

Dear Parent/Guardian,

In order to determine a student's eligibility for Upward Bound, we require a federal income tax return copy or family financial statement of each applicant. We use the statements to help us comply with the terms of our federal grant which require us to have at least two-thirds of our participants from low income families.

Federal regulations further require us to have on hand a family financial statement or income tax return for each participant in Upward Bound. When we are visited by a Department of Education program official, she/he takes a random sample of student applications and checks to be sure all the parts are on file. Therefore, we must have the financial statements here.

Only the director sees the statements or works with them. To ensure that this level of privacy is maintained, you may seal your income tax return copy or financial statement into a separate envelope and include this along with other information requested in the larger envelope attached.

If you have further concerns or questions, please call me at 785-8760 or email krause.paul@uwlax.edu.

Sincerely,

Paul Krause

Director, Upward Bound

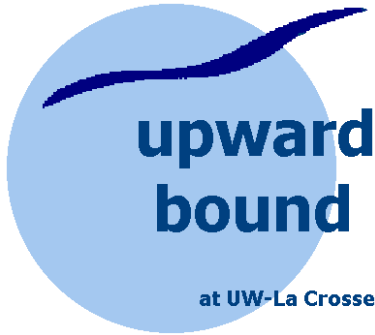
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INSTRUCTIONS FOR PROVIDING VERIFICATION OF INCOME

Please provide verification for each of the applicable types of income listed below:

- If parent(s) or guardian(s) file a Federal 1040 Income Tax form: provide a signed copy of pages one and two of the most recent form showing the number of exemptions claimed and the taxable income. Caution – be sure to provide the form covering the most recent tax year.
- If you cannot provide a federal income tax return: please complete and sign the attached income statement. Attach verification of all income described. Be sure to include all sources of income. This form must be notarized.
- If parent(s) or guardian(s) receive welfare (TANF, AFDC, General Assistance, etc.): request verification of monthly benefits from your local social services office. Attach them to the signed, notarized income statement.
- If parent(s) or guardian(s) receive Social Security payments (SSI, Disability, etc.): request verification of monthly benefits from your local Social Security office. Attach it to the signed, notarized income statement.
- Foster Children or Wards of the Court: no income verification is required – provide a signed letter from foster parent or guardian detailing foster child/ward of the court status. Include caseworker's name, address and telephone number.

INCOME STATEMENT



Complete this form only if Federal form 1040 or 1040A income tax return for last year is not available.

STUDENT'S FULL LEGAL NAME: _____
(last) (first) (middle)

ONLY IF NO RETURN WAS FILED COMPLETE THIS CHART. *Fill in only one of the three columns.*

Do only one column!	Weekly	Bi-weekly	Monthly
Wages/Salary			
TANF/Welfare Assistance			
Pension/Retirement			
Social Security			
Child Support/Alimony			
Other (describe) _____			
Other (describe) _____			
Other (describe) _____			
TOTAL			

My signature below indicates this chart is true and correct to the best of my knowledge.

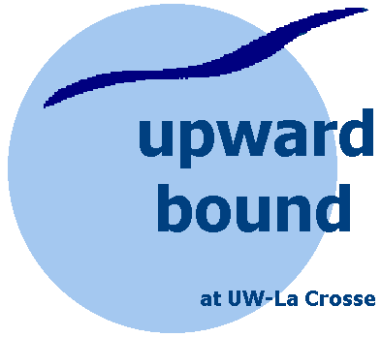
(signature of parent/guardian) _____
(date)

++++
 State of Wisconsin County of _____

This signature was acknowledged before me on _____ by _____

(Signed by) _____, Notary Public

My commission expires on _____.



PARENT/GUARDIAN INFORMATION

This form must be completed by a parent, guardian or other adult legally responsible for the applicant. The information is needed to determine eligibility for Upward Bound. Information will be kept confidential but must be on file, along with required income information before the applicant can be considered for selection.

