Auglaize County Preschool Enrollment Packet 2020-21

Preschool Locations:
Auglaize County Preschool at the New Bremen location
Auglaize County Preschool at St. Marys Primary

Auglaize County ESC
1045 Dearbaugh Ave., Suite 2
Wapakoneta, OH 45895
(419) 738-3422

Auglaize County Educational Service Center

Shawn Brown, *Superintendent*

Telephone: (419) 738-3422 Fax #: (419) 738-1267
www.auglaizeesc.org

1045 Dearbaugh, Suite 2
Wapakoneta, OH 45895

Enrollment Checklist

_______ Preschool application
_______ Medical & Family History
_______ Emergency Information and Medical Authorization
_______ Physician's Request for Medication Administration by School Personnel
_______ Parent Consent Statements
_______ Kid Facts
_______ Dental Examination Form (Due by September 30, 2020)
_______ Child Medical Statement (Due by September 30, 2020)
_______ Parent Tuition Agreement—Typicals Only
_______ Application for Reduced Tuition—if applicable

Copies of documents to submit with your Enrollment Packet

_______ Birth Certificate
_______ Social Security Card
_______ Immunization Records
_______ Divorce Decree (if applicable)
_______ Custody Orders (if applicable)

Enrollment packet and copies of documents are due **before** your child starts school. Dental and Medical forms are due within the first 30 days of attendance.

All Enrollment packets should be sent/dropped off to:

Auglaize Co. Preschool
1045 Dearbaugh Ave., Suite 2
Wapakoneta, OH 45895

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Lisa Tobin, Preschool Director
Email: ltobin@auglaizeesc.org

Jenny Berning, Secretary
Email: jberning@auglaizeesc.org

Preschool Application 2020-21

Today's Date: ________________ Grade: ☒ Preschool

Residential School District: ☐ Minster ☐ New Bremen ☐ New Knoxville ☐ St. Marys

Child's First Name: ________________ **Middle Name:** ________________ **Last Name:** ________________
(as it appears on Birth Certificate)

Date of Birth: ________ **Age:** ____ **Gender:** ☐ Male ☐ Female **City of Birth:** ________________ **SS#:** ________________

Size of Family: (adults and children) _____ **Gross Income of entire household:** ________________

Is your child currently covered by Medicaid? ☐ Yes ☐ No

Is the student of Hispanic/Latino Heritage? ☐ Yes ☐ No

(check all that apply)
Ethnicity ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian/Alaskan Native

Native Language: ☐ English ☐ Other: ____________

Address (residence): ____
Street City State Zip

Mailing Address: ________________________________ **Home Phone:** ( ) ________________

Previous Preschools (if any): ____

☐ **private therapy services currently in place** ________________________________

Father/Guardian: ________________ Mother/Guardian: ________________

Address: ________________ Address: ________________
Street City Street City

Home Phone: ( ) ________________ Home Phone: ( ) ________________

Father's Employer: ________________ Mother's Employer: ________________

Work Phone: ( ) ________ Cell Phone: ( ) ________ Work Phone: ( ) ________ Cell Phone: ( ) ________

Email: ________________ **Email:** ________________

Do you live with relative or other acquaintances at this time? ☐ Yes ☐ No
If yes, please explain: ____
Parents: ☐ married ☐ separated ☐ divorced ☐ never married
Is someone else designated as legal guardian for this child? ☐ Yes ☐ No If yes, whom? ________________

I understand that I am responsible for transporting my child to and from preschool unless my child has an identifying handicapping condition and then the district is required to provide transportation. I will pick up my child at the designated times or supply the school with a note stating who will pick up my child. If my child is left at the school after school hours, I know that the school will call a local agency to take care of my child. I also realize that I am responsible for my own child's tuition payments. Failure to pay on time will result in my child being dismissed from preschool.

________________________________ ________________
Signature of Responsible Party Date
Check one: ☐ Parent ☐ Guardian

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CONFIDENTIAL AND PRIVILEGED MEDICAL AND FAMILY HISTORY FORM

The information requested in this form is needed in order to plan adequately to meet the needs of the individual child. If you object to any of the questions asked it is your privilege to omit those.

