2020-2021 Boone County Schools
Student Enrollment/Emergency Information

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

Legal Name of Student (Please Print) _____ (Last) _____ (First) _____ (Middle) Suffix _____ (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) _____

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 (other than parent/guardian)
If applicable, please complete a Residency Questionnaire (704 KAR 7:090)

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

☐ 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: _____ (Last) _____ (First) _____ (M. I.) DOB:____
Relationship to Student: _____
Phone: Home (__)_____ Work: (__)_____
Cell Phone: (__)_____
E-Mail: _____

Legal Name: _____ (Last) _____ (First) _____ (M. I.) DOB:____
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? _____
(A copy of the court order MUST be provided to the school.)
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? _____
(A copy of the court order MUST be provided to the school.)
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: _____

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	____

Revised 02/2020

REV 3/8/2019

Boone County Schools
KINDERGARTEN

2020-2021 Student Transportation Form

School: _____ School Code: _____ T Code _____ Effective Date: _____

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

Student Name: _____ D.O.B _____

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: _____

Parent/Guardian: _____ Phone: _____

BUS TRANSPORTATION NEEDED YES___ OR NO ___ IF YES, CHOOSE OPTION(S) BELOW

- ☐ **BUS TRANSPORTATION TO SCHOOL**
- ☐ **BUS TRANSPORTATION FROM SCHOOL**
- ☐ **BUS TRANSPORTATION TO & FROM SCHOOL**

ALTERNATIVE PICKUP & DROP OFF LOCATIONS

Per District Policy, students are permitted ONLY 1 AM and 1 PM Drop Off and Pick Up

****NO ALTERNATE DAYS****

☐ 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 Transportation Information

To be Completed by School Official Only

AM Pick-up Information:

Bus # _____ Stop Location: _____

PM Drop-off Information:

Bus #_____ Stop Location: _____

Car Rider Number_____ **Daycare Name and Assigned #** _____

Kindergarten Prior Setting Data

Dear Parent/Guardian;

School readiness for all children is critical to the success of students. Through an initiative begun by then-Gov. Steve Beshear in 2010, Kentucky is focused on ensuring that all young children who enter kindergarten are ready to grow, ready to learn and ready to succeed. One way that our district can support our families, stakeholders and community partners with promoting school readiness is by learning more about the early care settings our children have experienced before they enter school.

Our district is required, as part of 704 KAR 5:070, to collect information about where your child received early care services for the **12 months** prior to coming to kindergarten. There are five basic categories that children may receive care before entering kindergarten:

State-funded preschool: Children who attend the state-funded preschool program, which, as defined in 704 KAR 3:410, provides preschool services to at-risk 4-year-olds and 3- and 4-year-olds with identified special needs.

Head Start: Children who attend Head Start, which provides early childhood services to 3- and 4-year-old children who are at risk.

Child care: Children who attend any child care **or** private preschool setting that is licensed by the Division of Regulated Child Care. This includes Type 1, Type 2 and Family Certified Homes.

Home: A child who is at home with a parent/guardian before entering school.

Other: A child receiving care from one of the following:

- a family member, such as a grandparent, aunt, uncle, sibling
- a private sitter, who is not certified, such as a neighbor, nanny or other
- other early childhood setting that does not meet the above definitions

On the attached form, please provide the following information in the fields that are applicable to your child's **previous 12 months**. There may only be one prior setting your child participated in, or there may be multiple settings. If you need more space than is provided for any category, please provide the information on the back of the document.

1. Child's name: last, middle initial, first name
2. Child's date of birth (month, day, year)
3. Child's street address, including city, state, zip code
4. Prior Setting Information: Where has the child received early care services within the last 12 months? You may choose more than one option, if necessary. For example, your child may have had a change in care within the last 12 months. You would also need to choose more than one setting if your child attended a half-day program, then spent the other half-day at a child care facility, babysitter or at home.

If you have questions about prior setting information, please ask your child's teacher or office manager for clarification. We look forward to working with your family to ensure your child's success throughout kindergarten and beyond.

Sincerely,
District/School Staff

Kindergarten Enrollment Prior Setting Data

Name: _____ Date of Birth: _____

Address: _____

Please provide information about every early care setting your child attended during the year prior to kindergarten. **Fill out a new box for each location.**

Setting 1:

State-funded preschool **Head Start** **Child Care** **Home** **Other** **(circle one)**

Facility/School Name: _____

Address: _____

Start Date: _____ End Date: _____

Setting 2:

State-funded preschool **Head Start** **Child Care** **Home** **Other** **(circle one)**

Facility/School Name: _____

Address: _____

Start Date: _____ End Date: _____

Setting 3:

State-funded preschool **Head Start** **Child Care** **Home** **Other** **(circle one)**

Facility/School Name: _____

Address: _____

Start Date: _____ End Date: _____

Setting 4:

State-funded preschool **Head Start** **Child Care** **Home** **Other** **(circle one)**

Facility/School Name: _____

Address: _____

Start Date: _____ End Date: _____

Setting 5:

State-funded preschool **Head Start** **Child Care** **Home** **Other** **(circle one)**

Facility/School Name: _____

Address: _____

Start Date: _____ End Date: _____

Home Language Survey

Dear Parent/Guardian:

The purpose of the home language survey (HLS) is to determine the primary or home language of the student. This information is essential in order for schools to provide meaningful instruction for all students. The HLS is part of the statewide identification process required under Section 3113(b)(2) of the Every Student Succeeds Act (ESSA) and 703 KAR 5:070 and the related Inclusion of Special Populations Guidance.

The HLS must be given to all students in grades K-12 upon their initial enrollment in the district as a first screening process to identify potential English learner students. The HLS is administered one time, upon initial enrollment in grades K-12 and remains in the student's cumulative file.

