



Every graduate ready for College, Career and Life

WELCOME TO BOONE COUNTY SCHOOLS

A Distinguished District

Student Name: _____

Registration Date: _____

The following is a list of information that will be needed to enroll your child in our school district. These items are needed in addition to the registration forms provided:

- _____ *Student Enrollment/Emergency Information Form
- _____ Certified Birth Certificate (within 30 days)
- _____ *Immunization Certificate (new students only)
- _____ Preventative Health Care Examination Form (within 30 days)
- _____ Kentucky Eye Exam (first time entering a public school, for ages 3-6)
- _____ Kentucky Dental Screening Form (first time entering a public school, ages 5-6)
- _____ *Legal Custody Papers (if applicable)
- _____ *Proof of Residency at enrolling address in parent/guardians name
 - a. Drivers license
 - b. Lease, contract, mortgage, etc.
 - c. Utility bill
- _____ *Adjudication/Expulsion Affidavit Form (most will check #4 and sign)
- _____ Transportation Card (prior to riding bus)
- _____ Social Security Card or waiver
- _____ Permission to Videotape/Photograph/Publish Release Form

***Required at time of enrollment**

Boone County Schools
District Office
8330 US Hwy 42
Florence, KY 41042
(p) 859-283-1003
(f) 859-282-2376
www.boone.kyschools.us

The Boone County School District does not discriminate against any person on the basis of race, sex, color, religion, national origin, citizenship status, age or disability in any of its educational or employment programs or activities.

2017-2018 Boone County Schools Student Enrollment/Emergency Information

Office Use Only
School: _____
Start Date: _____
Teacher: _____

Legal Name of Student (Please Print) _____
(Last) (First) (Middle) (Jr., III, etc)

Grade: _____ Date of Birth: _____ Male Female SS# (Optional) _____

Has your child repeated a grade? Yes No If yes, which grade? _____

Birthplace: (Country) _____ (County) _____ (State) _____ Phone #: (____) _____

Student Address: (Street) _____ (Apt #) _____ (City) _____ (State) _____ (Zip) _____

(Check only if applicable*) Shelter Motel House or apartment shared with friends or family members Friends/Family member
*If applicable, please complete a Residency Questionnaire (704 KAR 7:090) (other than parent/guardian)

Student Mailing Address: (if different) _____ (City) _____ (State) _____ (Zip) _____
(Street or PO Box and Apt #)

There are no changes to student's address or phone number. Parents/Guardians, please initial here _____

Ethnicity: Is your child Hispanic/Latino: Yes No

Student Race: (Check all that apply) White Black or African American Asian Native Hawaiian or other Pacific Islander
 American Indian or Alaskan Native

U.S. Citizen: Yes No If no, country of residence: _____ Migrant Immigrant Refugee: (Country) _____

Last School Attended: _____ Kentucky School: Yes No

Last Date Attended: _____ School Telephone #: (____) _____

School Address: (City) _____ (County) _____ (State) _____

- Race/Ethnic Group Categories**
- White (not Hispanic)-A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.
 - Black/African American (not Hispanic)-A person having origins in any of the black racial groups of Africa.
 - Hispanic/Latino-A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture of origin regardless of race.
 - Asian-A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.
 - Pacific Islander-A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
 - American Indian or Alaskan Native-A person having origins in any of the original peoples of North & South America and who maintains culture identification through tribal affiliation or community attachment.

Parents/Guardians Living in Same Household as Student

Legal Name: _____ DOB: _____ <small>(Last) First (M. I.)</small> Relationship to Student: _____ Phone: Home (____) _____ Work: (____) _____ Cell Phone: (____) _____ E-Mail: _____	Legal Name: _____ DOB: _____ <small>(Last) First (M. I.)</small> Relationship to Student: _____ Phone: Home (____) _____ Work: (____) _____ Cell Phone: (____) _____ E-Mail: _____
---	---

Siblings Living in Same Household as Student

Legal Name: _____ Suffix: _____ Birth Date _____ Sex: _____ Grade: _____ Name of Boone County School: _____	Legal Name: _____ Suffix: _____ Birth Date _____ Sex: _____ Grade: _____ Name of Boone County School: _____
Legal Name: _____ Suffix: _____ Birth Date _____ Sex: _____ Grade: _____ Name of Boone County School: _____	Legal Name: _____ Suffix: _____ Birth Date _____ Sex: _____ Grade: _____ Name of Boone County School: _____

