



Sponsored by  
Yakama Nation Alcoholism  
Program

3-6 Year Olds

July 5<sup>th</sup> - July 8<sup>th</sup>

7-9 Year Olds

July 11<sup>th</sup> - July 15<sup>th</sup>

10-12 Year Olds

July 18<sup>th</sup> - July 22<sup>nd</sup>

13-14 Year Olds

July 25<sup>th</sup> - July 29<sup>th</sup>

**In order to participate, you  
MUST turn in registration form**

**BY JUNE 17<sup>th</sup>, 2016**

**NO EXCEPTIONS!!!!**



If you have any questions,  
please call: (509)865-5121

Ext: 4354 or 4356

Or Mikal at Ext. 4464



**MEMORANDUM**

**MAY 18, 2016**

**TO: WHOM IT MAY CONCERN  
YN ADMINISTRATION**

**FROM: ANNA HOGAN, INTERIM PROGRAM MANAGER** *AH*

**RE: CAMP CHAPARRAL SUMMER CAMP APPLICATIONS**

Camp Chaparral Camper Applications have been revised to help both parents and staff become more efficient in the application process. We are asking that **ALL** applications be turned in by **June 17, 2016** so that our staff can be better prepared for the summer camp program and accommodate our campers. There will be **NO onsite applications accepted**. The check in process for each camper will also be modified this year to better serve our campers and staff. Campers will be asked to keep their luggage with them until after their head check is complete and signed off before moving on to the next check in station. Please be patient through this process as this will be new to staff, campers, and parents. There will also be a check out procedure as well to ensure that all campers and their luggage are received.

**CONCUR:** *Jerry Meninick*  
Jerry Meninick, Deputy Director

**CONCUR:** *Elizabeth Nason*  
Elizabeth Nason, Tribal Director

**CONCUR:** *JoDe Goudy*  
JoDe Goudy, Tribal Chairman



YAKAMA NATION CAMP CHAPARRAL CAMP INFORMATION

**APPLICATION DUE FRIDAY, JUNE 17, 2016 BY 3:00PM**

**NO ONSITE REGISTRATION WILL BE ACCEPTED!!!**

**REGISTRATION PROCEDURES: PARENT/GUARDIAN MUST COMPLETE THE APPLICATION FORM FOR EACH CAMPER WITH THE NECESSARY DOCUMENTATION (DO NOT LET CAMPER FILL OUT THIS FORM)**

**ONLY COMPLETED APPLICATIONS WILL BE ALLOWED TO PARTICIPATE**

**PARENT/GUARDIAN MUST SIGN IN THEIR CAMPER & COMPLETE CHECK IN PROCESS**

**PARENT/GUARDIAN MUST SIGN OUT & PICK UP THEIR CAMPER**

**Application can ONLY be turned in at the Camp Chaparral Office!!!**

CAMP CHAPARRAL'S OFFICE:

IHS ANNEX (OLD Clinic) 20 Gunnyon Rd. Toppenish, WA 98948 (509) 865-5121 EXT. 4356/4354

<b>SESSION</b>	<b>DATES</b>	<b>AGE GROUP</b>
SESSION 1	JULY 5-8, 2016	3-6 YEAR OLDS <b>(MUST ATTEND WITH PARENT/GUARDIAN)</b>
SESSION 2	JULY 11-15, 2016	7-9 YEAR OLDS
SESSION 3	JULY 18-22, 2016	10-12 YEAR OLD
SESSION 4	JULY 25-29, 2016	13-14 YEAR OLDS
SEPARATE APPLICATION TO BE TURNED INTO WILDLIFE PROGRAM	AUGUST 1-5, 2016	WILDLIFE CAMP - TEENS
SEPARATE APPLICATION TO BE TURNED INTO WILDLIFE PROGRAM	AUGUST 8-12, 2016	WILDLIFE CAMP - TEENS

**THIS IS A TENTATIVE SCHEDULE AND IS SUBJECT TO CHANGE.**

**TOPPENISH** DROP OFF AND PICK UP LOCATION WILL BE AT THE STANELY SMARTLOWIT EDUCATION CENTER (TRIBAL SCHOOL)

**WHITE SWAN** DROP AND PICK UP LOCATION WILL BE AT THE MT ADAMS COMMUNITY CENTER

**DROP OFF TIME:** Check in will be at 8:30am. Roll Call according to applications will be at 9:00am and departure will be at 10:00 am **BREAKFAST WILL NOT BE PROVIDED**

