

MENAHGA PUBLIC SCHOOLS

216 Aspen Avenue SE, PO Box 160, Menahga, MN 56464

218-564-4141

"Home of the Braves"



Authorization of Information

Independent School District No. 821 - Menahga, Minnesota 56464

I hereby authorize _____

to send the following information regarding (*Students Name*) _____

in (*Grade*) _____ to:

Menahga Elementary School
Attn: Susie Hillstrom
216 Aspen Ave SE
PO Box 160
Menahga, MN 56464
Phone# 218-564-4141
Fax# 218-564-4502
Email: shillstrom@menahga.k12.mn.us

- All transcript records
- Current report card
- All disciplinary records
- Health records and complete immunization records
- Psychological and special education reports and IEPs
- Record of extra-curricular participation
- MARSS information

(Date): _____ (Parent/Guardian Signature): _____



The Mission of Menahga School District #821 is to build strong partnerships with stakeholders to ensure all learners succeed.



Enrollment / Permanent Record Form

Menahga Public Schools #821

District Use Only	
MARSS# _____	<input type="checkbox"/> Food
Open Enrolled: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Trans.
	<input type="checkbox"/> Trello

School Enrolling In: Menahga High School Menahga Elementary Preschool Expected Start Date: _____

School most recently attended by student:

School: _____ District: _____ Date Left: _____ Last Grade Completed: _____

Address: _____ Phone: _____ Fax: _____

First Name (Legal)	Middle Name (Legal)	Last Name (Legal)	Birthdate	Gender	Enrolling Grade
				<input type="checkbox"/> Male <input type="checkbox"/> Female	

Ethnicity/Race:

Is your student Hispanic/Latino? Yes No

Ethnic Background: *(Mark all that apply.)*

- American Indian or Alaska Native Hawaiian / Pacific Islander
 Asian White
 Black or African American

Current Address (Student):

House Number (Physical Address)	Unit #	City	State	Zip

(If applicable) P.O. Box#: _____ City: _____ State: _____ Zip: _____

Current Resident School District:

1. Does parent/guardian completing this form have physical and legal custody of student? Yes No

2. Do any court orders apply? Yes *(Provide Copy)* No

3. Is student receiving special education services (has an IEP)? Yes No

If yes, what is your student's disability? *(Mark all that apply.)*

<input type="checkbox"/> Autism Spectrum Disorders	<input type="checkbox"/> Speech/Language Impairments	<input type="checkbox"/> Specific Learning Disabilities
<input type="checkbox"/> Developmental Cognitive Disability	<input type="checkbox"/> Severely Multiple Impaired	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Emotional/Behavior Disorders	<input type="checkbox"/> Other Health Disabilities
<input type="checkbox"/> Deaf-Hard of Hearing	<input type="checkbox"/> Visually Impaired	<input type="checkbox"/>
<input type="checkbox"/> Deaf-Blind	<input type="checkbox"/> Physically Impaired	<input type="checkbox"/>

4. Title Reading Math

5. Does student have a 504 Plan? Yes No

6. Has this student been receiving English Language Learner (ELL) services? Yes No

Preschool Only:

7. Has this student had an Early Childhood Screening? No Yes Location: _____ Date: _____

Student lives with: Both Parents *(In same house.)* Mother & Stepparent Joint Physical Grandparent
(Mark all that apply.) Mother Father & Stepparent Joint Legal Other
 Father Foster Parent Other Relative Alone
 Guardian

Father / Guardian 1: Are you the legal guardian? Yes No

How would you like to be notified / contacted? *(Check below what type of messages you would like to receive.)*

By Phone Voice Text { Emergency Attendance Behavior General Food Service Priority Teacher

What would you like access to? *(Check all that apply.)*

Receive Mailings Access to IC Portal Email / Messenger

First Name	Middle Initial	Last Name	Relationship to Student		
Home Phone	Cell Phone	Work Phone	Email Address		
If different from above - House Number (Physical Address)		Unit #	City	State	Zip
<i>(If applicable)</i> P.O. Box #:		City:	State:	Zip:	

Mother / Guardian 2: Are you the legal guardian? Yes No

How would you like to be notified / contacted? *(Check below what type of messages you would like to receive.)*

By Phone Voice Text { Emergency Attendance Behavior General Food Service Priority Teacher

