Metamora Community Consolidated School District 1 - Information and Registration

Directions: Please fill out this form for EACH of your children enrolling in Metamora CCSD#1 and return it as soon as possible to the school office.

Student Information

LEGAL Last Name:_____ First Name:_____ Middle Name:_____ Nickname:_____

(Please Circle One) Male Female

(Please Circle One) American Indian or Alaska Native | Asian | Black/African American | Hispanic/Latino of Any Race | Native Hawaiian or Other Pacific Islander | Two or More Races | White

Student's Residential Address_____

Student's Birthday (Month, Day, Year)_____ Home Phone Number ( )_____ Entering Grade_____

Name of Legal Guardian(s)_____

Will your child ride a bus to school? (Please Circle One) Yes No Bus Number (Assigned by Office)_____

Contact Information

Mother's first and last name_____

Mother's Address (if different from student's)_____

Mother's place of employment_____

Mother's e-mail_____

Mother's cellular phone( )_____ Mother's business phone( )_____

Father's first and last name_____

Father's Address (if different from student's)_____

Father's place of employment_____

Father's e-mail_____

Father's cellular phone( )_____ Father's business phone( )_____

Home Language Survey

IL State Board of Education requires this information…

Student Native Langage (Please check one) ____ English ____ Spanish ____ Other _____

Language Spoken at Home (Please check one) ____ English ____ Spanish ____ Other _____

Names of other children living in your home attending Metamora Grade School and/or Metamora High School

Last Name	First Name	Teacher	Grade

Sitter's Name_____ Sitter's Phone ( )_____ Sitter's Address_____

Please list additional people to contact in the event of an emergency

	Name	Phone
1.		
2.		
3.		

Please list the hospital you prefer in the event of an emergency_____

Other Information

Please list any allergies_____

Please list any medicines needed at school and complete Medical Authorization Form_____

Should your child be wearing glasses at school?_____ Does your child have a hearing loss?_____

Is your child receiving Special Education Services?_____ Speech Therapy Services?_____ Reading/Title I Support?_____

Last School Attended_____ Address_____

Permission for office to share emergency medical information with staff as needed (Please Circle One) Yes No

Permission to publish name/address/phone information in student directory (Please Circle One) Yes No

PLEASE INFORM THE SCHOOL IMMEDIATELY IF THERE ARE ANY FUTURE CHANGES TO PHONE NUMBERS OR E-MAIL ADDRESSES.

Signature_____ Date_____

On the back of this sheet, please list any additional physical, social, or emotional situation that might affect your child's behavior or performance at school. Please include any feedback or comments.
THANK YOU.

Illinois State Board of Education
New U.S. Department of Education Race and Ethnicity Data Standards

Student's Name: _____ Student's Grade_____

INSTRUCTIONS: This form is to be filled out by the student's parents or guardians, and **both questions must be answered**. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

Part A. Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Choose only one.

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino**

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to the question below by marking one or more boxes to indicate what you consider this student's race to be.

Part B. What is the student's race?

Choose one or more.

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
- ☐ **Asian** (A person 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.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Parent/Guardian Signature _____Date _____

Office Initials_____

Metamora CCSD # 1 309-367-2361
http://mgs.metamora.k12.il.us

METAMORA CCSD #1
Home Of The Redbirds

STUDENT REQUEST FOR THE LOAN OF TEXTBOOKS AND MATH/SCIENCE EQUIPMENT

I hereby request the loan of secular textbooks in accordance with Public Act 79-961 of 1975 and mathematics/science equipment and instructional materials in accordance with Section 2-3.54 of The School Code. I understand that this request will remain valid so long as my son/daughter is enrolled in Metamora Grade School and that I may at any time withdraw this request.

Metamora Community Consolidated School District #1
Metamora, Illinois, Woodford County.

Signed _____
Student, Parent, Guardian

Date _____

For School Use Only:

Date of Student Transfer:

_____

Date of Student Graduation:

_____

Illinois Department of Public Health
PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle			Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code			Telephone:
Name of School:		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:		Address (of parent/guardian):	

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 1/2 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 _____

Signature of Dentist _____ Date _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

Printed by Authority of the State of Illinois
P.O.#346085 5M 10/05

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	**Birth Date** Month/Day/Year	**Sex**	**Race/Ethnicity**	**School /Grade Level/ID#**
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	**1** MO DA YR	**2** MO DA YR	**3** MO DA YR	**4** MO DA YR	**5** MO DA YR	**6** MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																			
Age/ Grade																			
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																			
Hearing																			

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Student's Name Last First Middle	**Birth Date** Month/Day/ Year	**Sex**	**School**	**Grade Level/ ID #**

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION (**List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **(NOT REQUIRED FOR DAY CARE)** **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONAIRRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionairre Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed ☐** **Test performed ☐**
Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION **Yes ☐ No ☐ Modified ☐** **INTERSCHOLASTIC SPORTS** (for one year) **Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to October 15 of the year the child enters an Illinois school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Sex _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of Exam _____