Please note that the answers to the survey below are student-specific. **If a language other than English is recorded for ANY of the required survey questions below, the district is legally obligated to do further assessment of your child to determine if they are eligible for language support.**

Answers will not be used for determining legal status or for immigration purposes. If your child is identified for English language services, you may decline some or all of the services offered to your child.

If you have any questions on how to complete the HLS, please contact your child's school.

Student Information (required):

Name: _____ **Grade:** _____

Student Language Background (required):

1. What is the language most frequently spoken at home? _____
2. Which language did your child learn when they first began to talk? _____
3. What language does your child most frequently speak at home? _____
4. What language do you most frequently speak to your child? _____

Language for School Communication (not required):

5. In which language would you prefer to receive all school information: _____

Parent/Guardian Signature: _____ **Date:** _____

By signing here, you certify that responses to the four required questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for language support services, to help them become fluent in English. Students qualifying for language support services are entitled to services as an English learner and will be tested annually to determine their English language proficiency as required by ESSA 1111(b)(2)(G).

For School Use Only

School personnel who administered and explained the HLS and potential placement of a student into an English language development program if a language other than English was indicated:

Name: _____ **Date:** _____

Collins Elementary School

Thomas W. Loring Jr., Principal
Ashley Jacobs, Guidance Counselor

Laurie Veatch, Assistant Principal
Elizabeth Nordman, Guidance Counselor

9000 Spruce Drive • Florence, KY 41042 • 859.282.2350 • 859.282.2356 Fax

BOONE COUNTY SCHOOLS
PARENTAL CONSENT FOR RELEASE OF RECORDS

To the Principal of: _____
(Name of School)

_____
(Address)

_____
(City, State, Zip)

_____ _____
(Phone #) (Fax #)

You are authorized to release records on: _____ DOB: _____ Grade: _____
(Student's Name)

___ Release all the checked information

___ Release all information

___1. Cumulative Records
___2. General identifying date (Name, Address, DOB, Grade Level Completed Grades, Class Standing, Attendance Record)
___3. Standardized Achievement and Aptitude
___4. Medical/Health Records
___5. Special Education Due Process File
___6. Gifted File
___7. Title I File
___8. ESS File
___9. Limited English Proficiency/ English as Second Language
__10. Record of Extra Curricular Activities
__11. Other (Specify) _____
_____

SEND TO: COLLINS ELEMENTARY SCHOOL
9000 SPRUCE DRIVE
FLORENCE, KY 41042
PHONE: 859-282-2350
FAX: 859-282-2356

The reason for this request is:
_____Transfer to school due to change in residence
_____Other

_____
Signature of Parent or Legal Guardian

_____
Address

_____
Telephone Number

_____
Date

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

Boone County Schools
Permission to Videotape/Photograph/Publish

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 or fund raising 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, publication on the school or District Web site, event programs and newsletter and in school yearbooks,

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***

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 INDENTIFYING 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 ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☐	Failed ☐ Referred ☐
	Left 20/_____		Hearing - Left	Passed ☐	Failed ☐ Referred ☐

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:** _____

(Over)

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

☐ SCHOOL READINESS
- Establish routines
- After-school care/activities
- Friends
- Bullying
- Communicate with teachers

☐ MENTAL HEALTH
- Family time
- Anger management
- Discipline for teaching not punishment
- Limit TV, computer

☐ NUTRITION AND PHYSICAL ACTIVITY
- Healthy weight
- Well-balanced diet, including breakfast
- Fruits, vegetables, whole grains, dairy
- 60 minutes of exercise/day

☐ ORAL HEALTH
- Regular dentist visits
- Brushing/Flossing
- Fluoride

☐ SAFETY
- 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: _____

KDE/DSS

Kentucky Eye Examination Form for School Entry

KDE3HS004

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: ف Amblyopia ف Strabismus ف Glaucoma ف Diabetes

Other: _____

Other Pertinent Information: _____

Refraction with cycloplegic? (Please indicate one.) ف YES ف 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:

ف Normal ف Myopia ف Hyperopia ف Astigmatism ف Strabismus ف Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: ف YES ف NO
2 _____
3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

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

Signed: _____ Date: _____
Optometrist/Ophthalmologist

Address: _____ Telephone: ( ) _____

OAS/DSS

Kentucky Dental Screening/Examination Form for School Entry

KDESHS005

Kentucky law, KRS 156.160(i), 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.

Student Name: _____
Last First Middle

Birth date: ____/____/____ Gender: ☐ 0 Male ☐ 1 Female

Parent or Guardian: _____
Name Relationship

Address: _____ City: _____

Phone Number: _____ School: _____

Date of Exam/Screening ____/____/____

Test Type (check one)

☐ Screening

☐ Exam

Screener's Name: _____

Screener's Address: _____

_____

Phone Number: _____ Screening Date: _____

Screener's Signature: _____

Professional affiliation: (Please check one)

☐ Dentist ☐ Dental Hygienist

☐ Physician Assistant ☐ Registered Nurse with training

☐ APRN ☐ Physician

Untreated Decay: (Check one)

☐ 0 No untreated cavities

☐ 1 Untreated cavities

Treated Decay: (Check one)

☐ 0 No treated cavities

☐ 1 Treated cavities

Pattern of Early Childhood Cavities: (Check one)

☐ 0 No Early Childhood Cavities

☐ 1 Early Childhood Cavities Present

Treatment Urgency: (Check one)

☐ 0 No obvious problem

☐ 1 Early dental care needed

☐ 2 Referral for Urgent Care
NOTE: Comment required if marked.

Comments:

OH-12

3/16/2015