Parents/Guardians Living at an Address Different from Student

Does this parent/guardian have joint custody? _____ Should this parent/guardian receive school information? _____ Is this person legally restricted access to this student? _____ <small>(A copy of the court order MUST be provided to the school.)</small> Legal Name: _____ DOB: _____ Relationship to Student: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: Home (____) _____ Work: (____) _____ Cell Phone: (____) _____ E-Mail: _____	Does this parent/guardian have joint custody? _____ Should this parent/guardian receive school information? _____ Is this person legally restricted access to this student? _____ <small>(A copy of the court order MUST be provided to the school.)</small> Legal Name: _____ DOB: _____ Relationship to Student: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: Home (____) _____ Work: (____) _____ Cell Phone: (____) _____ E-Mail: _____
---	---

Special Services

Does this student have special needs, or receive special education services? Yes No
 Does this student have a 504 plan? Yes No Does this student receive Title I services? Yes No
 Does this student receive services for speech? Yes No
 Has this student been formally identified as Gifted/Talented? Yes No

Transportation

Primary Transportation to School (check all that applies): Car Rider Walker School Bus Bus #: _____ (assigned by school district staff)
 Transportation by BCS: A.M. P.M. Both A.M & P.M. More Than 1 Mile Less Than 1 Mile None Daycare: _____

Language

Is English **most frequently** spoken in the home? ___ Yes ___ No, what language? _____
 Did your child learn English when he/she **first** began to talk? ___ Yes ___ No, what language? _____
 Does your child **most frequently** speak English at home? ___ Yes ___ No, what language? _____
 Is English **most frequently** spoken to the child at home? ___ Yes ___ No, what language? _____

(If any answers above are other than English, please complete the "Home Language Survey")

Medical Information

List and identify health conditions (such as severe allergies, chronic medical conditions, and/or allergies to medications): _____

*Per state regulation, any student with a health condition (such as asthma, allergies, diabetes, seizures, etc.) must have a health care plan on file. For more information, please contact the school Nurse or Health Clerk.

Regular Medication: _____ Dosage: _____
 An "Authorization to Give Medication" form must be on file for any medication to be given to a student during the school day.

Physician Name: _____ Telephone: _____

I give school officials permission to contact the named Health Care Provider: _____
 (Parent/Guardian Signature)

Emergency Information

If needed, what hospital should this student be taken to? _____

IN AN EMERGENCY, if parent/guardian cannot be contacted, please call and/or release my child to one of the following:

Name: _____ Relationship to student _____ Telephone No: (____) _____

Name: _____ Relationship to student _____ Telephone No: (____) _____

If there is anyone **NOT ALLOWED** access to this student, list their name and relationship: (Legal documentation **MUST** be provided to the school.)

Name: _____ Relationship to student _____

The school is not responsible for students authorized by parent to leave school during school hours or for students in elementary and middle school authorized by parent to privately return to their homes after school.

If there are changes made during the year, please contact the school office IMMEDIATELY.

Parent/Guardian Signature _____ Date: _____

Office Use Only	
New Enrollment	_____
Revised Enrollment	_____
Office Personnel	_____
Date	_____

PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____ Gender: M F Grade: _____
 Date of Birth: _____ Age: _____ yrs _____ months Preferred Language: _____
 Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies: _____

Current Prescribed Medications to be taken daily at school: _____

Significant Historical Information: _____

SCREENING RESULTS:

Height: _____ ft _____ inches Weight _____ BMI: _____ BMI% _____ B/P: _____

Vision	Right 20/ _____	Passed <input type="checkbox"/>	Hearing - Right	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
	Left 20/ _____	Failed <input type="checkbox"/>		Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
		Referred <input type="checkbox"/>	Hearing - Left	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>

Optional: Hct/HGB: _____ Lead: _____ Urinalysis: _____

Gross dental (teeth and gums) Normal Abnormal _____ Refer/Tx: _____
 Head/scalp/skin Normal Abnormal _____ Refer/Tx: _____
 Eyes/Ears/Nose/Throat Normal Abnormal _____ Refer/Tx: _____
 Chest/Lungs/Heart Normal Abnormal _____ Refer/Tx: _____
 Abdomen Normal Abnormal _____ Refer/Tx: _____
 Scoliosis assessment Normal Abnormal _____ Refer/Tx: _____

This child has the following problems that may impact the educational experience:

- Vision
- Hearing
- Speech/Language
- Physical
- Social/Behavioral
- Cognitive

Specify: _____

This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

- This child may participate fully in school activities including physical education.
- This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> SCHOOL READINESS <ul style="list-style-type: none"> • Establish routines • After-school care/activities • Friends • Bullying • Communicate with teachers <input type="checkbox"/> MENTAL HEALTH <ul style="list-style-type: none"> • Family time • Anger management • Discipline for teaching not punishment • Limit TV, computer <input type="checkbox"/> NUTRITION AND PHYSICAL ACTIVITY <ul style="list-style-type: none"> • Healthy weight • Well-balanced diet, including breakfast • Fruits, vegetables, whole grains, dairy | <ul style="list-style-type: none"> • 60 minutes of exercise/day <input type="checkbox"/> ORAL HEALTH <ul style="list-style-type: none"> • Regular dentist visits • Brushing/Flossing • Fluoride <input type="checkbox"/> SAFETY <ul style="list-style-type: none"> • Sexual safety • Pedestrian safety • Safety helmets • Swimming safety • Fire escape plan • Smoke/carbon monoxide detectors • Guns • Sun • Appropriately restrained in all vehicles |
|---|---|

Additional comments or recommendations: _____

Signed: _____ Date: _____
 Physician/APRN/PA/EPSDT Provider

Address: _____ Telephone: _____

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION

Date of student's enrollment: _____

Date of Vision Examination: _____

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

CASE HISTORY

Date of Exam: _____

Ocular History: Normal or Positive for: _____

Medical History: Normal or Positive for: _____

Drug Allergies: NKDA or Allergic to: _____

Family Ocular and Medical History: Amblyopia Strabismus Glaucoma Diabetes

Other: _____

Other Pertinent Information: _____

Refraction with cycloplegic? (Please indicate one.) YES NO

	OD	OS
Unaided Acuity	20/	20/
Best Corrected Acuity	20/	20/

Type of Examination	Normal	Abnormal	Notable to Assess
External Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

Diagnosis:

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: YES NO

2 _____

3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

- Educate (parents/patients) about eye/vision disorders and needed vision care
- Counsel (parents/patients) regarding eye safety
- Stress importance of early, preventative eye care
- Recommend re-examination, as appropriate

Signed: _____
Optometrist/Ophthalmologist

Date: _____

Address: _____

Telephone: () _____

Kentucky law, KRS 156.160(f), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

<p>Student Name: _____ <small>Last First Middle</small></p> <p>Birth date: ____/____/____ Gender: <input type="checkbox"/> 0 Male <input type="checkbox"/> 1 Female</p> <p>Parent or Guardian: _____ <small>Name Relationship</small></p> <p>Address: _____ City: _____</p> <p>Phone Number: _____ School: _____</p> <p>Date of Exam/Screening ____/____/____</p>		<p>Test Type (check one)</p> <p><input type="checkbox"/> Screening</p> <p><input type="checkbox"/> Exam</p> <p>Screener's Name: _____</p> <p>Screener's Address: _____</p> <p>Phone Number: _____ Screening Date: _____</p> <p>Screener's Signature: _____</p> <p>Professional affiliation: (Please check one)</p> <p><input type="checkbox"/> Dentist <input type="checkbox"/> Dental Hygienist</p> <p><input type="checkbox"/> Physician Assistant <input type="checkbox"/> Registered Nurse with training</p> <p><input type="checkbox"/> APRN <input type="checkbox"/> Physician</p>	
<p>Untreated Decay: (Check one)</p> <p><input type="checkbox"/> 0 No untreated cavities</p> <p><input type="checkbox"/> 1 Untreated cavities</p>		<p>Treated Decay: (Check one)</p> <p><input type="checkbox"/> 0 No treated cavities</p> <p><input type="checkbox"/> 1 Treated cavities</p>	
<p>Pattern of Early Childhood Cavities: (Check one)</p> <p><input type="checkbox"/> 0 No Early Childhood Cavities</p> <p><input type="checkbox"/> 1 Early Childhood Cavities Present</p>		<p>Treatment Urgency: (Check one)</p> <p><input type="checkbox"/> 0 No obvious problem</p> <p><input type="checkbox"/> 1 Early dental care needed</p> <p><input type="checkbox"/> 2 Referral for Urgent Care</p> <p>NOTE: Comment required if marked.</p>	
<p>Comments:</p>			

Boone County Schools

2017-18 Student Transportation Form

School: _____ School Code: _____ School Year: _____

Student Name: _____ D.O.B. _____

Gender: _____ Grade: _____ Student ID: _____ Teacher: _____

Circle One: K = All Day KA = AM Kindergarten KP = PM Kindergarten

(All students will be routed to their home address unless an alternative address is provided.)