What would you like access to? *(Check all that apply.)*

Receive Mailings Access to IC Portal Email / Messenger

First Name	Middle Initial	Last Name	Relationship to Student		
Home Phone	Cell Phone	Work Phone	Email Address		
If different from above - House Number (Physical Address)		Unit #	City	State	Zip
<i>(If applicable)</i> P.O. Box #:		City:	State:	Zip:	

Emergency Contact 1 (Other than those listed above) :

First Name	Last Name	Relationship to Student
Cell Phone	Home Phone	Work Phone

Emergency Contact 2 (Other than those listed above) :

First Name	Last Name	Relationship to Student
Cell Phone	Home Phone	Work Phone

In case of an injury or illness, a parent/guardian or person designated by the parent/guardian will be notified. If we are unable to contact one of these people, the family physician will be contacted and their advice will be followed. 9-1-1 will be called if it is felt necessary.

***Pertinent Health Information will be shared with faculty members as needed.*

By signing, I am stating that I am the legal parent or guardian of this student.

Parent/Guardian Signature _____ *Current Date:* _____

<p>Please include the following information when submitting enrollment paperwork:</p> <ul style="list-style-type: none">• Copy of Birth Certificate• Enrollment/Permanent Record Form• Confidential Health Form• Transportation Form• Chromebook Agreement Form	
<p>Menahga High School Attn: Lindsay Shepersky 216 Aspen Ave. SE P.O. Box 160 Menahga, MN 56464 lshepersky@menahga.k12.mn.us</p>	<p>Menahga Elementary School Attn: Susie Hillstrom 216 Aspen Ave. SE P.O. Box 160 Menahga, MN 56464 shillstrom@menahga.k12.mn.us</p>



**NOTIFICATION OF CHANGE IN STUDENT ENROLLMENT
 REQUEST FOR STUDENT STATE IDENTIFICATION NUMBER**

Method of Transmittal:

MAIL*:

FAX E-MAIL OTHER

*Please provide address for the Transfer District when checked

Date of Transmittal:	Number of Pages:
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PRIOR DISTRICT INFORMATION

**Routing: To: From:

MARSS Contact Person:	District Name:	District Number/Type:
Telephone Number:	Email Address:	Fax Number:

TRANSFER DISTRICT INFORMATION

**Routing: To: From:

MARSS Contact Person:	District Name:	District Number/Type:	Telephone Number:	Fax Number:
Email Address:	Address:	City:	State:	Zip:

****Routing: PLEASE CHECK THE APPROPRIATE BOXES.**

I have provided you with this student's name, birthdate, grade level, state aid code and status start date. Please provide me with the student's State Reporting Number. Please verify that the status start date I have recorded **does not** overlap with the status end date you have.

Student Name (Last, First, Middle)	State Reporting Number	Birthdate (MM/DD/YYYY)	Student Grade Level	State Aid Code	Status Start Date

Additional Transmittal Information:

Minnesota Language Survey

Minnesota is home to speakers of more than 100 different languages. The ability to speak and understand multiple languages is valued. The information you provide will be used by the school district to see if your student is multilingual. In Minnesota, students who are multilingual may qualify for a Multilingual Seal upon further assessment. Additionally, the information you provide will determine if your student should take an English proficiency test. Based upon the results of the test, your student may be entitled to English language development instruction. **Access to instruction is required by federal and state law. As a parent or guardian, you have the right to decline English Learner instruction at any time.** Every enrolling student must be provided with the Minnesota Language Survey during enrollment. Information requested on this form is important to us to be able to serve your student. Your assistance in completing the Minnesota Language Survey is greatly appreciated.

Student Information	
Student's Full Name: (Last, First, Middle)	Birthdate or Student ID:

	Check the phrase that best describes your student:	Indicate the language(s) other than English in space provided:
1. My student first learned:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
2. My student speaks:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
3. My student understands:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
4. My student has consistent interaction in:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	

Language use alone does not identify your student as an English learner. If a language other than English is indicated, your student will be screened for English language proficiency.

Parent/ Guardian Information	
Parent/Guardian Name (printed):	
Parent/Guardian Signature:	Date:

* All data on this form is private. It will only be shared with district staff who need the information to best serve your student and for legally required reporting about home language and service eligibility to the Minnesota Department of Education. At the district and at the Minnesota Department of Education, this information will not be shared with other individuals or entities, except if they are authorized by state or federal law to access the information. Compliance with this request for information is voluntary.

