South Page Community School District
Blanchard-Braddyville-College Springs-Coin-Shambaugh
Box 98, College Springs, Iowa 51637
Phone: 1-712-582-3211

Rhonda Sheldon
PK-12 Principal
rsheldon@southpageschools.com

2019-2020 Fee List

Registration will be August 5, 2019 10am-6pm
All forms are on South Page website
These fees will be due on this day as follows:

Technology/Instructional Fee:
K-12 Students
$50.00 per student

Breakfast Prices:
PK-12 $1.60
Adult $1.75
Reduced Breakfast: $.30
Extra Milk: $.40

Lunch Prices:
PK-12 $2.35
Adult $3.75
Reduced Lunch $.40
Extra Milk $.40

Parents – Remember - Students must have money in their account for extra items.

Class Dues will be due at Registration:
Seniors: $20.00
Juniors: $20.00
Sophomores: $10.00
Freshmen: $10.00
8th Grade: $5.00
7th Grade: $5.00
6th Grade: $5.00

South Page Community Schools 2019-2020 Calendar

August 2019					Student Days/Hours		
M	T	W	TH	F	Student days	PD days	Paid Holidays
			1	2			
5	6	7	8	9			
12	13	14	15	16			
19	20	21	22	23	1	3	
26	27	28	29	30	6		0
September 2019							
2	3	4	5	6	10		
9	10	11	12	13	15		
16	17	18	19	20	20		
23	24	25	26	27	24	1	
30					25		1
October							
	1	2	3	4	29		
7	8	9	10	11	34		
14	15	16	17	18	39		
21	22	23	24	25	44		
28	29	30			48	0	0
November							
				1		1	
4	5	6	7	8	53		
11	12	13	14	15	58		
18	19	20	21	22	63		
25	26	27	28	29	65	1	1
December							
2	3	4	5	6	70		
9	10	11	12	13	75		
16	17	18	19	20	79	1	
23	24	25	26	27			
30	31				14		1
January							
		1	2	3	81		
6	7	8	9	10	86		
13	14	15	16	17	91		
20	21	22	23	24	96		
27	28	29	30	31	101	0	1
February							
3	4	5	6	7	106		
10	11	12	13	14	110	1	
17	18	19	20	21	115		
24	25	26	27	28	120		0
March							
2	3	4	5	6	125		
9	10	11	12	13	130		
16	17	18	19	20	134	1	
23	24	25	26	27	139		
30	31				141		0
April							
		1	2	3	144		
6	7	8	9	10	148		
13	14	15	16	17	152		
20	21	22	23	24	157		
27	28	29	30		161	0	1
May							
				1	162		
4	5	6	7	8	167		
11	12	13	14	15	172		
18	19	20	21	22	176	1	
25	26	27	28	29			0
Total					176	10	5

- Registration
- Professional Development for Staff (No school for students)
- First Day of School
- No School
- Late Start Monday
- End of Quarter/Semester
- Parent/Teacher Conferences
- Graduation
- Last Day of School

Aug.
- 5 Registration
- 19 New Staff Workshop
- 20-22 Staff Inservice
- 23 First Day of School

Sept.
- 2 No School - Labor Day
- 16 Late Start Monday
- 27 Professional Develoment
- 30 Late Start Monday

Oct.
- 14 Late Start Monday
- 25 End of 1st Quarter
- 29 PT Conferences
- 30 PT Conferences

Nov.
- 1 Professional Develoment
- 4 Late Start Monday
- 18 Late Start Monday
- 27-29 No School - Thanksgiving Break

Dec.
- 9 Late Start Monday
- 20 Professional Develoment
- 23-31 No School - Christmas Break

Jan.
- 1 No School - Christmas Break
- 10 End of 2nd Quarter/1st Semester
- 13 Late Start Monday
- 27 Late Start Monday

Feb.
- 14 Professional Develoment
- 17 Late Start Monday

March
- 2 Late Start Monday
- 13 End of 3rd Quarter
- 17 PT Conferences
- 19 PT Conferences
- 20 No School
- 30 Late Start Monday

April
- 10 No School - Easter Break
- 13 No School - Easter Break
- 20 Late Start Monday