**PICK UP TIME:** Departure from camp will be at 2:00pm. Approximate arrival at pick up locations will be 3:30pm (The luggage may arrive before the campers)

THE STAFF OF CAMP CHAPARRAL AGREE TO CARE FOR YOUR CHILD UNTIL THE PARENT/GUARDIAN ARRIVES TO PICK UP THE CHILD. ONLY PARENTS/GUARDIANS WILL PICK UP CHILD, OR THOSE LISTED AS EMERGENCY CONTACTS. IF CAMPER IS NOT PICKED UP BY 5:00PM, IT IS CONSIDERED CHILD NEGLECT AND TRIBAL POLICE WILL BE NOTIFIED. IN THE EVENT OF AN EMERGENCY CAMP CHAPARRAL STAFF WILL NOTIFY PARENT/GUARDIAN, PLEASE ENSURE ALL PHONE NUMBERS LISTED ARE CURRENT.

PARENTS ARE RESPONSIBLE FOR MAKING SURE THEIR CHILD EATS BREAKFAST BEFORE THEY ARRIVE TO CAMP DROP OFF. BREAKFAST **WILL NOT** BE SERVED ON MONDAY MORNING.

**YAKAMA NATION CAMP CHAPARRAL**  
**PARENT INFORMATION**

- CAMP CHAPARRAL HAS RULES, WHICH MUST BE FOLLOWED BY ALL CAMPERS. VIOLATION OF GIVEN RULES IS JUST CAUSE FOR SENDING PARTICIPANTS HOME.
  
- **VALUABLES**  
DO NOT BRING ANY ARTICLES OF VALUE (MONETARY OR SENTIMENTAL) THAT MIGHT BE DAMAGED OR STOLEN. CAMP CHAPARRAL IS NOT RESPONSIBLE FOR ANY LOSS, DAMAGED, OR THEFT OR PERSONAL PROPERTY. THERE IS NO NEED FOR ANY MONEY AT CAMP.
  
- **LUGGAGE SEARCH**  
ALL CAMPERS WILL HAVE A MANDATORY LUGGAGE SEARCH COMPLETED BY CAMP CHAPARRAL STAFF. ALL CAMPERS MUST KEEP THEIR LUGGAGE WITH THEM UNTIL THEIR HEAD CHECK IS COMPLETED AND SIGNED OFF DURING CHECK IN. THEY WILL THEN LOAD THEIR LUGGAGE/SLEEPING BAGS ONTO THE TRUCK.
  
- **ZERO TOLERANCE POLICY WILL BE IN EFFECT-ANY ILLEGAL DRUGS, DRUG PARAPHERNALIA, OR ALCOHOL FOUND ON A CAMPER, IN A CAMPER'S POSSESSION, OR BEING USED BY A CAMPER WILL AUTOMATICALLY RESULT IN IMMEDIATE DISMISSAL FROM CAMP CHAPARRAL AND TRIBAL POLICE WILL BE NOTIFIED.**
  
- **CONFIDENTIAL INCOME STATEMENT**  
THE CONFIDENTIAL INCOME STATEMENT FORM IS AN **IMPORTANT REQUIREMENT** OF THE USDA SUMMER FOOD PROGRAM. ALL INFORMATION WILL BE KEPT CONFIDENTIAL. PLEASE ENSURE THAT ALL 5 PORTIONS ARE FILLED OUT:
  - CHILD'S NAME AND DATE OF BIRTH
  - FOSTER CHILD, BASIC FOOD, TANF, FDPIR (COMMODITIES) **WITH CASE NUMBER** (IF APPLICABLE)
  - ALL OTHER MEMBERS OF THE HOUSEHOLD NAMES AND INCOME
  - ADULT HOUSEHOLD MEMBER, NAME, SIGNATURE AND LAST 4 OF SOCIAL SECURITY NUMBER
  - SIGNATURE OF ADULT HOUSEHOLD MEMBER
  
- **FOOD ALLERGIES/INTOLERANCE**  
**ANY CHILD WITH FOOD ALLERGIES MUST HAVE THE ALLERGY DOCUMENTED ON THE FOOD ALLERGY FORM BY A MEDICAL DOCTOR WITH LISTED SUBSTITUTE FOODS.** CAMP MUST PROVIDE A DOCTOR PRESCRIBED SUBSTITUTE FOR A FOOD ALLERGY BUT NOT REQUIRED FOR FOOD INTOLERANCE.