Ethnic and Racial Demographic Designation Form

Student's First Name: _____ Middle Name/Initial: _____ Last Name: _____

Date of Birth: _____ District: _____ School: _____

Schools are required to report ethnicity and race to the state and to the U.S. Department of Education. Because of recent changes to Minnesota state law, Minnesota disaggregates each category into detailed groups to further represent our student populations. Parents or guardians are not required to answer the federal questions (**in bold**) for their children. If you choose not to answer the federal questions (**in bold**), federal law requires schools to choose for you. This is a last resort—we prefer if parents or guardians complete the form. State questions are labeled as “Optional” and schools will not fill in this information for you.

This information helps improve teaching and learning for everyone and helps us accurately identify and advocate for students currently underserved. The information this form collects is considered private information. You can review the privacy notice to learn more about the purpose of collecting this information, how it will be used and not used, and how the detailed groups were identified. The privacy notice can be found in our [Frequently Asked Questions: Ethnic and Racial Designation Form](#).

Is the student Hispanic/Latino as defined by the federal government? The federal definition includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.¹

[You must select “yes” or “no” to this question.]

Yes *[If yes, go to Question A.]*

No *[If no, go to Question 1.]*

Optional Question A: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Decline to indicate | <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Salvadoran | <input type="checkbox"/> Other Hispanic/Latino |
| <input type="checkbox"/> Colombian | <input type="checkbox"/> Mexican | <input type="checkbox"/> Spaniard/Spanish/
Spanish-American | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Ecuadorian | <input type="checkbox"/> Puerto Rican | | |

Go to Question 1.

[Select “yes” to at least one of the Questions (1-6) below.]

Question 1: Does the student identify as American Indian or Alaska Native as defined by the state of Minnesota? The state of Minnesota definition includes persons having origins in any of the original peoples of North America who maintain cultural identification through tribal affiliation or community recognition. [This question is needed to calculate state aid/funding.]

Yes *[If yes, go to Question 1a.]*

No *[If no, go to Question 2.]*

Optional Question 1a: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

- | | | |
|--|--|---|
| <input type="checkbox"/> Decline to indicate | <input type="checkbox"/> Cherokee | <input type="checkbox"/> Other North American Indian Tribal Affiliation |
| <input type="checkbox"/> Anishinaabe/Ojibwe | <input type="checkbox"/> Dakota/Lakota | <input type="checkbox"/> Unknown |

Go to Question 2.

¹Federal Register, Vol. 72, No. 202/Friday, October 19, 2007/Notices/59274

Question 2. Is the student American Indian from South or Central America?

Yes [Go to Question 3.]

No [Go to Question 3.]

Question 3. Is the student Asian as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.¹

Yes [If yes, go to Question 3a.]

No [If no, go to Question 4.]

Optional Question 3a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

- | | | | |
|--|-----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Decline to indicate | <input type="checkbox"/> Chinese | <input type="checkbox"/> Karen | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Korean | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Burmese | <input type="checkbox"/> Hmong | <input type="checkbox"/> Vietnamese | |

Go to Question 4.

Question 4. Is the student black or African American as defined by the federal government? The federal definition includes persons having origins in any of the black racial groups of Africa.¹

Yes [If yes, go to Question 4a.]

No [If no, go to Question 5.]

Optional Question 4a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Decline to indicate | <input type="checkbox"/> Ethiopian-Other | <input type="checkbox"/> Somali |
| <input type="checkbox"/> African-American | <input type="checkbox"/> Liberian | <input type="checkbox"/> Other black |
| <input type="checkbox"/> Ethiopian-Oromo | <input type="checkbox"/> Nigerian | <input type="checkbox"/> Unknown |

Go to Question 5.

Question 5. Is the student Native Hawaiian or Other Pacific Islander as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.¹

Yes [Go to Question 6.]

No [Go to Question 6.]

Question 6. Is the student white as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Europe, the Middle East, or North Africa.¹

Yes

No

Parent(s)/Guardian Name _____ Date _____

Parent(s)/Guardian Signature _____

MENAHGA PUBLIC SCHOOLS

216 Aspen Avenue SE, PO Box 160, Menahga, MN 56464

218-564-4141

"Home of the Braves"



Dear Parent/Guardian:

Our school offers healthy meals each day. All students can get one breakfast and one lunch free of charge each day at school. Although no application is required to receive this free meal benefit, filling out the Application for Educational Benefits is still important! Your application may help the school qualify for education funds.