1. STUDENT'S FULL LEGAL NAME: _____
(last) (first) (middle)

2. **COMPLETE THIS ITEM ONLY IF STUDENT DOES NOT LIVE WITH PARENT(S):**

- Student lives in foster home Student lives with other relatives *specify* _____
- Student lives alone (independent) Student is in institutional housing
- other *describe* _____

3. PLEASE CHECK ALL ITEMS THAT APPLY FOR STUDENT, FAMILY OR BOTH:

- | <u>Student</u> | <u>Family</u> | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | lives in federally or state supported low-income housing. |
| <input type="checkbox"/> | <input type="checkbox"/> | only one parent living in home. |
| <input type="checkbox"/> | <input type="checkbox"/> | receives state or federal welfare payments. |

4. TOTAL FAMILY SIZE _____ TOTAL NOW LIVING IN THE HOME _____

5. OTHER CHILDREN IN THE FAMILY PRESENTLY LIVING AT HOME:

Name _____	Age _____	School _____	Grade _____
Name _____	Age _____	School _____	Grade _____
Name _____	Age _____	School _____	Grade _____
Name _____	Age _____	School _____	Grade _____

6. OTHER CHILDREN IN THE FAMILY NOT PRESENTLY LIVING AT HOME:

7. OTHER PEOPLE NOT LISTED ABOVE LIVING IN YOUR HOME:

8. Please discuss your child's strengths/weaknesses. What are her/his strong points as a thinker, doer, person?

9. What are her/his weak points as a thinker, doer, person?

10. What educational benefits would you most like to see your child get from participation in Upward Bound?

11. What social or personal benefits would you like to have your child get from the Upward Bound experience?

14. Federal regulations require that parent education information be on file for each Upward Bound student.

Mother's name

Highest grade completed

Highest degree earned

Father's name

Highest grade completed

Highest degree earned

15. Upward Bound collects student participants' social security numbers to aid in postsecondary tracking required by the grant provider, the U.S. Department of Education. In addition, Upward Bound reports annually to the Department on participants' progress in the program. The Department asks us to provide student's social security numbers on these annual reports. Please read their Privacy Act Notification and check one box below:

Privacy Act Notification: *In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U. S.C. 552A), you are hereby notified that the Department of Education is authorized to collect information to implement the Upward Bound program under Title IV of the Higher Education Act of 1965, as amended (Pub. Law 102-325, sec. 402C). In accordance with this authority, the Department receives and maintains personal information on participants in the Upward Bound program. The principle purpose for collecting this information is to administer the program, including tracking and evaluating participants' academic progress. Providing your student's social security number (SSN) on this application is voluntary; failure to disclose a SSN will not result in denial of any right, benefit or privilege to which the participant is entitled. Information collected on this form will be retained in the program files and may be released to other Department officials in the performance of official duties.*

Upward Bound may release my student's social security number in its reports to the Department of Education

I would prefer that UB not release my student's social security number in its reports to the Dept. of Education

Your signature below means that statements made on this form are true. It also indicates that you give your permission for the student to take part in all aspects of the Upward Bound Project, including transportation to and from scheduled activities, except as noted on the health form, for as long as she/he is a member of Upward Bound.

SIGNATURE: _____ Date _____

(please print or type name)

Relationship to applicant

ADDRESS: _____
(street address or box and/or route number)

(town/city)

(state)

(zip)

TELEPHONE: (_____) _____
home

OTHER NUMBER: (_____) _____
work or alternate

UPWARD BOUND HEALTH HISTORY QUESTIONNAIRE

Participant _____ Birth date _____ Height ____ Weight ____
Address _____ City _____ State ____ Zip ____
Parent/Guardian _____ Relationship _____
HOME PHONE _____ Work/Alternate/Cell Phone _____
Address (if different) _____ City _____ State ____ Zip ____

In case of emergency (injury or illness), if parent/guardian cannot be reached, whom shall we contact?