Ocular History: ❑ Normal or Positive for _____

Medical History: ❑ Normal or Positive for _____

Drug Allergies: ❑ NKDA or Allergic to _____

Other Information _____

Examination

Refraction:	**Distance**			**Near**
	Right	Left	Both	Both
Unaided Visual Acuity	20/	20/	20/	20/
Best Corrected Visual Acuity	20/	20/	20/	20/

Was refraction performed with cycloplegic agents? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	❑	❑	❑	_____
Internal Exam (media, lens, fundus, etc.)	❑	❑	❑	_____
Neurological Integrity (pupils)	❑	❑	❑	_____
Binocular Function (stereopsis)	❑	❑	❑	_____
Accommodation and Vergence	❑	❑	❑	_____
Color Vision	❑	❑	❑	_____
IOP (glaucoma)	❑	❑	❑	_____
Oculomotor Assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective Lenses: ❑ No ❑ Yes, glasses should be worn for:
   ❑ Constant Wear ❑ Near Vision ❑ Far Vision
   ❑ May Be Removed for Physical Education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name_____
Optometrist or Physician who provides eye examinations

Address _____

_____

Phone _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____
Optometrist or Physician who provides eye examinations

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois
5/08

IISG08-1048

METAMORA CCSD #1

Home Of The Redbirds

ADMINISTERING MEDICINE AT SCHOOL

Please complete for **prescription or non-prescription medicine** to be administered to your child/children.

DOCTOR'S REQUEST FOR ADMINISTERING MEDICINE AT SCHOOL

STUDENT'S NAME_____ BIRTHDATE_____

ADDRESS_____ SCHOOL Metamora CCSD#1

PARENT/GUARDIAN_____

SPECIFIC DIAGNOSIS_____

It is required that this medicine be given during school hours for the comfort and convenience of this child.

Name of Medicine_____

Dosage_____

Specific Directions_____

Possible Side Effects_____

_____ _____

Doctor's Signature Date

_____ _____

Office Address Phone

GUARDIAN REQUEST FOR ADMINISTERING NON-PRESCRIPTION MEDICINE AT SCHOOL

These non-prescription medicines may be administered at Metamora CCSD#1.

Medicines:_____

Children's Names:_____

Parent Signature:_____

Doctor's Signature:_____

Martin Payne, *Superintendent*
Cathy Costello, *Principal*
Tim Damery, *Dean of Students*

Metamora Community Consolidated School District No. 1

815 East Chatham Street **Metamora, IL 61548**
Tel. (309) 367-2361 **Fax (309) 367-2364**

Website: http://mgs.metamora.k12.il.us

Outdoor Recess Injury Waiver

Health and Physical Education

Students in all grades receive physical education daily. Students receive a grade of S or U. A request to be excused from PE due to illness or exceptional circumstances must be submitted in writing by the parents. Any student who must be excused longer than two days must have a doctor's written statement stating the length of excused absence. A student under doctor's excuse must obtain a written statement from the doctor before reentry into PE. In most cases, *any student excused from physical education due to illness or injury will also be excused from recess, extracurricular practices, and extracurricular events.*

However, we understand that at times, **students excused from PE in grades K-8** may need to be outside at recess to enjoy the weather or to get fresh air. We would like to be able to allow this without risking further injury to the student. Recess and student activity is unpredictable in general at this age.

With a parent signature, we will allow students excused from PE to be outside with restricted activity. The recess monitors on duty will be notified of the student with restricted activity and will direct the student. Students must remain on the bench or sidewalk between the gymnasium and the playground and remain out of the pathway of other students who could potentially harm them. Students who choose to move around on the playground will be taking a risk of further injury to themselves.

If the weather does not allow for students to be outside, they should remain in the office instead of the gymnasium. This is for their protection, as the space in the gymnasium is confined.

Please sign this form, in order to give permission to your student who has a doctor's excuse to miss PE to be outdoors during recess. This signature indicates that you understand that allowing this could potentially cause further injury, but you still give permission. A student signature indicates that the student understands that he or she will comply with the rules and regulations set forth by the recess monitors and the principal regarding their outdoor activity. When giving permission to be outdoors during recess in no way affects participation in PE.

_____
Student Name (Printed)

_____ _____
Student Signature Today's Date

_____ _____
Parents Signature Today's Date

Date **restricted** outdoor recess is to begin_____

Date **restricted** outdoor recess will end _____

METAMORA CCSD #1
Home Of The Redbirds

Welcome to Metamora Community Consolidated School District #1.

We trust this will be the beginning of a mutually beneficial relationship. We are here to benefit your children as they grow and mature. We trust we have your support as we work together to educate your children.

Illinois law has several requirements that need to be addressed as your children begin their school years with us. These laws are for the protection of your children.