Child's Name: ______________________________ Date of Birth: ____________

Location: ☐ ABC Center ☐ St. Marys Preschool

Is the child adopted? ☐Yes ☐No If yes, please provide court documents.

Is there a step-parent living in the home? ☐Yes ☐No

If yes, please specify and provide current custody papers______________________________

Are there any other relative(s)/persons living in the home? ☐Yes ☐No

Is someone else appointed legal guardian of this child? ☐Yes ☐ No

If yes, please specify and provide current legal documents______________________________

Name and address of family doctor:______________________________

____

Number of children in family__________ Names and ages of:

Brother(s):______________________________

Sister(s):______________________________

Have any of the children had any serious illness? ☐Yes ☐ No If yes, please explain briefly:

____

____

Has your child attended any of the following types of structured activities? (check all that apply)

☐Sunday School ☐Head Start ☐Early Intervention ☐Preschool

Family History – Please check any of the following diseases which parents, grandparents, aunts, uncles, brothers, or sisters have had and indicate which family member had the disease.

☐Seizures	☐Allergies	☐Nervous Breakdown	☐ High Blood Pressure	☐Heart Disease
☐Cancer	☐Diabetes	☐Hay Fever	☐ Blindness	☐Tuberculosis
☐Deafness	☐ Asthma	☐ Mental Retardation	☐ Serious Skin Disease	☐ Kidney Disease

Infections, Illness, Etc.

Has your child had three attacks of severe headaches in the last year? ☐Yes ☐No

Has your child had at least three throat infections with a fever in the last year? ☐Yes ☐No

Has your child ever had a convulsion (seizure)? ☐Yes ☐No A high fever? ☐Yes ☐No

Over

CONFIDENTIAL AND PRIVILEGED MEDICAL AND FAMILY HISTORY FORM (cont'd)

Has your child ever had any of the following? (check all that apply)

☐Measles	☐Scarlet Fever	☐ Pneumonia	☐Broken Bones
☐Rubella	☐Rheumatic Fever	☐ Seizures	☐An Operation
☐Allergies	☐Poisoning	☐ Chicken Pox	☐Asthma, Hay Fever
☐Hives	☐Mumps	☐ Whooping Cough	☐Wheezing
☐Impetigo	☐Serious Injury	☐ Meningitis	☐Encephalitis

Explain briefly:____

Is your child currently taking medication on a regular basis? ☐Yes ☐No
If yes, detail name, dosage and reason for each medication ______________________
____

Will your child need to take medication while at school? ☐Yes ☐No
If yes, please explain and enclose "Physicians' Request for Medication Form" ______________
____

Is your child allergic to bee/wasp stings? ☐Yes☐No
Did your child have difficulty breathing? __________
What other reactions does the child have? __________
Was it necessary to go to the emergency room or doctor's office for treatment? __________
What was the treatment? ____
Does your child have an emergency bee sting kit prescribed by the doctor? ______________

Developmental History – Please give the approximate age at which your child did the following things:

Sat alone ______ Crawled ______ Walked ______ Rode Tricycle ______ Babbled ______

Spoke 1st word ______ Said 3-word sentence ______

How has your child developed compared to brothers/sisters?______________________

Please describe the general behavior of your child?______________________
____

Does your child have any of the following behavior traits?

☐ Nightmares	☐ Toilet training problems	☐ Carries security object in public
☐ Thumb sucking	☐ Nail biting	☐ Stuttering
☐ Discipline problems	☐ Temper tantrums	☐ Unusual sleep habits

Does your child have a regular bedtime? ☐Yes ☐ No Average hours of sleep per night ________

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EMERGENCY INFORMATION AND MEDICAL AUTHORIZATION

Student's Name____ Date of Birth: ____________

For your child's protection Auglaize County Preschool Programs will NOT release a child to anyone other than to the parents or to the adults that the child's parents/guardians designate to do so. **Both parents are automatically included on this list unless custody documents are in place. If so, please enclose a copy of legal documentation.**
If your child is injured or we face an early dismissal due to inclement weather and/or another unforeseen calamity we need the following information: Please rank in order (1,2) who is to be called for illness or in an emergency situation.