May
- 4 Late Start Monday
- 21 End of 4th Quarter/2nd Semester
- 22 Professional Develoment

Total Teacher Contract days = 191

2019-2020 ENROLLMENT FORM for SOUTH PAGE CSD

GENERAL INFORMATION

Student's Name _____
Last First Middle

Address _____ Box #_____ H. Phone # _____

City _____ State _____ Zip _____

Parents' E-Mail_____ Cell Phone No. _____

2019-2020 Grade Level _____ Social Security No. _____

Date of Birth _____ Place of Birth _____

Ethnicity: Black Hispanic Asian/Pacific Islander Native American White

Father's Name _____ Mother's Name _____

Occupation _____ Occupation _____

Employer _____ Phone _____ Employer _____ Phone _____

FAMILY INFORMATION: Parents:_____ Married _____Divorced _____Separated

This student lives with _____ (mother, father, stepmother, etc.)

Legal Guardian_____ (name of legal guardian(s)

Names & birthdays of brothers & sisters of school age or younger living in the household

_____ _____

_____ _____

Are there any individuals with whom this student should not be allowed to have contact?_____ If the individual is a parent, is there a court order on file that prohibits this contact?_____

FIELD TRIP INFORMATION

_____ I give my permission for this student to accompany the class on any field trip or out-of-school activity that may occur during the school year. If there are any exceptions to the permission being granted, I have listed them here:

_____ _____

_____I would prefer to give permission for each activity as it occurs. Please send permission slips home each time with my child. If the slip is not returned, my child should not go on the field trip.

VIDEO INFORMATION

_____YES _____NO I give my permission for my child to be videotaped for teaching purposes.

_____YES _____NO I give my permission for my child to be pictured on the South Page Web Site

2019-2020 EMERGENCY / HEALTH INFORMATION

Student _____ **Grade** _____

Parent _____ **-- Cell Phone#** _____

WE MUST HAVE THE NAMES AND TELEPHONE NUMBERS OF TWO LOCAL PEOPLE WE MAY CALL DURING THE DAY IN CASE OF ILLNESS OR EMERGENCY IF PARENTS CANNOT BE REACHED:

1. **Name** _____ **Phone:** _____
2. **Name** _____ **Phone:** _____

Have these people agreed to assume this responsibility in case of an emergency? _____YES ____NO

Does this student wear eyeglasses or contacts? _____Full time _____Part Time _____No

Does this student have any health problems of which we should be aware?

___Hearing ___Speech ___Visual ___Diabetes ___Seizures
_____FOOD ALLERGIES ___Allergies ___Bee Stings ___Asthma ___Other

Explain: _____

_____

Has this student had any surgery? Kind _____
Date _____

Is this student taking any medication? _____YES _____NO

FOR _____
MEDICATION: _____

What is the date of the last tetanus shot? _____

Are there any education background facts about this student that you would like us to be aware of that would help us serve him/her better?

If any of this information changes, please call the office immediately.712-582-3211

Parent's Signature _____ **Date** _____

SOUTH PAGE COMMUNITY SCHOOL SUPPLY LISTS FOR 2019-2020

Listed below are the supply lists for each grade level. Please read carefully for your child's grade level. Also, **please mark all items with your child's name.**

PRESCHOOL SUPPLY LIST

___ 1. School bag with child's name on it
___ 2. 1 box of 8 JUMBO Crayola crayons
___3. 1 bottom Pocket Folder
___4. 1 Box 8 ct. Washable Crayon Markers
___5. 2 Elmer's Glue Stick
___ 6. 1 bottle of Elmer's school glue
___ 7. 2 Large box of Kleenex
___ 8. 3 Container of Disinfectant Wipes
___9. 1 Box of Qrt Ziploc Bags
___10. 1 Plastic rest mat (4 yr old only)

