WELCOME TO

BOONE COUNTY SCHOOLS

A Distinguished District

Every graduate ready for College, Career and Life!

Student Name: _____

Registration Date: _____

The following is a list of information that will be needed to enroll your kindergarten child in our school district. These items include 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

_____ Kentucky Dental Screening Form

_____ *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

_____* Student 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

_____ *Prior Settings Form

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

2019-2020 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: _____

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 pla 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 01/2017

REV 3/8/2019

Boone County Schools

2019-2020 Student Transportation Form

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

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

Student Name: _____ D.O.B _____

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 # _____

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

Goodridge Elementary
Videotape/Photography/Publish Release Form

At some time during the school year, school/District personnel or other District authorized persons may videotape or photograph activities or special projects in which your child participates during or after the school day for staff/student evaluation, 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, event programs and newsletters, or on the school or District Web site.

All Goodridge Elementary students will have their name and picture included in the yearbook.

If you wish for your child to be **EXCLUDED** from the yearbook, please indicate below.

Please review this form carefully, sign, date and submit to the school.

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

_____ Please **DO NOT** publish my child's picture in the yearbook.

_____ I **do not give** the Boone County School District permission to release my child's name, photograph, and/or audio/video reproduction for publication concerning school functions and activities, including academic and athletic activities.

Child's Name: _____

Parent/Guardian's Name: _____

Teacher's Name: _____

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** **KDESHS004**

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: _____ 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:

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:**_____