To apply, complete the enclosed Application for Educational Benefits and return it to:

Menahga Public Schools
216 Aspen Ave SE
PO Box 160
Menahga, MN 56464

Who should complete this application? Children in households participating in the Supplemental Nutrition Assistance Program (SNAP), Minnesota Family Investment Program (MFIP) or Food Distribution Program on Indian Reservations (FDPIR), and foster, homeless, migrant and runaway children qualify without reporting household income. Alternatively, children can qualify if their household income is within the maximum income shown for their household size on the instructions.

COMMON QUESTIONS:

I get WIC or Medical Assistance. Can my children qualify? Children in households participating in WIC or Medical Assistance do not automatically qualify. Children may be eligible depending on other household financial information. Please fill out an application.

Who should I include as household members? Include yourself and all other people living in the household, related or not (such as grandparents, other relatives, or friends).

May I apply if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens for you to complete an application.

What if my income is not always the same? List the amount that you normally get. If you normally get overtime, include it, but not if you get overtime only sometimes. For seasonal work, write in the total annual income.

Will the income information or case number I give be checked? It may be. We may also ask you to send written proof.

How will the information be kept? Information you provide on the form, and your child's approval, will be protected as private data. For more information, see the back page of the Application for Educational Benefits.

If I don't qualify now, may I apply later? Yes. Please complete an application at any time if your income goes down, your household size goes up, or you start getting SNAP, MFIP or FDPIR benefits.

If you have other questions or need help, please call the District Office at 218-564-4141.

Sincerely,

Jay Kjos

Superintendent



The Mission of Menahga School District #821 is to build strong partnerships with stakeholders to ensure all learners succeed.

How to Complete the Application for Educational Benefits

Complete the Application for Educational Benefits form for school year 2025–26 if any of the following applies to your household:

- Any household member currently participates in the Minnesota Family Investment Program (MFIP), the Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR) or
- The household includes one or more foster children (a welfare agency or court has legal responsibility for the child) or
- The total income of household members is within the guidelines shown below (**gross earnings before deductions**, not take-home pay). Do not include as income: foster care payments, federal education benefits, MFIP payments, or value of assistance received from SNAP, WIC, or FDPIR. Military: Do not include combat pay or assistance from the Military Privatized Housing Initiative. The income guidelines are effective from July 1, 2025 through June 30, 2026.

Maximum Total Income

Household size	\$ Per Year	\$ Per Month	\$ Twice Per Month	\$ Per 2 Weeks	\$ Per Week
1	28,953	2,413	1,207	1,114	557
2	39,128	3,261	1,631	1,505	753
3	49,303	4,109	2,055	1,897	949
4	59,478	4,957	2,479	2,288	1,144
5	69,653	5,805	2,903	2,679	1,340
6	79,828	6,653	3,327	3,071	1,536
7	90,003	7,501	3,751	3,462	1,731
8	100,178	8,349	4,175	3,853	1,927
Add for each additional person	10,175	848	424	392	196

Step 1: Children

List all infants and children in the household, their school and grade if applicable, and birthdate. Attach an additional page if needed to list all children. Check the box if a child is in foster care (a welfare agency or court has legal responsibility for the child).

Step 2: Case Number

If any household member currently participates in SNAP, MFIP or FDPIR, write in the case number and then go to Step 4. If you do not participate in any of these programs, leave Step 2 blank and continue to Step 3.

Step 3: Adult and Child Incomes / Last 4 Digits of Social Security Number

- **Social Security Number/Total Household Members.** An adult household member must provide the last four digits of their Social Security number or check the box if they do not have a Social Security number. Report the total number of household members and ensure all household members are listed individually on the application in the child or adult section as applicable.
- **Child Income.** If any children in the household have regular income, such as SSI or part-time jobs, list the total amount of regular incomes received by all children, and check the box for the frequency: weekly, bi-weekly, twice a month, or monthly. Do not include occasional earnings like babysitting or lawn mowing.
- **Adult income.** Report the names of adult household members and income in this section.
 - List all adults living in the household not listed in Step 1, whether related or not, such as grandparents, relatives, or friends.
 - **Gross Earnings from Work.** This is usually the money received from working at jobs where a paycheck is received. For each income, check the box to show how often the income is received: weekly, bi-weekly, twice per month, or monthly.
 - List gross incomes before deductions, not take-home pay. Do not list an hourly wage rate. For adults with no income to report, enter a '0' or leave the section blank. For seasonal work, write in the total annual income.
 - **Are you Self-Employed or a Farmer?** List the net income per month or year after business expenses. Do not list the same income twice on the application. A loss from farm or self-employment must be listed as 0 income and does not reduce other income.
 - **Any Other Gross Income.** List gross incomes before deductions from all other sources, such as SSI, unemployment, child support, public assistance, social security, rental income or annuities.