KINDERGARTEN SUPPLY LIST

___ 1. Scissors with rounded edge
___ 2. 1 Hard Plastic Pencil case
___ 3. 2 Large box of Kleenex
___ 4 1 box Crayola colored pencil(12 count)
___ 5. Back Pack- Big enough for 2 pocket folder
___ 6. 1 Bottle Elmer's school glue
___ 7. 1 pack of #2 pencils (no mechanical)
___ 8. 1 Large Eraser
___ 9. 1 Box of Sandwich Ziploc bags
___ 10. 2 Double bottom pocket folder
___ 11. Gym shoes to leave at school)
___ 12. 1 box of 8 LARGE Crayons
___ 13. Water bottle, Clear see through
___14. 2 Elmer's Glue Sticks
___15. Head Phones (NO EAR BUDS)
___16. 1 Disinfectant Wipes
___17. 3 prong Folder

FIRST Grade Supply

___ 1. 1 -1 inch Binder
___ 2. 3 Large box of Kleenex
___ 3. Headphones/ NO Earbuds
___4. Scissors
___5. 1 Clear Water Bottle
___6. 2 Packets of Wide Loose leaf paper
___7. 1 bottle of white GLUE ALL
___8. 12 Count Colored Pencils
___ 9. Pencil Bag for all Art Supplies
_____10. 3-3 Hole Punch Folder or divider folder
_____11. PE shoes to leave at school
_____12. Boots for Cold Weather
_____13. 1 Box 24 Crayons
_____14. Erasers (white)
_____15. Back Pack
_____16. #2 wood pencils
_____17. 3-containers of Disinfectant Wipes
_____18. Gallon, Pint, Snack Bags

Second/Third Grade

___ 1. 3 Bottom Pocket Folders
___ 2. 3 Large Box Kleenex
___3. Scissors
___4. 6 wide ruled spiral notebooks
___5. 12 count colored pencils
___6. Gym shoes left at school
___7. 1 Box of Ziploc Bags
___8. #2 Wood pencils
___9. Ruler with inches
___10. Pencil box
___11. 1 Highlighter
_____12. Boots for cold weather
_____13. Headphones/or earbuds
____ 14. Clear Water Bottle
_____15. 1 Bottle of school glue
_____16. Back Pack
_____17. Box of 48 crayons
_____18. Erasers
_____19. 3 Containers of Disinfectant Wipes
_____20. Germ X Bottle 8 oz
_____21. 2 -8packs of washable markers

SOUTH PAGE COMMUNITY SCHOOL
SUPPLY LISTS for 2019-2020

Listed below are the supply lists for each grade level. Please read carefully for your child's grade level. Also, **please mark all items with your child's name**.

FOURTH /FIFTH /SIXTH GRADE SUPPLY LIST

___ 2 Boxes of # 2 lead pencils
____ 5 Bottom pocket folders
____ 5 Spiral Notebooks
____ 4 Large Box Kleenex
_____ Erasers
____ Ruler/Inch-centimeter
____ Headphones or Earbuds
____ Gym Shoes to leave at school
____ 8oz White Glue Bottle
____ Protractor
_____ 2 Book Covers
_____ 1 Package of White Board Markers
____ 2 containers of disinfectant wipes
_____ Scientific Calculator(TI-30Xa)
_____ Red, Blue, Black Marking Pens
_____ Colored Pencils
_____ Scissors
_____ Back Pack
_____ Pencil Bag
_____ 1 Pack of Top Pencil erasers
_____ 1 Pack highlighters
_____ 1 package of Loose leaf paper
_____ 1 Package of Index Cards
_____ 2 Glue Sticks

SEVENTH-----TWELVETH GRADE SUPPLY LIST

___ 6- # 2 wood pencils
____ Red/Blue marking pens
____ Erasers
____ 2 Bottom Pocket Folders
____ 2 Spiral Notebooks
____ 3 Large boxes of Kleenex
____ Headphones/Earbuds for Computer
____ Scientific Calculator (exampleTI-30Xa)

South Page Community Schools

HOME LANGUAGE SURVEY

Student Name: _____ Birth Date: _____ Sex: ❑ Male ❑ Female

Parent/Guardian Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

School: _____ Grade: _____ Date: _____

1. Was your child born in the United States? ❑ Yes ❑ No
   If yes, in which state? _____
   If no, in what other country? _____

