

**This is NOT a
Free/Reduced
Application**

Registration Fee Waiver Form

Please return to the Food Service Office at the Administration

Center (1401 12th Ave N) or to your child(rens) school.

If your child(ren) qualifies for free or reduced price meals, you may also be eligible for other benefits. One of these benefits is **school fees**. If you would like registration fees waived, please list your child(ren) below.

Full Waiver _____ Partial Waiver _____

Name of Student: _____ School: _____ Grade: _____

Name of Student: _____ School: _____ Grade: _____

Name of Student: _____ School: _____ Grade: _____

Name of Student: _____ School: _____ Grade: _____

Name of Student: _____ School: _____ Grade: _____

I understand that I will be releasing information that will show that I applied for free and reduced price school meals for my child(ren).

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____

Low-Cost Health Insurance for Children

My signature below indicates I DO NOT want school officials to share information with Medicaid & hawk-i:

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____

If your children do not have health insurance, many families getting free or reduced price meals can also get free or low-cost health insurance for their children. The law requires public schools to share your free and reduced price meal eligibility information with Medicaid & **hawk-i**, the State's medical insurance program for children. Specifically, we will give them your child's name, your name & address. Medicaid & **hawk-i** can only use the information to identify children who may be eligible for free or low-cost health insurance and contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose or to share it with any other entity or program. You are not required to allow us to share this information, it will not affect your child's eligibility for free or reduced price meals. **If you do NOT want your information shared with Medicaid or hawk-i, you must tell us by completing the information above.**

OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Date Received: _____