___Mother/Guardian ____________________	___Father/Guardian ____________________
Home Address (if different)	Home Address (if different)
Home Phone (if different)	Home Phone (if different)
Cell Phone	Cell Phone
Employer	Employer
Work Phone	Work Phone

List neighbors or nearby relatives who will know your whereabouts and assume temporary care of your child if you cannot be reached. We must have two (2) alternative contacts. Please notify us *immediately* **in writing** if you desire to make changes to this information.

Name ____________________ Address ______________________ Telephone ____________

Name ____________________ Address ______________________ Telephone ____________

**Please inform the people above that they may be asked to show a picture identification card when picking up your child.

List 5 Emergency Contacts (other than parents):

1. Name: ________________________ Relationship: ________________________
   Phone: ________________ Address: ________________________________
2. Name: ________________________ Relationship: ________________________
   Phone: ________________ Address: ________________________________
3. Name: ________________________ Relationship: ________________________
   Phone: ________________ Address: ________________________________
4. Name: ________________________ Relationship: ________________________
   Phone: ________________ Address: ________________________________
5. Name: ________________________ Relationship: ________________________
   Phone: ________________ Address: ________________________________

EMERGENCY INFORMATION AND MEDICAL AUTHORIZATIO (cont'd)

Purpose of the following information: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under authority, when parents or guardians cannot be reached. Fill out only Part I or Part II.

PART I – MEDICAL CONSENT

In the event reasonable attempts to contact me at (Tel. No.)__________________ have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by (Physician) Dr. ____________________ at (Tel. No.) __________ at (address) _____________________or (Dentist) Dr. ____________________ at (Tel. No.) ______________ at (address) _____________________, or in the event the designated preferred practitioner is not available, by another physician or dentist; and (2) the transfer of the child to (preferred hospital) ____________________________ at (address) ______________ ____________or any hospital reasonably accessible.
This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.
Facts concerning my child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: ____

____

Signature of Parent/Guardian ____ Date: ___________

PART II – REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action but to do the following: ____

____

Signature of Parent/Guardian ____ Date: ___________

Request for Administration of Prescription and Non-Prescription Medication, Food Supplement, Fluoride Supplement or Modified Diet

Note: Please complete a separate form for each medication.

Section I: Parent Request for Administration of Medication or Supplement
I hereby request and give permission to the authorized staff member to administer the following medication to my child:

Name of Child ______________________________ Age of Child ____________

Name of Medication or Supplement to be administered ______________________________

Dosage ______________ Time(s) of Dosage ______________________________

______________________________ ______________________________
Signature of Parent/Guardian Date

Section II: Physician's or Dentist's Instructions:

Name of Child: ______________________________
is under my care and should receive (Name or medication or supplement)

______________________________ Dosage: ______________

Specific instructions for administration: ______________________________

____

Possible side effects: ______________________________

____
Signature of Physician/Physician Assistant/Clinical Nurse Specialist/Certified Nurse or Dentist

Date ______________________________ Phone ______________________________

Please Print Physician's/Dentist Name ______________________________

Over

Medication or Supplement Log for ______________________
Student Name

Date and Time of Dosage	Amount of Dosage	Signature of Authorized Staff Member

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Parent Consent Statements
2020-2021 School Year

Child's Name:____

Center: ☐ABC Center ☐ St. Marys Preschool

Classroom Information Consent

This information will be for the current school year and will not be furnished to any person other than a parent or staff member of the Auglaize County Preschool Program.

☐**Yes,** I give permission for my name, my child's name, phone number and address to appear on a roster to be given to parents of children in his/her class.
☐**No,** I do not authorize the above information printed on the roster.

Field Trip Consent

Our classes will be taking various field trips throughout the school year. To try to eliminate excessive paperwork, we are requesting that each parent/guardian sign this consent, which will be valid for the entire school year. We will continue to send home the information of dates, times, and locations for each of these events.

☐**Yes,** my child may attend field trips approved by the Auglaize County Preschool Program.
☐**No,** my child may not attend field trips and they will not attend school on those days.