2. Has your child attended any school in the United States for any three years during their lifetime? ❑ Yes ❑ No
   If yes, please provide school name(s), state, and dates attended:
   Name of School _____ State _____ Dates Attended _____
   Name of School _____ State _____ Dates Attended _____
   Name of School _____ State _____ Dates Attended _____

3. What language is spoken by you and your family most of the time at home? _____

4. If available, in what language would you prefer to receive communication from the school? _____

5. Is your child's first-learned or home language anything other than English? ❑ Yes ❑ No

If you responded "Yes" to question number 5 above, please answer the following questions:

6. What language did your child learn when he/she first began to talk? _____

7. What language does your child most frequently speak at home? _____

8. What language do you most frequently speak to your child? (Father) _____
   (Mother) _____

9. Please describe the language <u>understood by your child</u>. (Check only one)
   A. ❑ Understands only the home language and no English.
   B. ❑ Understands mostly the home language and some English.
   C. ❑ Understands the home language and English equally.
   D. ❑ Understands mostly English and some of the home language.
   E. ❑ Understands only English.

_____ _____
Parent or Guardian's Signature Date

OFFICE USE ONLY			
Student ID #	Date Distributed	Date Received	

South Page Community Schools

Student Race and Ethnicity Reporting

Student Name: _____ Date Form Completed: _____

Date of Birth: _____ ❑ Male ❑ Female

Person Completing This Form: ❑ Parent/Guardian ❑ Student ❑ Other: _____

The U.S. Department of Education has implemented new standards for school districts to report student race and ethnicity. Your answers to the following will be held strictly confidential and data will be used only in the aggregate.

1. Is your child of Hispanic, Latino, or Spanish ethnicity: ❑ Yes ❑ No
   Includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

If you answered "**Yes**" to question #1, you may also check one or more of the racial categories in question #2. If you answered "**No**", please check one or more of the following racial categories.

2. Racial Categories:

   ❑ American Indian or Alaska Native
   Origins in any of the original peoples of North, Central, and South America who maintain a tribal affiliation or community attachment.

   ❑ Asian
   Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam.

   ❑ Black or African American
   Origins in any of the black racial groups of Africa

   ❑ Native Hawaiian or Other Pacific Islander
   Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   ❑ White
   Origins in any of the original peoples of Europe, the Middle East, or North Africa.

Please complete the entire form and return it to:

Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

South Page Community School District
Blanchard-Braddyville-College Springs-Coin-Shambaugh
Box 98, College Springs, Iowa 51637
Phone: 1-712-582-3211

Tim Hood
Superintendent

Rhonda Sheldon
PK-12 Principal

Pat Behrhorst
Admin Assistant/Board Secretary

With all the paperwork needed to get your child registered for school, it is important to let us know what medications you want us to administer to them while at school. Please circle the medications that it **IS** ok for us to give. We will administer medicine based on the package directions unless you request otherwise.

Tylenol Ibuprofen

Students name:_____Grade_____

Parents/Guardian signature_____

Date:_____

Comments:_____

Authorization for administration of medication/health services

Student's Name (Last) (First) (Middle) Date

Birthday School

School medications and health care services are administered following these guidelines:

- Parent signed, dated authorization to administer medication and Physician's authorization for health care services.
- The medication is in the original labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student name, name of the medication, directions for use and date.
- Annual renewal of authorization and immediate notification, in writing, of changes. I understand the school may refuse to administer medication when the manufacturers recommendations differ from the order or no manufacturers recommendations exist.

Medication/Health care Dosage Route Time at School

Administration instructions

Discontinue/Re-evaluate Follow-up Date

Prescriber Date

Prescriber's Address Emergency Phone

I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record maintained. The student has experienced NO previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

Parent's Signature Date

Parent's Address Home Phone

Additional Information Business Phone

Discovering Success on the South Page Pages of Life

South Page Community School District

Blanchard-Braddyville-College Springs-Coin-Shambaugh
Box 98, College Springs, Iowa 51637
Phone: 1-712-582-3211

SOUTH PAGE REBELS

Tim Hood
Superintendent

Rhonda Sheldon
PK-12 Principal

Pat Behrhorst
Admin Assistant/Board Secretary

School Health Requirements (listed by grade):