Step 4: Signature and Contact Information An adult household member must sign the form. If you do not want your information to be shared with Minnesota Health Care Programs, check the “Don’t share” box in Step 4.

Optional: Please provide the information on ethnicity and race that is requested on the second page of the form. This information is not required and does not affect eligibility. The information helps to ensure we are meeting civil rights requirements and fully serving our community.

2025-26 Application for Educational Benefits

Mail or return completed form to: School/District Information

STEP 1: List ALL Household Members who are infants, children, and students up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper).

Definition: A Household Member is "Anyone living with you and shares income and expenses, even if not related." Read *How to Complete the Application for Educational Benefits* for more information. Adults over grade 12 living in the same household should be reported in Step 3. If children in the household attend different districts or charter/nonpublic schools, return an application at each one.

Child's First Name (list all children in household)	MI	Child's Last Name	School	Grade	Birthdate	Foster Child (Y)
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>

STEP 2: Do Any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, MIFP or FPIR? Medical assistance **does not** qualify. **If NO** > Go to STEP 3.

If YES > Enter SNAP, MIFP or FPIR Case Number (between 4-9 digits, do not report EBT card number) _____ then go to STEP 4 (Do not complete STEP 3)

STEP 3: Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

A. Last Four Digits of Social Security Number (SSN) of Adult Household Member: XXX-XX-____ Or Check if Adult has **No SSN:** **Total Number of All Household Members (Children + Adults)**

B. Child Income.

Sometimes children in the household earn or receive income, such as from a part time job or SSI. Please include the TOTAL income received by all children listed in STEP 1. Do not include income received by adults in the box to the right.

Total Income Received by All Children	Weekly	Bi-weekly	2x Month	Monthly
\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. All Adult Household Members (including yourself). For each Household Member listed, if they do receive income, report total gross income only. If they do not receive income from any source, write '0' or leave any fields blank. You are certifying (promising) that there is no income to report. Not sure what income to include here? Flip the page and review "Sources of Income" for information. "Sources of Income" will help you with the Child Income section and All Adult Household Members section.

Names of All Adult Household Members (First and Last)	Gross Earnings from Working at Jobs				Are you Self-Employed or a Farmer?		Any Other Gross Income				
	Weekly	Bi-weekly	2x Month	Monthly	Monthly	Yearly	Weekly	Bi-weekly	2x Month	Monthly	
List all Household members not listed in STEP 1 (including yourself) even if they do not receive income. Include children who are temporarily away at school or in college.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				\$ _____		\$ _____				\$ _____	

STEP 4: Contact information and adult signature. "I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information I may be prosecuted under applicable State and Federal laws."

I have checked this box if I do not want my information shared with Minnesota Health Care Program as allowed by state law.

Printed name of adult signing form _____ Daytime Phone _____

Address (if available) _____ Apt# _____ City _____ Zip _____

SIGN HERE: Signature of Household Adult _____ **Date** _____

Do Not Fill Out: For School Office Use Conversions to Annualize All Income:	All Total Income (Include child and adult income)					Household Size:	Free After Verified			Reduced After Verified	Denied After Verified												
	Weekly	Bi-weekly	2X Month	Monthly	Annualize		Free	Reduced	Denied														
X52	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X26	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X24	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Annualize	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Free	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Denied	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Verified	<input type="checkbox"/>	<input type="checkbox"/>	Verified	<input type="checkbox"/>

Determining Official Signature: _____ **Date:** _____

Confirming Official Signature: _____ **Date:** _____

OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility. Respond to both Step One, *Ethnicity* and Step Two, *Race*.