______________________________ ______________________
Signature of Parent/Guardian Date

Auglaize County Preschool

Child's name (Last)	(First)	Nickname (if any)
By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff who care for your child.		
Who is in the child's family(siblings, parents, etc.)?		
Who lives at home with your child(other than siblings or parents)?		
What is the primary language spoken in your child's home?		
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc? ☐ Yes ☐ No? Additional Details?		
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) ☐ Yes ☐ No? Additional Details?		
Are there any cultural or religious practices of your family of which we should be aware? (dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? ☐ Yes ☐ No? Additional Details? (center based, in home, with family, with parents, etc.)		
How often does your child drink during the day (milk, juice, water, etc.)?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Child Care Licensing requires a form be completed for children with food allergies and/or dietary restrictions)		

OVER

What are your child's favorite TV shows?
What are your child's favorite chores?
Who are your child's favorite people?
Please circle all of the words that best describe your child's personality and behavior: active, adventurous, affectionate, anxious, bossy, bright, busy, calm, cautious, cheerful, content, creative, curious, easily-angered, emotional, energetic, excitable, friendly, gives-in-easily, happy hesitant, insecure, jealous, likes structure/routines, loud, loving, mellow, outgoing, prefers adult attention, quiet, sensitive, serious, shares-well, social, spontaneous, stubborn, tentative, other:
Are there additional personality and behavior characteristics that would be useful to know about your child?
Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?
What routines/actions or items do you use to comfort your child?
What causes your child to feel angry or frustrated?
What methods do you use to respond to your child's negative behavior?
Does your child use any special comfort or support items that help them go to sleep? If so, what?
What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?
Where does your child sit at the table? (high-chair, booster seat, etc.)
Is your child toilet trained? If not, have your started the toilet training process? Please explain the process used.
Does your child need assistance when using the toilet? If so, how?
What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?	
What time(s) and for how long does your child usually nap?	
Does your child have trouble sleeping? (Night terrors, trouble going to sleep, etc.) ☐ Yes ☐ No? Please explain.	
What might you and/or child be anxious about as he/she starts in this program?	
What are you and/or your child excited about as he/she starts in this program?	
What are your expectations of this program?	
What other information would be helpful for the staff caring for your child to know?	
Parent/Guardian's Signature	Date

Parent Permission to Display Photographs, Video, or Electronic Images, Artwork and Stories

I give consent (or do not give consent) for photographs, audio, video or electronic images of my student; original written materials, artwork, or other work created by my child during the course of instruction; to be used by the Auglaize County ESC and St. Marys City School District for exhibition, public display, publication, publicity materials, news media stories, video, audio, or other electronic media such as district/building website. I understand that my child's full name may also be used with such display.

Student Name: ________________________________

_________ I give consent for photographs, audio, video or electronic images of my students, original written materials, artwork, or other work created by my child during the course of instruction; to be used by the Auglaize County ESC and St. Marys City School District for media publications such as the **district/building website**, **Facebook**, and/or community news media.

_________ I do not give consent for photographs, audio, video or electronic images of my students, original written materials, artwork, or other work created by my child during the course of instruction; to be used by the Auglaize County ESC and St. Marys City School District for media publications such as the district/building website, Facebook, and/**or community news media (The Evening Leader, Community Post, and The Daily Standard).**

Parent/Guardian Name **Printed** ____

Parent/Guardian **Signature** ____

Date Signed ____________________

Dear Parent(s),

Districts are required to identify students whose parents or legal guardians have been an active member of the Armed Forces, National Guard, or Reserves at any time throughout the **current** school year. Please put a check mark by the one that pertains to your student. If your status changes during the school year, please let your teacher know.