Preschool: physical-immunizations-lead screening

Kindergarten: physical-immunizations-dental screening-vision screening-lead screening

3rd Grade: vision screening

7th Grade: TDAP & Meningococcal vaccinations ****SEE BELOW**

9th Grade: dental screening (*must be completed by a dentist)*

12th Grade: Meningococcal vaccination **** SEE BELOW**

All 7-12 athletes: sports physical & "Heads Up" concussion form

****By law, if a 7th or 12th grade student is not fully immunized for meningitis, he/she could be kept out of school and all school-related activities (sports, cheer, etc.) as early as day 1. Students entering 7th or 12th grade in the 2018-19 school year should check with their healthcare provider about their need for the Meningococcal vaccination & provide the school nurse with an updated immunization record before school starts.**

--
Rhonda Sheldon
South Page CSD Principal

Iowa Department of Public Health
Child Vision Screening

1. Parents or guardians need to make sure their child has a vision screening at least once before starting kindergarten and again before starting 3rd Grade.

2. Kindergarten Screenings: A screening will be counted if it is done no earlier than 1 year before and no later than 6 months after school starts.

3. 3rd Grade Screenings: A screening will be counted if it is done no earlier than 1 year before and no later than 6 months after school starts.

4. The requirement for a child vision screening will count by any of the following:
    a. A vision screening or comprehensive eye exam by an eye doctor (ophthalmologist or optometrist).
    b. A vision screening conducted at a doctor's office, a free clinic, a child care center, a local public health department, a public or accredited nonpublic school, or a community-based organization or by an advanced registered nurse practitioner or physician assistant.
    c. A vision screening done by Prevent Blindness Iowa volunteers or Iowa KidSight and Lion's Club Volunteers.

5. The child vision screening requirement does not apply if the child vision screening conflicts with a parent's or guardian's genuine and sincere religious belief.

6. A child will not be withheld from school because a parent or guardian did not provide proof that the child received a vision screening.

Please direct questions regarding vision screening to:
Iowa Department of Public Health - Bureau of Family Health
321 E 12th Street - Des Moines, IA 50319
FAX 515-725-1760 - Phone 800-383-3826

Iowa Department of Public Health
CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent or Guardian Name:	Telephone (home or mobile):	
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: ☐ Male ☐ Female

Screening Information (health care provider must complete this section)

Date of Dental Screening: _____

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

☐ **No Obvious Problems** – the child's hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ **Requires Dental Care** – tooth decay[1] or a white spot lesion[2] is suspected in one or more teeth, or gum infection[3] is suspected.

☐ **Requires Urgent Dental Care** – obvious tooth decay[1] is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

[1] Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.
[2] White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.
[3] Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check ONE only):
☐ DDS/DMD ☐ RDH ☐ MD/DO ☐ PA ☐ RN/ARNP (High school screen must be provided by DDS/DMD or RDH)

Provider Name: (please print) _____ Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider or Recorder*: _____ Date: _____

*Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, or RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health • Oral Health Center
515-242-6383 • 866-528-4020 • http://idph.iowa.gov/ohds/oral-health-center
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

8/17/2016

Iowa Department of Public Health
CERTIFICATE OF VISION SCREENING

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent/Guardian Telephone Number:	Student Address:	
Zip Code:		

Screening Information (vision screening provider must complete this section *or parents may attach a copy of vision screening results given to them by a provider.*)

Date of Vision Screening: _____

Results (visual acuity):

Right Eye_____ Left Eye_____

Overall Result (Please select one):

Pass ○ or Fail ○

Referral to eye health professional (Please select one):

Yes ○ or No ○

Screening Provider: _____

Provider Business Name/Source of Screening: (please print) _____

Provider Name: (please print) _____ Phone: _____

Signature and Credentials of Provider: _____ Date: _____

A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten **and** again before enrollment in the 3rd grade.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in Kindergarten and no later than six months after the date of the child's enrollment in Kindergarten.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in 3rd grade and no later than six months after the date of the child's enrollment in 3rd grade.