- **IF YOUR CHILD NEEDS MEDICATION ADMINISTERED TO THEM, THEY WILL ALSO NEED THE AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FORM COMPLETED AND SIGNED BY A PHYSICIAN. IF A NEW MEDICATION IS PRESCRIBED TO THEM AFTER THEIR APPLICATION HAS BEEN TURNED IN, THEN A NOTE FROM THE PHYSICIAN WILL BE NEEDED.**

- **HEAD LICE**

HEAD LICE IS A VERY COMMON PROBLEM AND IS EASILY PASSED TO OTHERS. FOR THIS REASON, WE ARE REQUIRING THAT **ALL** CAMPERS BE CHECKED FOR HEAD LICE BY OUR HOME HEALTH NURSING STAFF BEFORE THEY ARE ALLOWED TO GO TO CAMP. **ALL** CAMPERS WILL BE CHECKED AT THE SIGN IN LOCATION ON MONDAY MORNING. **A PARENT/GUARDIAN MUST BE PRESENT WHILE THE CHILD IS BEING CHECKED. WE ASK THAT CAMPERS' HAIR BE LEFT OUT OF BRAIDS, PONY TAILS, AND BARRETTES SO ALL OF THE HEAD CAN BE CHECKED WITH EASE.** THE PURPOSE FOR THIS IS TO ENSURE THE HEALTH OF ALL CAMPERS. **IF YOUR CHILD HAS HEAD LICE OR OPEN SORES ON THE SCALP, THEIR HAIR, CLOTHING AND BEDDING WILL HAVE TO BE TREATED & THEY WILL NOT BE ABLE TO ATTEND CAMP THIS YEAR.**

- **FIELD TRIPS**

THE EDUCATION SPECIALIST WILL DOCUMENT ANY FIELD TRIPS WITH THE CAMP CHAPARRAL PROGRAM INTO THE CURRICULUM. THE CHILD WILL AGREE TO BEHAVE AND CONDUCT HIM/HERSELF IN A MANNER IN ACCORDANCE TO THE YAKAMA NATION CAMP CHAPARRAL RULES & REGULATIONS, NONCOMPLIANCE IS TERMS FOR THE CAMPER TO BE SENT HOME IMMEDIATELY.

- **CAMPER/STAFF CONTACT**

WE RECOGNIZE THAT CAMPERS & COUNSELORS DEVELOP CLOSE, TRUSTING RELATIONSHIPS WITH ONE ANOTHER AT CAMP & THAT THESE RELATIONSHIPS ARE HEALTHY, WHOLESOME, AND BENEFICIAL TO CAMPERS & STAFF ALIKE. WE ALSO RECOGNIZE THAT IT IS NATURAL FOR CAMPERS TO WANT TO KEEP IN TOUCH WITH THEIR FAVORITE COUNSELORS AFTER CAMP. AS A CAMP WE **DO NOT** ENCOURAGE OR SANCTION THE EXCHANGE OF CONTACT INFORMATION BETWEEN CAMPERS AND OUR STAFF.

