

**PARTICIPANT MUST PROVIDE APPROPRIATE PROOF OF ELIGIBILITY**

Program Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Number in Household: \_\_\_\_\_

I certify that all of the information on this form is true and correct and that all income is reported. I understand that this information is being given for the receipt of government funds and that District officials may verify the information on the application, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**PROOF OF ELIGIBILITY SHOWN**

(Must Provide One of the Following - Check Applicable Box)

- |   |   |
|---|---|
| <input type="checkbox"/> Proof that child is eligible for the Free or Reduced School Lunch Program  | <input type="checkbox"/> Proof that family is eligible for food stamps  |
| <input type="checkbox"/> Proof that a sibling attending school is eligible for the Free or Reduced School Lunch Program (if participant is too young to attend school)  | <input type="checkbox"/> Proof that family is eligible for Medi-Cal, Kern Family Health Care or Healthy Families Services |
| <input type="checkbox"/> Proof that family is eligible for assistance from the Department of Human Services or is receiving Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) | <input type="checkbox"/> Proof that family is eligible for WIC benefits   |

\_\_\_\_\_  
Approved NOR Representative Signature & Title