Step One: Ethnicity (check one): Hispanic or Latino Not Hispanic or Latino

Step Two: Race (check one or more): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

INSTRUCTIONS: Sources of Income

Sources of Income for Children

Sources of Child Income	Examples
<ul style="list-style-type: none"> Earnings from work Social Security Disability payments <ol style="list-style-type: none"> Survivor's benefits Income from person outside the household Income from any other source 	<ul style="list-style-type: none"> A child has a regular full or part-time job where they earn a salary or wages A child is blind or disabled and receives Social Security A parent is disabled, retired, or deceased, and their child receives Social Security benefits A friend or extended family member regularly gives a child spending money A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance / Allimony / Child Support	All Other Income
<ul style="list-style-type: none"> Salary, wages, cash bonuses (before deductions or taxes) Net income from self-employment (farm or business) If you are in the U.S. Military: <ol style="list-style-type: none"> Basic pay and cash bonuses (do NOT include combat pay, FISA or privatized housing allowances) Allowances for off-base housing, food and clothing 	<ul style="list-style-type: none"> Cash Assistance from State or local government Supplemental Security Income Unemployment benefits Worker's compensation Allimony payments Child support payments Veteran's benefits Strike benefits 	<ul style="list-style-type: none"> Social Security Disability benefits Regular Income from trusts or estates Annuities Investment income Rental Income Regular cash payments from outside household

The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met. Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, 'Check if no Social Security Number.' Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number. Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

At public school districts and charter schools, each student's eligibility status also is recorded on a statewide computer system used to report student data to MDE as required by state law.

Nondiscrimination statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or (2) **fax:** (833) 256-1665 or (202) 690-7442; or (3) **email:** program.intake@usda.gov

This institution is an equal opportunity provider.

TRANSPORTATION AND CENSUS INFORMATION

Please include all school age and preschooler children living in your home.

Child's Name	Male/Female	Age and Birthdate	Grade

Mother's Name _____

Address _____

Telephone Home _____ Work _____ Cell _____

Father's Name _____

Address _____

Telephone Home _____ Work _____ Cell _____

Directions to your home from Menahga. Please be specific.

Do you live in the Menahga School District? _____

If not, what district do you reside in? _____

Number of miles from your home to the school. _____

MENAHGA PUBLIC SCHOOL - IND. SCHOOL DISTRICT NO. 821

Tel: (218) 564-4141 Fax: (218) 564-4502

Health Update Form

Student Name: _____ **DOB:** _____ **Grade:** _____

Complete one form per student. Please be thorough. This information is important for providing a safe and healthy environment for your child. Pertinent information will be shared with school staff that work directly with your child.

Medical History (Check all that apply)					
Hematologic	<input type="checkbox"/>	Bleeding Disorder	Cardiovascular	<input type="checkbox"/>	Heart Condition
	<input type="checkbox"/>	Frequent Nose Bleeds	Respiratory	<input type="checkbox"/>	Asthma (need Asthma Action Plan)
Endocrine	<input type="checkbox"/>	Thyroid problems	Skin	<input type="checkbox"/>	Eczema/Psoriasis
	<input type="checkbox"/>	Diabetes	Neurological	<input type="checkbox"/>	Headaches
Musculoskeletal	<input type="checkbox"/>	Mobility/Joint Problems		<input type="checkbox"/>	Fainting Spells
Gastrointestinal	<input type="checkbox"/>	Bowel Problems		<input type="checkbox"/>	Seizures/Epilepsy
	<input type="checkbox"/>	Frequent Stomach Aches	Genitourinary	<input type="checkbox"/>	Urinary Tract Infections
	<input type="checkbox"/>	Nausea/Vomiting		<input type="checkbox"/>	Kidney Problems
				Eyes	<input type="checkbox"/> Vision Problems
					<input type="checkbox"/> Wears glasses/contacts: Y / N
				Ears/Nose/Throat	<input type="checkbox"/> Hearing Problems
					<input type="checkbox"/> Hearing Aids R:___ L: ___
				Dental	<input type="checkbox"/> Dental Problems
				Psychiatric	<input type="checkbox"/> Mental Health Diagnosis
					<input type="checkbox"/> Emotional/Behavioral Concerns

Other:
If any of the above were checked, please explain: _____

Allergies _____ No Known Allergies
OR
(Check all that apply) _____ Environmental _____ Food _____ Drug _____ Skin _____ Pet _____ Insect Sting _____ Other
Please describe the specific trigger, reaction, and interventions you have found to be helpful: _____