______ Not applicable (Not a Military Student)

______ Active Duty – Student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marines Corp or Coast Guard)

______ National Guard – Student is a dependent of a member of the National Guard (Army or Air)

______ Reserves

Auglaize County Preschool – Typical Program
Parent Tuition Agreement

We agree to pay the fee of **$115.00 or $60 (if qualified) per month** to the Auglaize County Educational Service Center. For this payment, our child will be eligible to attend the ABC Center or the St. Marys Preschool for four (4) days per week (2 ½ hours each day). Services included in this agreement include, but may not be limited to:

- Full time teacher
- Full time teacher assistant
- Field trips
- Snacks
- Preschool program
- Arts/crafts

All Children must be potty trained before entering the program

Transportation of the child is the parent's responsibility!

____

Child's Name (please print)

* Registration will include submission of all forms and payment of the 1st month's tuition. Thereafter, payment is due by the 1st of each month. **A $5 late fee will be assessed to all late payments received after the first day of the month. Continuous late payments (without prior notification) will result in your child being withdrawn from the program.** Tuition must be paid in full even if the child misses school due to illness, weather calamity or family vacation. Cash, money order or check payable to "Auglaize County Educational Service Center" must be sent or delivered to:

Auglaize County Educational Service Center
Attention: Jenny Berning
1045 Dearbaugh Ave., Suite 2
Wapakoneta, OH 45895

Return Policy: First month's tuition may only be refunded if our programming needs change and preschool is discontinued or if classroom space has already been filled.

****Personal checks returned for non-sufficient funds will be assessed an extra $30 fee.**

I REQUEST THAT THE ABOVE-NAMED APPLICANT BE ACCEPTED INTO THE AUGLAIZE COUNTY PRESCHOOL PROGRAM AT

__________________________________.

(Building location)

Session (PREFERRED—please circle one) : AM PM

I agree to the terms and conditions set forth in this Tuition Agreement.

____

Signature of Parent/Guardian Date

Auglaize County Preschool

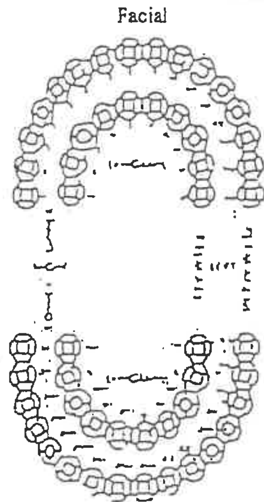
1045 Dearbaugh Avenue, Suite 2, Wapakoneta, OH 45895
Phone: (419) 738-3422 Fax: (419) 738-1267

DENTAL FORM

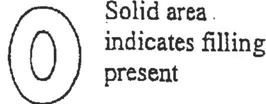
Child's Name ______________________ Sex ______ D.O.B. ______

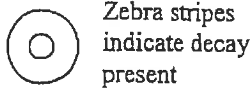
Parent/Guardian's Name ______________________ Phone ______

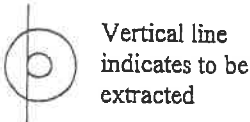
Address ______________________ Zip Code ______ Center ______

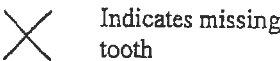


DIAGNOSTIC CODE:


Solid area indicates filling present


Zebra stripes indicate decay present


Vertical line indicates to be extracted


Indicates missing tooth

If follow-up is needed, please explain the treatment plan.

Is there any indication of baby bottle tooth decays?

_____Yes _____No

1. How many restorations are needed? ______
2. How many visits will be needed to complete the follow-up? ______
3. Date of next appointment? ______

PRIORITY GROUP:
____Needs Attention Immediately
____Needs Attention Soon ____Needs Routine Care

PLEASE CHECK SERVICES PROVIDED:

_____Fluoride _____Prophylaxis _____Instruction in oral hygiene
_____Restoration of decayed teeth ____ Pulp therapy
_____Extraction

SERVICES PROVIDED: (Please record each treatment on a separate line)

Month	Day	Year	Tooth	Surface	Material	Description of Work

*Treatment code: Surfaces, M=Mesial, Distal, O=Occlusal, L=Lingual, I=Incisal, B=Buccal or Libial, A=Amalgam, S=Silicate, P=Arcylic, C=Steel Crown, O=Other

Important: _______Check if additional work required _______Check if all work for this child has been completed
_______Check if treatment discontinued: explain above