**YAKAMA NATION CAMP INFORMATION**  
**ITEMS YOU NEED TO BRING TO CAMP**

SUIT CASE/DUFFLE BAG	5 CHANGES OF SHIRTS (LONG SLEEVE/SHORT SLEEVE)
SLEEPING BAG PACKED IN A PLASTIC GARBAGE BAG	5 CHANGES OF LONG PANTS/JEANS
PILLOW	SHORTS/SWIM WEAR
OPTIONAL – EXTRA BLANKET	5 PAIR OF SOCKS & UNDERWEAR
2 TOWELS & WASHCLOTH	TENNIS SHOES
TOILETRIES (HAIR BRUSH, COMB, SHAMPOO CONDITIONER, LOTION, DEODORANT, TOOTHBRUSH/TOOTHPASTE	SECOND PAIR OF SHOES (CAN BE RECREATIONAL SANDALS, MUST HAVE BACK STRAP & STURDY SOLES)
BACKPACK	WARM JACKET
LIGHT COAT, SWEATSHIRT, OR SWEATER	RAIN COAT
GARBAGE BAG FOR DIRTY/WET CLOTHES	
<b>OPTIONAL ITEMS</b>	
SMALL FLASHLIGHT	INSECT REPELLENT
CHAP STICK	READING MATERIAL
WIND UP CLOCK	NOTEBOOK/PENCILS
DISPOSABLE CAMERA	WATER BOTTLE W/ NAME

- **PLEASE LABEL EVERYTHING** THAT YOU BRING TO CAMP WITH A PERMANENT MARKER
- PLEASE PACK SLEEPING BAGS INSIDE A PLASTIC GARBAGE BAG. **BE SURE BOTH THE GARBAGE BAG & SLEEPING BAG ARE VISIBLY MARKED.** DO NOT ROLL EVERYTHING INSIDE THE SLEEPING BAG.

**DO NOT BRING!!!!**

THESE ITEMS WILL BE CONFISCATED IF YOU CHOOSE TO BRING THEM. THEY WILL BE GIVEN TO YOUR PARENTS BEFORE DEPARTURE OR RETURNED TO THE CAMPER UPON RETURNING FROM CAMP. PLEASE LEAVE ALL VALUABLE ITEMS AT HOME!!!!

POP	COLOGNE/PERFUME
CANDY/ <b>ANY FOOD ITEM</b>	MAKE UP
SUNFLOWER SEEDS	RAZORS-FOR FACE/LEGS
KNIVES/WEAPONS	<b>ANY AND ALL ELECTRONIC DEVICES, INCLUDING, CELL PHONES, MP3 PLAYERS, HAND HELD GAMES</b>
DRUGS/ALCOHOL	MARKERS/PENS/HIGHLIGHTERS
MONEY	

- **PRESCRIBED MEDICATIONS BY A DOCTOR ARE ALLOWED & MUST BE TURNED INTO THE CAMP NURSE ALONG WITH MEDICAL FORMS SIGNED BY A PHYSICIAN DURING THE CHECK IN PROCESS**

**CAMPER INFORMATION**

**PLEASE PRINT LEGIBLY USING BLACK/BLUE INK!**

CAMPER'S NAME: \_\_\_\_\_ MALE: \_\_\_ FEMALE: \_\_\_

AGE: \_\_\_\_\_ DOB: \_\_\_\_\_ YAKAMA ENROLLMENT # (CHILD OR PARENT): \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ WA: \_\_\_\_\_ ZIP: \_\_\_\_\_

DIRECTIONS TO RESIDENCE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ WORK #/EXT: \_\_\_\_\_ CELL #: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ WORK #/EXT: \_\_\_\_\_ CELL #: \_\_\_\_\_

EMERGENCY CONTACTS MUST BE 2 DIFFERENT CONTACTS OTHER THAN THE PARENTS/GUARDIANS (IF UNABLE TO CONTACT)

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

PICK UP POINT: \_\_\_\_\_ WHITE SWAN \_\_\_\_\_ TOPPENISH

DROP OFF POINT: \_\_\_\_\_ WHITE SWAN \_\_\_\_\_ TOPPENISH

**CHECK THE SESSION IN WHICH YOUR CHILD WILL ATTEND**

X	SESSION	DATES	AGE GROUP
	SESSION 1	JULY 5-8, 2016	3-6 YEAR OLDS (MUST ATTEND WITH PARENT/GUARDIAN)
	SESSION 2	JULY 11-15, 2016	7-8-9- YEAR OLDS
	SESSION 3	JULY 18-22, 2016	10-12 YEAR OLDS
	SESSION 4	JULY 25-29, 2016	13-14 YEAR OLDS