*Please submit a completed **Allergy Action Plan** to the health office prior to the first day of each school year for any student who requires medical care related to allergies.*

Medication Is medication required for any condition? At home? _____ Yes _____ No At school? _____ Yes _____ No
*The school prefers that all medication be given at home, if possible. If medication is required during school hours, please complete the **Authorization to Administer Medication** form available in the school health office. Medication orders must be updated each school year.*

Other Medical Information Please list any operations, injuries, hospitalizations, or prolonged illnesses with dates: _____
Please describe any restrictions or modifications needed (Gym, recess, etc...): _____
Please list any other information that you feel will help the school staff to better understand and work with your child (use back side if needed): _____

Parent/Guardian Release of Information and Consent

The information on the front and back of this form may be released to school personnel as needed to provide a safe and healthy learning environment for my child.

Parent/Guardian Signature: _____ **Date:** _____

Phone Number(s): _____

Reviewed by Health Office (Initial): _____



Emergency Contact Information

Parent/Guardian Name : _____ Home: _____
(Call First)

Cell: _____ Business: _____

Parent/Guardian Name: _____

Cell: _____ Business: _____

If my child becomes ill, and I cannot be reached, please call:

1. _____ Phone No. _____

2. _____ Phone No. _____

Parent/Guardian Signature: _____ **Date:** _____

By signing this form, you are giving consent for this information to be shared with school staff who teach, interact or work with your child during the school day.
Notify the school if your address or telephone number changes.

The welfare of your child is the first priority of school authorities. In case of a **serious emergency**, the school will contact emergency services, then contact you. In less serious instances, you will be called first. You will be contacted in either event.

It is your responsibility to make arrangements for proper care of your child should he meet with an accident or become too ill to remain in school at a time when you are not home. Please complete this form and promptly return it to the school.

List all students in the household:

Complete a separate **Health Update Form** for any new student or any student with a new health condition.
Health Update Forms will be entered into the student health record.

1. Name: _____ DOB: _____ Grade: _____

Check any that apply: Allergies Asthma Medical Condition Medication at School

If checked, please explain: _____

2. Name: _____ DOB: _____ Grade: _____

Check any that apply: Allergies Asthma Medical Condition Medication at School

If checked, please explain: _____

3. Name: _____ DOB: _____ Grade: _____

Check any that apply: Allergies Asthma Medical Condition Medication at School

If checked, please explain: _____

4. Name: _____ DOB: _____ Grade: _____

Check any that apply: Allergies Asthma Medical Condition Medication at School

If checked, please explain: _____

Last Name: _____

5. Name: _____ DOB: _____ Grade: _____

Check any that apply: Allergies Asthma Medical Condition Medication at School

If checked, please explain: _____

6. Name: _____ DOB: _____ Grade: _____

Check any that apply: Allergies Asthma Medical Condition Medication at School

If checked, please explain: _____

7. Name: _____ DOB: _____ Grade: _____

Check any that apply: Allergies Asthma Medical Condition Medication at School

If checked, please explain: _____

8. Name: _____ DOB: _____ Grade: _____

Check any that apply: Allergies Asthma Medical Condition Medication at School

If checked, please explain: _____

9. Name: _____ DOB: _____ Grade: _____

Check any that apply: Allergies Asthma Medical Condition Medication at School

If checked, please explain: _____

10. Name: _____ DOB: _____ Grade: _____

Check any that apply: Allergies Asthma Medical Condition Medication at School

If checked, please explain: _____

Students in Grades 6-12 ONLY

Over-the-Counter **Non-Prescription** Medication Permission

I give permission for my child[ren] in grades 6-12: _____, to self-administer over-the-counter medication[s] such as acetaminophen, ibuprofen, naproxen, tums, etc... at school. The medication must be used in a manner consistent with labeling instruction and not shared with any other student. **No products containing ephedrine or pseudoephedrine are allowed.** The privilege to self-administer non-prescription medication will be revoked if the student does not follow the above guidelines.

**Students must provide their own medication in the original container.
The school does not provide any medication.**

This permission is valid for students in **grades 6-12** for the current school year only.

Please list OTC Medication(s): _____

Parent/Guardian Signature: _____ Date: _____

Are Your Kids Ready?

Minnesota K-12 Immunization Law

Students are required to receive certain vaccines for school or submit an exemption. This requirement applies for all public, private, online, and home schools in Minnesota. Look for your child's grade in the chart below and see how many total doses of each vaccine are needed for their grade.