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health – Bureau of Family Health
321 E 12th Street - Des Moines, IA 50319
FAX 515-725-1760 – Phone 800-383-3826
http://idph.iowa.gov/family-health/child-health/vision-screening

Diet Modification Request Form

Description: The United States Department of Agriculture (USDA) reimburses home day care providers, child and adult care centers, summer food service sponsors, schools, residential child care institutions, preschools, and Head Start for meals served to participants that meet USDA requirements. The Child Nutrition Program participating home provider or organization is listed below for meals served in their program. If a participant needs to avoid specific foods for a medical reason, a prescribing licensed medical professional must document the diet modifications and sign this form.

Please complete this form and return to your organization or provider: _____
(Name of home provider or organization)

Participant's Name: _____ Birth Date: _____ Grade: _____

Parent/Guardian's Name: _____

1) Does the participant have a disability? ❑ No ❑ Yes (identify)	
If yes, describe the major life activity or functions affected by the disability (see link for definitions of disability http://www.eeoc.gov/laws/statutes/adaaa_info.cfm)	
If yes, explain why the disability restricts the participant's diet:	
If no, identify the medical condition that does not rise to the level of a disability:	
2) Food(s) or Formula to Omit:	**Food(s) or Formula to Substitute:**
3) Texture modifications:	
Infants must receive iron-fortified infant formula or breast milk unless an allergy/exception statement is on file.	
The back of this form includes additional descriptions ❑ No ❑ Yes	

Licensed prescribing medical professional*: _____
Name (Print or Type) Title

*In Iowa licensed prescribing medical professionals include Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician's Assistant (PA), or Advanced Registered Nurse Practitioner (ARNP).

_____ _____
Signature of medical professional Date

If the participant has a disability, the provider must offer to supply the food substitutions unless doing so would be a documented financial hardship. If the participant does not have a disability, the provider is not required to supply the food substitutions.

The parent/guardian may request a nutritionally equivalent substitute for fluid milk without medical professional direction. This site chooses to offer this nutritionally–equivalent product: _____. Check here if you would like to request the soy milk listed in place of fluid milk and list the reason for the request. ❑ _____

USDA allows a parent/guardian to supply substitute foods. Check here if you wish to provide the substitute foods: ❑

Parent/Guardian signature: _____ Date: _____
(To document choices and for permission to release information)

Developed by the Iowa Department of Education, Bureau of Nutrition and Health Services

Check the box in front of food groups that should NOT be served and list the foods to be served instead.

Lactose/milk – ***Do not serve the items checked below:*** Fluid milk as a beverage or on cereal? ¼ cup of fluid milk to be used on cereal? __yes __no Milk based desserts such as ice cream and pudding Hot entrees with cheese as a prime ingredient such as grilled cheese, cheese pizza, or macaroni & cheese Cheese baked in products such as a casserole or on meat pizza Cold cheese such as string cheese or sliced cheese on a sandwich Milk in food products such as breads, mashed potatoes, cookies or graham crackers	**SERVE THESE ITEMS INSTEAD:**
Soy - ***Do not serve the items checked below:*** Protein products extended with soy Processed items cooked in soy oil Food products with soy as one of the first three ingredients Food products with soy listed as the fourth ingredient or further down the list	**SERVE THESE ITEMS INSTEAD:**
Egg - ***Do not serve the items checked below:*** Cooked eggs such as scrambled eggs or hard cooked eggs served hot or cold Eggs used in breading or coating of products Baked products with eggs such as breads or desserts	**SERVE THESE ITEMS INSTEAD:**
Seafood – ***Do not serve the items checked below:*** Fish Shrimp Crab Oysters Other:_____	**SERVE THESE ITEMS INSTEAD:**
Peanuts – ***Do not serve the items checked below:*** Peanuts, individually or as an ingredient Foods containing peanut oil Foods items identified as manufactured in a plant that also handles peanuts	**SERVE THESE ITEMS INSTEAD:**
Tree nuts – ***Do not serve the items checked below:*** All nuts Food items identified as manufactured in a plant that also handles nuts Other: _____	**SERVE THESE ITEMS INSTEAD:**
Wheat – ***Do not serve the items checked below:*** Foods containing wheat Foods containing gluten Other: _____	**SERVE THESE ITEMS INSTEAD:**