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

Date of Examination ______________________

Dentist Signature ______________________ Address ______________________

City ______________________ Zip Code ______ Phone ______

Reason for objection to completing the dental examination: ______________________

Name: ______________________ Title: ______________________

Auglaize County Preschool

1045 Dearbaugh Avenue, Suite 2, Wapakoneta, OH 45895
Phone: (419) 738-3422 Fax: (419) 738-1267

DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: ______________________ Birth Date: __________
Last First Middle

Address: ______________________ Telephone: __________
Street City State Zip Code

Name of School: __________ Grade Level: ______ Gender: ☐Male ☐Female

Parent or Guardian: ______________________

Parent/Guardian Address: ______________________
Street City State Zip Code

To be completed by dentist

Oral Health Status (check all that apply)

☐Yes ☐No **Dental Sealants Present**

☐Yes ☐No **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 1st molars.

☐Yes ☐No **Untreated Caries**—At least ½ mm of tooth structure loss at the enamel surface. Brown to dark brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐Yes ☐No **Soft Tissue Pathology**

☐Yes ☐No **Malocclusion**

Treatment Needs (check all that apply)

Urgent Treatment—abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

Restorative Care—amalgams, composites, crowns, etc.

Preventive Care—sealants, fluoride treatment, prophylaxis

Other—periodontal, orthodontic
Please note: ______________________

______________________ ______________
Dentist Signature Date

____

____
Address & Phone

Over

Department of Education

Office of Early Learning and School Readiness

Child Medical Statement

Revised 2/23/2017

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Child Medical Information

Child's Name ______________________

Date of Birth __________ Height ______ Weight ______

Immunizations:		**Exempt from Immunization:**	
Complete for Age	◯ Yes ◯ No	Religious Conviction	◯ Yes ◯ No
In Process	◯ Yes ◯ No	Health	◯ Yes ◯ No

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name ______________ Provider Address ______________

Provider Phone Number __________ Provider City __________ Provider State ______ Provider Zip ______

Check box of examining medical professional:

- ☐ Physician
- ☐ Physician's Assistant
- ☐ Advanced Practice Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional ______________________ Date of Exam __________

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

INSTRUCTIONS FOR APPLYING FOR REDUCED TUITION

For verification of eligibility for reduced rate at the Auglaize County Preschool, please complete this application and attach the requested documentation. This form should be completed, signed and dated by the parent or guardian responsible for the tuition of the child/children attending the preschool. If the parents/guardians are divorced or separated, only the parent responsible for the tuition and any other adult residing in the household should fill out the form. If tuition is shared, each responsible party must provide the proper documentation.

Please attach a photocopy of your 2019 Federal Tax Return Form 1040, 1040A or 1040EZ with dependents listed. If you receive non-taxable income you must submit photocopies of your 2019 year-end Cash Assistance documentation. Housing Assistance documentation and/or Social Security Income statement, showing the total amount received in 2019 for all members of the household

---

Child's full name: ____

****

Parent's name living in the home ______________________________________

Sibling's name living in the home ______________________________________

____

____

____

Total number of family members living in the home ____________________

Total combined gross family income for 1 full year ____________________

REFUSAL ____________________

(If you refuse you will not be eligible for a reduced rate)

I, ______________________________, attest that the information supplied on this page is accurate, true and complete.

Signature ___________________________ Date ___________________________

For Office Use Only

__________ Eligible for reduced rate $60.00 per month

__________ Not eligible to receive reduced rate

INCOME CHART ON BACK

FEDERAL INCOME CHART For School Year 2019-20					
Household size	**Yearly**	**Monthly**	**Twice Per Month**	**Every Two Weeks**	**Weekly**
1	23,107	1,926	963	889	445
2	31,284	2,607	1,304	1,204	602
3	39,461	3,289	1,645	1,518	759
4	47,638	3,970	1,985	1,833	917
5	55,815	4,652	2,326	2,147	1,074
6	63,992	5,333	2,667	2,462	1,231
7	72,169	6,015	3,008	2,776	1,388
8	80,346	6,696	3,348	3,091	1,546
Each additional person:	8,177	682	341	315	158