Required Immunizations	Kindergarten to Sixth Grade	Seventh Grade to Eleventh Grade	Twelfth Grade
Hepatitis B (Hep B)	3 Doses	3 Doses	3 Doses
Polio (IPV)	4 Doses	4 Doses	4 Doses
Measles, mumps, rubella (MMR)	2 Doses	2 Doses	2 Doses
Varicella (Chickenpox)	2 Doses	2 Doses	2 Doses
Diphtheria, tetanus, and pertussis (DTaP)	5 Doses	5 Doses	5 Doses
Tetanus, diphtheria, and pertussis (Tdap)		1 Dose	1 Dose
Meningococcal ACWY (MenACWY)		1 Dose	2 Doses

Note: The number of doses may be different if your child is behind schedule. If your child has fallen behind on their vaccinations it is not too late to catch-up, talk to their health care provider.

Recommended but not required for school

Influenza (flu), COVID-19, Human Papillomavirus (HPV), Meningococcal B (MenB) and other vaccines are recommended for children to ensure they are fully protected. Talk to your health care provider about when your child should receive these immunizations. For more information visit [CDC: Vaccine Schedules For You and Your Family \(www.cdc.gov/vaccines/imz-schedules/index.html\)](https://www.cdc.gov/vaccines/imz-schedules/index.html).

Tips for parents and guardians

- Make sure your child has received all of the required immunizations before their first day of school or submit an exemption.
- Submit a copy of your child's immunization record to their school. You can get a copy of their record from the clinic or find their record on [Find My Immunization Record \(www.health.state.mn.us/people/immunize/miic/records.html\)](https://www.health.state.mn.us/people/immunize/miic/records.html).
- Please complete the reverse side if your child requires an exemption for medical reasons or if you are opting for a non-medical exemption due to personal beliefs.



[Vaccines for Infants, Children, and Adolescents \(www.health.state.mn.us/people/immunize/basics/kids.html\)](https://www.health.state.mn.us/people/immunize/basics/kids.html)

Medical and non-medical exemptions

Instructions for documenting medical or non-medical exemptions and history of chickenpox (varicella)

Follow steps 1 and 2 below to document a medical exemption, non-medical exemption, or history of chickenpox.

1. Place an X in the box to indicate a medical or non-medical exemption. If you are exempting your child from more than one vaccine, mark each vaccine you are exempting them from with an X.
2. Obtain signatures for exemptions or history of chickenpox disease.

Required Immunizations	Medical	Non-Medical
Hepatitis B (Hep B)		
Polio (IPV)		
Measles, mumps, rubella (MMR)		
Varicella (Chickenpox)		
Diphtheria, tetanus, and pertussis (DTaP)		
Tetanus, diphtheria, and pertussis (Tdap)		
Meningococcal ACWY (MenACWY)		

Medical exemption: A health care provider must review and sign a medical exemption. A health care provider includes a licensed physician, nurse practitioner, or physician assistant.

By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____
(of health care practitioner)

Date: _____

Non-medical exemption: A parent/guardian must sign for a non-medical exemption and the form must be signed and stamped by a notary. A child is not required to have an immunization that is against their parent or guardian's beliefs. Choosing not to vaccinate may put the health of your child or others they are around at risk. Unvaccinated children who are exposed to a vaccine preventable disease may be required to stay home from school and other activities for up to 21 days to protect themselves and others.

By my signature I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs and I understand that they may be required to remain out of school and other activities for up to 21 days if exposed to a vaccine preventable disease.

Signature: _____ Date: _____
(of parent/guardian)

Non-medical exemptions must also be signed and stamped by a notary:

Notary Stamp

This document was acknowledged before me on

_____ (date),

by _____
(name of parent or guardian)



Notary Signature: _____

State of _____
County of _____

History of chickenpox (varicella) disease: If a child has previously had chickenpox, they are not required to receive the varicella vaccine. A health care provider must sign this form if the disease happened after Sept. 1, 2010. If the child had chickenpox before Sept. 1, 2010, a parent or guardian may sign this form.

My signature below means that I confirm this child does not need the varicella vaccine because they had chickenpox in the month and year _____

Signature: _____ Date: _____
(of health care practitioner, representative of a public clinic, or parent/ guardian)