**PLEASE BE ADVISED, CHILDREN WILL ONLY BE ALLOWED IN THEIR OWN AGE GROUP, UNLESS PRIOR APPROVAL.**

AS A PARENT/GUARDIAN OF THE ABOVE CAMPER NAMED, WHO IS VOLUNTARILY ATTENDING THE YAKAMA NATION CAMP CHAPARRAL PROGRAM, I UNDERSTAND THAT CAMPING PROGRAMS INVOLVE INHERENT RISK AND POSSIBLE INJURY BECAUSE OF THE NATURE OF THE ACTIVITY, EVEN WHEN CONDUCTED IN A SAFE MANNER. I GIVE MY PERMISSION FOR HIM/HER TO ATTEND CAMP & PARTICIPATE IN ALL PHASES OF THE PROGRAM INCLUDING OFF SITE ACTIVITIES & RELATED TRANSPORTATION.

AS THE PARENT/GUARDIAN OF THE ABOVE CHILD, I GIVE PERMISSION FOR THE ABOVE CHILD TO BE PHOTOGRAPHED &/OR AUDIO/VIDEO TAPED DURING THIS EVENT FOR THE IMAGES &/OR RECORDINGS TO BE PUBLISHED, REPRODUCED OR DISTRIBUTED BY YAKAMA NATION CAMP CHAPARRAL AND ITS AFFILIATES IN ALL OUTLETS, INCLUDING BUT NOT LIMITED TO TELEVISION, NEWSPAPER, INTERNET, COUNCIL PUBLICATIONS, RECRUITMENT MATERIALS & ADS WITHOUT LIABILITY OR LIMITATIONS OR CLAIMS ON MY MINOR'S PART. I HAVE READ THE ABOVE STATEMENTS AND UNDERSTAND THE INFORMATION AND AGREE TO ABIDE BY THE TERMS.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

**YAKAMA NATION CAMP CHAPARRAL SUMMER PROGRAM  
AUTHORIZATION & MEDICAL HISTORY FROM**

DOES YOUR CHILD HAVE/HAD ANY OF THE FOLLOWING CONDITIONS? (**YOU MUST FILL OUT/MARK THESE QUESTIONS**). (IF MORE SPACE IS NEEDED LIST NUMBER & EXPLAIN ON A SEPARATE SHEET.) (IF ALLERGIES IS MARKED "YES" PLEASE LIST ANY ALLERGIES ON A SEPARATE SHEET)

	CONDITION	YES	NO	EXPLAIN		CONDITION	YES	NO	EXPLAIN
1	RHEUMATIC FEVER				16	HEART MURMUR			
2	HEART TROUBLE				17	DIABETES			
3	TUBERCULOSIS				18	FAINTING/DIZZINESS			
4	HIVES/SKIN RASH				19	CONVULSIONS			
5	KIDNEY TROUBLE				20	NOSE BLEEDS			
6	FREQUENT HEADACHES				21	HIGH BLOOD PRESSURE			
7	ANEMIA				22	MENTAL/EMOTIONAL HEALTH CONCERNS			
8	JAUNDICE				23	BACK PROBLEMS			
9	BRUISE EASILY				24	DISLOCATIONS			
10	FREQUENT SPRAINS				25	ASTHMA/HAY FEVER			
11	EAR ACHES				26	BED WETTING			
12	BEE STINGS				27	ARTHRITIS			
13	HEARING AIDS				28	GLASSES/CONTACTS			
14	HANDICAPPED				29	MINOR OPERATIONS			
15	MAJOR OPERATIONS				30	SLEEP WALKS			

IS THE CAMPER CURRENT ON ALL VACCINES? YES \_\_\_\_\_ NO \_\_\_\_\_

DOES THE CAMPER HAVE ANY PHYSICAL AND OR MENTAL IMPAIRMENT, WHICH WOULD INTERFERE WITH HIS/HER PARTICIPATION IN THE PROGRAM OR ASPECTS OF THE PROGRAM? YES\_\_ NO\_\_

IF SO, PLEASE NOTE ANY SPECIAL INSTRUCTIONS, HEALTH PROBLEMS, OR INFORMATION YOU WISH THE CAMP TO HAVE. \_\_\_\_\_

\_\_\_\_\_

PHYSICIAN'S CARE? YES \_\_\_\_\_ NO \_\_\_\_\_ PLEASE LIST ANY MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

