeth due to Caries

Oral Health Status (check all that apply):

Excellent Good Fair Poor

No Yes **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 teeth

No Yes **Oral Cancer** — in last 10 years of tooth structure loss of the oral cavity, ulcer, or any other condition of the oral cavity that requires treatment as well as those on enamel tooth surfaces. If present, list details that the above have not included by tooth, tooth or teeth, and date with treatment type and treatment result unless a certain tooth is also present.

No Yes **Oral Infection** — abscess, severe periodontitis, advanced disease state, signs or symptoms that include pain, infection, or swelling

Treatment Needs (check all that apply). Please list appointment date or date of most recent treatment include date:

Restorative Care — composite, composite veneers, etc. Appointment Date: _____

Periodontal Care — scaling, fluoride treatment, prophylaxis. Appointment Date: _____

Pediatric Dental Referral Recommended. Treatment Completion Date: _____

Dental Office Address: _____ Office Phone Number: _____

Signature of Dentist: _____ Date: _____

Illinois Department of Public Health, Division of Oral Health
217-785-6222 - TTY (hearing impaired use only) 800-647-6242 - www.idph.state.il.us

डेंटल टेस्ट

State of Illinois Eye Examination Report

Student Name: _____ Birth Date: _____ Sex: _____ Grade: _____ Address: _____

Parent or Guardian: Last Name _____ First Name _____

Phone: _____ Address: _____ City: _____ State: _____ ZIP Code: _____

Country: _____

To Be Completed By Examining Doctor

Case History

Date of Exam: _____

Outside History: Normal or Positive for _____

Medical History: Normal or Positive for _____

Drug Allergies: NKA or Allergic to _____

Other Information: _____

Examination

	Distance		Near	
	Right	Left	Right	Left
Uncorrected visual acuity	OD	OS	OD	OS
Best corrected visual acuity	OD	OS	OD	OS

Was refraction performed with dilation? Yes No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (JOL, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Internal exam (retina, 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"/>	
Optic nerve 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 Anisometropia

Other: _____

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द्रष्टि परीक्षा झोर्म

वधारानुं झोर्म: मझत लंय अेप्लिकेशन (जो तेओ लायक डोय तो)

- परिवारना तमाम सल्योना पगार स्टब्नो समावेश करो.

Schaumburg Community Consolidated School District 54
504 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 815-357-8327.

APPLICATOR/FREE MEALS: Complete One Application Per Household Per School District Institution or State.

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

NAME OF ALL HOUSEHOLD MEMBERS (Last, First, Middle Initial)	Relationship	Age	DOB (MM/DD/YYYY)	Student	Free Lunch
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

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

Household Migrant Runaway Head Start

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

4. Signature and Social Security Number (Adult must sign)

Adult Signature: _____ Date: _____
Social Security Number: _____

5. Contact Information

Home Telephone Number (include Area Code): _____ Other Telephone Number (include Area Code): _____ Home Address (include Street, City, State, ZIP Code): _____

6. Children's Race and Ethnicity (Optional)

Check one or more boxes:

Hispanic/Latino Asian Black or African American American Indian or Alaska Native Native Hawaiian or Other Pacific Islander

Not Hispanic/Latino White Two or More Races