Name _____ Relationship: _____ Phone _____
Physician/Clinic _____ Phone _____
Insurance _____ Policy # _____

MEDICAL INFORMATION

Has participant ever had major surgery or been hospitalized? YES NO Date of last physical exam _____

Explain significant operations, accidents or illnesses, and last medical attention and reason: _____

Does participant have any physical condition(s) requiring special considerations? Explain. _____

Does participant have allergic reactions to: Penicillin? yes no Other antibiotics? yes no Specify: _____

Other medicines? yes no Specify: _____ Insect bites/stings? yes no Specify: _____

Is participant currently taking any medication regularly? yes no If yes, identify: _____

Has participant had or presently experiencing:

- | | | |
|--|--|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Allergies | <input type="checkbox"/> YES <input type="checkbox"/> NO Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO Bleeding Disorder |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Cancer | <input type="checkbox"/> YES <input type="checkbox"/> NO Colitis | <input type="checkbox"/> YES <input type="checkbox"/> NO Diabetes |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Blackouts | <input type="checkbox"/> YES <input type="checkbox"/> NO Seizures | <input type="checkbox"/> YES <input type="checkbox"/> NO Epilepsy |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Hernia | <input type="checkbox"/> YES <input type="checkbox"/> NO High Blood Pressure |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Joint Injury/Surgery | <input type="checkbox"/> YES <input type="checkbox"/> NO Kidney Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Menstrual Problems |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Mental/Emotional Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO Back Pain or Injury | <input type="checkbox"/> YES <input type="checkbox"/> NO Neck Pain or Injury |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Rheumatic Fever | <input type="checkbox"/> YES <input type="checkbox"/> NO Tuberculosis | <input type="checkbox"/> YES <input type="checkbox"/> NO Ulcer |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Other: _____ | | |

Immunization Record:

MMR (measles, mumps, rubella) Dose 1 (at 12 months or after) ____/____/____ Dose 2: ____/____/____

Tetanus-Diphtheria ____/____/____ Year initial series completed _____ Year of last tetanus booster ____

Injuries or illnesses requiring medical attention will be referred to the surrounding medical community. The cost will be billed to you. Your signature indicates that all statements are as true and complete as you can make them. Further, you understand that you will be billed if your son or daughter requires medical attention while taking part in an Upward Bound activity.

Parent/Guardian signature

Date

TO THE PARENT(S) OR LEGAL GUARDIAN - CONSENT FOR MEDICATION ADMINISTRATION

If your son, daughter, or ward will be under the age of 18 while participating in the Upward Bound program at the University of Wisconsin-La Crosse, it is policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administered by designated program staff.

All medications must be in a medicine bottle and labeled with the student's name, doctor's name and phone number, medication name, and dosage. You must also complete the form below:

- No medication has been brought to Upward Bound.
- I want the medication or medical devices self-administered. (Age 14 and above only.)
- I want the medication or medical device administered by the designated camp staff. However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Name of Medication(s)	Prescribing Doctor	Doctor's Phone #
Amount to be taken	How is it taken?	Time(s) of day to be taken
Day(s) to be taken	Special Instructions	
Signature of Parent or Guardian (or student if age 18 or older)	Date	

CONSENT FOR MEDICAL TREATMENT

If your son, daughter, or ward will be under the age of 18 years while participating in Upward Bound, it is our policy to secure your consent for medical treatment.

By signing below you give your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.

By signing below you state that you are aware of and accept the risk inherent in the program activity.

By signing below you agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-La Crosse, their officers, employees and agents, from any and all liability, loss, damages, or expenses which are sustained, or required arising out of the actions of your dependent in the course of the camp/event.

Participant Name (Please Print)	Parent or Guardian signature (student if age 18 or older)	Date
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ASSUMPTION OF RISK, RELEASE AND INDEMNIFICATION

In full recognition and appreciation of the hazards and exposures involved I do hereby voluntarily agree to assume all of the risks and responsibilities involving my child's voluntary participation in the Upward Bound program at UW-La Crosse or any independent research or activities undertaken as an adjunct thereto; and, further, I do for myself, my heirs, and personal representative(s) hereby defend, hold harmless, indemnify and release and forever discharge the State of Wisconsin, Board of Regents of the University of Wisconsin System and all its officers, agents, employees and volunteers from and against any and all claims, demands, and actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from my child's participation in the Upward Bound program at UW-La Crosse.

I confirm that no health or accident insurance is provided for me by Upward Bound, the University or the State of Wisconsin. I have read and executed this document with full knowledge of its significance. In witness whereof, I have caused this release and indemnification agreement to be executed.

Student Signature	Date	Witness Signature	Date
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If Student/Intern/Volunteer is under the age of eighteen (18):

Parent/Guardian signature	Date	Witness Signature	Date
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