Birth Certificate Requirement

I. Illinois Public Act 84-1430 requires that **parents supply us with a certified copy of a student's birth certificate**; or documentation of the child's identity and an affidavit explaining the inability to produce a copy of the birth certificate. This may be obtained at the courthouse in the county where the child was born. We will make a copy of it so you can keep the original.

Physical Examinations Requirement

II. **Physical examinations are required for all children entering Kindergarten, Sixth Grade, or who are new to the state of Illinois**. Physical examinations should be conducted within one year of the date of entering school and be on a form similar to the one used by Illinois. For kindergarten students, a lead test is to be included with the physical examination. The physician can conduct them at the time of the physical. The family history on the physical form must be filled out or it will be returned.

Physical Examinations Requirement

III. Immunizations are available for everyone at the Woodford County Health Department for a fee set by their office. They will provide the injection regardless of ability to pay**. Parent/Guardian must accompany minors to the health department. Please remember to bring your permanent record immunization card along with your school physical record if you are obtaining these immunizations from the Woodford County Health Department.**

METAMORA CCSD #1

Home Of The Redbirds

IMMUNIZATION REQUIRED FOR STUDENTS

GRADE LEVEL	SHOT	REQUIREMENT
Kindergarten	DPT or DTaP	4 doses with the last dose on or after the 4th birthday
Kindergarten	POLIO	3 doses with the last dose on or after the 4th birthday
	CHICKEN POX (Varicella)	Must show evidence of having received 1 dose on/after 1st birthday or other proof of immunity.
Kindergarten	MEASLES	2 doses - the first at 12 months or later and the second no less than 1 month later.
Kindergarten	RUBELLA	1dose at 12 months or later
Kindergarten	MUMP	1dose at 12 months or later
5th	HEPATITIS B	The three injections Hepatitis B vaccination series must be started before entering fifth grade with a schedule for completion on file in the office. If your child had the Hepatitis series as a baby, it is not necessary to have it repeated.
6th	Tdap	1 dose
7th-12th	Tdap	1 dose if they have not already received immunization.

METAMORA CCSD #1
Home Of The Redbirds

Dental Requirement

IV. Dental examinations are required for kindergarten, second and sixth grades.

Medications Administered at School Requirements

V. It is the policy of the Illinois Department of Public Health that **permission is on file before students on school premises can take any medications**. The permission needs to be signed by parents and the family physician (most physicians will sign the form at no cost to patients). Permission needs to be on file for both prescription and over the counter medicines. This includes Tylenol and cough medicines Prescription medication permission needs to be renewed as prescriptions change. For over the counter medicines, only one form is required per family and that form will be kept on file throughout your child's school years. The medicine must be provided by parents and kept in the office in its original container with the student's name clearly marked. Cough drops may be sent to the classroom teacher if accompanied by a written note from parents giving permission for the child to use cough drops. 6th, 7th, & 8th grade students may carry cough drops in their pockets only if they also carry a note from parents giving permission for students to use cough drops.

Book Rental Fee

VI. There will be a book rental fee due when school begins in the fall.

Please contact us at 367-2361 K-5 and 367-2377 6-8 should you have additional questions. Thank you. We look forward to working with you.

Metamora CCSD #1

815 Chatham, Metamora, IL 61548-0552
http://mgs.metamora.k12.il.us

Lunch Program

Lunch balances are available on the Skyward Student Information System. This free service lets you access lunch account information securely from the district website. Please direct questions about Skyward to Paul Weber, Tech Coordinator, pweber@schools.mtco.com or 367-2361. He can sign you up and help you get started.

Students are assigned an individual lunch account when they enroll. This account balance follows the student as they move from grade to grade.

Students receive a plastic lunch card containing their lunch account information. At lunch, a cafeteria worker will scan their card, which deducts a lunch or milk fee from their account.

If your child eats breakfast, the breakfast charge is also deducted from the same account using a list rather than the plastic lunch card.

Please send lunch deposit tickets along with your payment in an envelope, with your child, to school. Your child will turn in lunch money to their teacher who will send it to the office. Deposit slips are available from the office and the district website http://mgs.metamora.k12.il.us.

Milk fees will be deducted from student lunch accounts. . Please deposit a minimum of $5 into the lunch account if your child would like milk with cold lunch. Please don't send a quarter with your child for milk as we have done in the past. Hot lunch includes one milk.

When a student balance dips below $5.25 we try to send out a reminder. You can also request email notification of low lunch balances from Skyward.

	Daily	*Weekly (5 days)*	*Monthly (20 Days)*	*School Year (170 Days)*
Lunch	$2.50	$12.50	$50.00	$425.00
Breakfast	$1.75	$8.75	$35.00	$297.50

Please send money in regularly. Please contact us if you have any questions. Thanks!

Metamora CCSD #1 Administration