Home Address: _____

City/State/Zip: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact: _____ Phone: _____

- NO BUS TRANSPORTATION NEEDED**
Car Rider Number _____ Daycare Name and Assigned # _____
- DAY CARE TRANSPORTS?** YES _____ NO _____
- AM TRANSPORTATION ONLY**
- PM TRANSPORTATION ONLY**
- AM & PM TRANSPORTATION NEEDED**
- ALTERNATE PICK-UP AND/OR DROP-OFF LOCATION NEEDED (Must be inside school boundaries)**

If using an alternate address please provide the following:

Pick-up Location: _____

Drop-off Location: _____

(Leave this area blank if being transported to home address or no transportation is needed)

Student Bus Information (To be completed by school official)

AM Pick-up Information:

Bus # _____ Stop Location: _____

PM Drop-off Information:

Bus # _____ Stop Location: _____



Commonwealth of Kentucky
Kentucky Department of Education
Boone County Board of Education
Adjudication/Expulsion Affidavit

K.R.S. 158.000 requires that a parent or guardian of a child who has been adjudicated guilty or previously expelled for homicide, assault, or violation of state law or school regulations relating to weapons, alcohol or drugs notify a new school of that fact by a sworn statement given to the school at the time of registration.

In compliance with that requirement, I swear or affirm that I am the parent or legal guardian of _____ who:

Student Name

1. Was adjudicated guilty and/or
2. Was previously expelled from _____ private or public school, either in state or out-of-state and/or
3. Was disciplined for a violation of state law or school regulation relating to weapons, alcohol or drugs.
4. Has never been adjudicated guilty or previously expelled or disciplined for violation of K. R. S. 158.000 as mentioned above.

The facts are as follows:

(Please attach a separate sheet as needed.)

I swear or affirm that, to the best of my knowledge and belief, the statements and information contained herein are true, factual and complete.

Affiant, Parent/Guardian

Date



Statement of Non-Disclosure
Of
Social Security Number

Date: _____

Parent/Guardian Name: _____

Address: _____

School Attending: _____

Student Name: _____ DOB: _____

In signing this waiver, I acknowledge that I am refusing to provide a copy of my child's Social Security Card to the Boone County School District. By signing this waiver your child **will not be eligible** for the Kentucky Educational Excellence Scholarship funds for their college education.

I also understand that any programs requiring my child's SS# for participation, within the Boone County School District and/or the Kentucky Department of Education, will not be available to my child.

Parent Signature _____ DATE: _____



Boone County Schools
Permission to Videotape/Photography/Publish
2017-2018

PLEASE COMPLETE THIS FORM AND SUBMIT IT TO THE SCHOOL.

Dear Parent/Guardian:

At some time during the school year, school/District personnel or other District-authorized persons may videotape or photograph classroom activities or special projects in which your child participates during or after the school day for staff/student evaluative, educational, or public awareness purposes. Such videotapes or photographs may be viewed by peers, faculty, or administrators. On special occasions such as a videotape or photograph of a class or school play or of an academic or athletic event, the film or photograph may be viewed by a general audience including, but not limited to, publishing pictures in yearbooks, event programs and newsletters, or on the school or District Web site.

Please review this form carefully, sign and date the form, and submit the form to the school. Although we will make efforts to comply with your request, bear in mind that we cannot monitor all adults at all times, especially during the special occasions when other parents may take pictures or may tape the event.

Once signed and dated, this form shall remain in effect for your child's enrollment in the District schools. However, at any time during the school year, you may amend this form only for future uses/preferences by notifying the Principal in writing of your request.

As the parent(s)/guardians(s) of _____, I/we give the
Student's Name

Boone County School District permission to release my/our child's name, photograph, and/or audio/video reproduction for publication concerning school functions and activities, including academic and athletic activities.

Name of Parent(s)/Guardian(s) (*Please print.*) _____

Parent/Guardian's Signature _____
Date

Parent/Guardian's Signature _____
Date

Principal/Designee's Signature _____
Date