I, HEREBY AUTHORIZE THE STAFF OF YAKAMA NATION CAMP CHAPARRAL PROGRAM TO ACT FOR ME ACCORDING TO THEIR BEST JUDGMENT IN AN EMERGENCY. IF EMERGENCY MEDICAL ATTENTION IS REQUIRED FOR \_\_\_\_\_ (CAMPER'S NAME), I HEREBY WAIVE AND RELEASE THE YAKAMA NATION CAMP CHAPARRAL PROGRAM AND ITS' STAFF FROM ANY AND ALL LIABILITY FOR ANY INJURIES INCURRED WHILE ATTENDING SAID CAMP PROGRAM.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



# Dietary Accommodations – Summer Food Service Program

## PART 1 – CHILD INFORMATION

Child's Name: \_\_\_\_\_

## PART 2 – DIET INSTRUCTIONS

Food / Beverage to be <b>Omitted</b>	Food / Beverage to be <b>Substituted</b>

## PART 3 – TO BE COMPLETED BY A RECOGNIZED MEDICAL AUTHORITY\*

Please check one:

- The child identified above has a **disability** that restricts the child's ability to consume specific food(s) or beverage(s).

An individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act (ADA) as a person who has a physical or mental impairment that substantially limits one or more major life activities/bodily functions. Refer to the end of this document for definitions of "disability" and "major life activities/bodily functions".

- The child identified above has a medical condition (**but not a disability**) that requires a dietary accommodation.

Example: Non-disabling allergies or food intolerances.

Name of Recognized Medical Authority\*(please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\*Recognized medical authority: licensed health care professional authorized to write medical prescription under Washington State Law

## PART 4 – DEFINITIONS

"A Person with a Disability" is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. "Physical or Mental Impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. "Major Life Activities" are functions such as caring for one's self, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working. "Major Life Activities" now include "Major Bodily Functions" such as functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions. "Has a Record of Such an Impairment" is defined as having a history of, or has been classified as having a mental or physical impairment that substantially limits one or more major life activities. Citations from Section 504 of the Rehabilitation Act of 1973.

## AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

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**THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL (LHP)  
PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY  
(Please clearly print legible instructions)**

<u>Name of Medication</u>	<u>Dosage</u>	<u>Method of Administration</u>	<u>Time(s) to Be Taken</u>
_____	_____	_____	_____

Diagnosis or reason for medication: \_\_\_\_\_

If given PRN, specify the minimum length of time between doses: \_\_\_\_\_

I request and authorize this student to carry their medication. \_\_\_\_\_ Yes \_\_\_\_\_ No

I request and authorize this student to self-administer their medication. \_\_\_\_\_ Yes \_\_\_\_\_ No

This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

Possible medication side effects: \_\_\_\_\_

Emergency procedure in case of serious side effects: \_\_\_\_\_

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from \_\_\_\_\_ (date) to \_\_\_\_\_ (date) **(not to exceed current school year)**. There exists a valid health reason which may make administration of the medication advisable during school hours.

\_\_\_\_\_  
Date of Signature Licensed Health Professional (LHP)

\_\_\_\_\_  
Telephone Number Name (please print)

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### THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- ♦ I request this medication to be given as ordered by the licensed health professional.
- ♦ I give Health Services Staff permission to communicate with the medical office about this medication. I understand oral medications may be administered by nonlicensed staff members who have been trained and are supervised by a Registered Nurse.
- ♦ Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- ♦ All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health professional.

I request and authorize my child to carry and/or self-administer their medication. \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Date of Signature Parent/Guardian Signature

Telephone Numbers: \_\_\_\_\_ (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell)

Reviewed by Registered Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

# SUMMER FOOD SERVICE PROGRAM

## 2016 Letter to Parents

Dear Parent/Guardian:

Providing free and nutritious meals to children is a growing financial challenge and requires our taking advantage of all available funding resources. One resource is the Summer Food Service Program (SFSP), a cash reimbursement program from the United States Department of Agriculture (USDA). The reimbursements are very helpful and aid us in providing better services to children.

In order for us to receive the maximum funds possible, we need information from you. This information will be kept strictly confidential. Please complete, sign and return the attached Confidential Income Statement form as soon as possible. Only one form is need per household.

Thank you for your cooperation.

MIKAL GADLEY  
Organizational Representative

(509) 865-5121 EXT. 4464  
Phone Number

### Income Eligibility Guidelines – Summer 2016

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly	What must be on the application?
1	\$21,775	\$1,815	\$908	\$838	\$419	<u>For households receiving Basic Food/FDPIR/TANF:</u> - All children's names and case numbers, as applicable. - If a child does not have a case number, enter the household member's name and case number. - Adult household member's information & signature.  <u>For households with a foster child:</u> - Child's name. - Adult household member's information & signature.  <u>For households NOT receiving Basic Food/FDPIR/TANF:</u> - All children's names. - All household members' names. - All household members' income, by source. - Adult household member's last 4 digits of social security number (or check the "I do not have a social security number" box if the adult signing does not have one). - Adult household member's information & signature.
2	29,471	2,456	1,228	1,134	567	
3	37,167	3,098	1,549	1,430	715	
4	44,863	3,739	1,870	1,726	863	
5	52,559	4,380	2,190	2,022	1,011	
6	60,225	5,022	2,511	2,318	1,159	
7	67,951	5,663	2,832	2,614	1,307	
8	75,647	6,304	3,152	2,910	1,455	
Each additional household member add:	+7,696	+642	+321	+296	+148	

### Instructions to Complete the Confidential Income Statement

- Using the Income Eligibility Guidelines chart above, find your household size. A household is defined as all persons, related and unrelated, who live in your home and are sharing living expenses (children, parents, grandparents, friends, etc.) You may also include foster children living with you in the household size.
- Now determine total household income. Total household income is defined as the income each household member receives before taxes are deducted. This includes wages, social security, pensions, unemployment, welfare, child support, alimony, and any other cash income. If including foster children as part of the household size, you must also include their personal income. Do not include foster payments for being foster parents as income.

3. If the household income is the same as or less than the amount on the chart above **OR** you receive Basic Food benefits, **OR** take part in the Food Distribution Program on Indian Reservations (FDPIR), **OR** receive Temporary Assistance for Needy Families (TANF) for your children, fill out the Confidential Income Statement using the directions provided above.
4. If the household income is more than the amount on the chart, check the "NA" box in Section 2 on the Confidential Income Statement and complete parts 1 and 4. Your social security number is not required.

If your child has been determined by a medical doctor to be disabled and the disability would prevent the child from eating the meals provided at our site, we will make any substitution(s) prescribed by the doctor at no charge to you. Bring the doctor's note that prescribes the alternative food(s) needed and verifies alternate meals are needed due to the disability. This applies to food allergies as well. A form for your doctor's use will be provided upon request.

### **NONDISCRIMINATION STATEMENT**

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](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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.



**5. Children's Racial And Ethnic Identities (Optional)**

Mark one or more racial identities:

- Asian
- White
- Black, or African American

- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Other

Mark one ethnic identity:

- Hispanic or Latino
- Not Hispanic or Latino

**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 (Basic Food), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

**OFFICIAL USE ONLY  
DO NOT WRITE BELOW THIS LINE**

ANNUAL INCOME CONVERSION: Weekly x 52; Every Two Weeks x 26; Twice a Month x 24; Monthly x 12. Do NOT convert to annual income unless household reports multiple pay frequencies.

**SPONSOR APPROVAL/DENIAL**

- Basic Food/TANF/FDPIR Household
- Income Household
- Foster Child (categorically free)

Total Household Size \_\_\_\_\_

Total Household Income \$ \_\_\_\_\_

Income Approved by (check one):  weekly  every two weeks  twice a month  monthly  annual

**APPLICATION APPROVED FOR:**

- Free Meals
- Reduced-Price Meals

**APPLICATION DENIED BECAUSE:**

- Income Over Allowed Amount
- Incomplete/Missing Information
- Other: \_\_\_\_\_

Date Notice Sent \_\_\_\_\_

Signature of Approving Official \_\_\_\_\_

Date \_\_\_\_\_

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](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 mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.