Dear Prospective Preschool Parent/Guardian:

Thank you for inquiring how a child qualifies for the Boone County Preschool Program and how the application process works.

**WHO is eligible?**
Must reside in Boone County School District and meet one or more of the following criteria:

- Be financially eligible (160% poverty level) and 4 years old by Aug. 1st of the school year. **NO income consideration for 3 year olds.**
- 3 and 4 year olds may qualify as a child with an educational disability (having a delay in one or more areas of development)

For suspected educational disability, a screening will be scheduled.

**WHAT does Screening mean?**

Identifying any potential areas of concern in a child’s development. Developmental skills that are screened; cognitive, fine and gross motor, speech/language, social and self-help skills. If there are concerns, interventions will be recommended.

If your 3 year old attends a screening and no areas of concern are noted, you may re-apply when the child turns 4 year old (by Aug. 1 of the school year), if you think your household may meet the income meets standards. Based on the outcome of the screening, your child may or may not require interventions. After the screening results are scored, the interventionists will discuss this further with you. If your child needs interventions, at their conclusion, the interventionists will discuss further steps if any are necessary.

**HOW the Preschool Application Process Works for a 3-year old Screening:**
Complete the forms & provide copies of documents as identified in red in the What We Need section below.

**WHAT WE NEED YOU TO BRING BEFORE THE SCREENING OR TO THE SCREENING:**
Complete & Provide the following items in red below: (*The items in black may be turned in after the child is in school in which case you can turn those items into their school office where their file will be.*)

<table>
<thead>
<tr>
<th></th>
<th>1- Student Enrollment/Emergency card (2 pages, signed &amp; dated)</th>
<th></th>
<th>5- Copy of Birth Certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2- Preschool Transportation card (2 pages, signed &amp; dated)</td>
<td></td>
<td>6- Copy of Social Security Card OR Completed Statement of Non-Disclosure of Social Security Number</td>
</tr>
<tr>
<td></td>
<td>3- Household Income Verification form (2 pages, signed &amp; dated) &amp; copies of supporting documents (last 2-3 pay stubs or tax return) <em>(Only fill out if child is 4 yrs old by August 1; do not complete if 3 yrs old)</em></td>
<td></td>
<td>7- Copy of Proof of Residence (copy of a bill with your name &amp; address on it or copy of your lease)</td>
</tr>
<tr>
<td></td>
<td>4- Copy of KY Certification of Immunization completed by Physician (must be current)</td>
<td></td>
<td>8- Copy of Custody/Guardianship Papers/Foster Parent Documents (if applicable)</td>
</tr>
<tr>
<td>9- Permission to Videotape / Photography/Publish form (signed)</td>
<td>*Preventative Health Care Examination Form (both sides) completed by a Physician (NOT due at time of preschool application)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10- Adjudication form (signed)</td>
<td>*KY Eye Examination Form (NOT due at time of preschool application)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11- Other Reports/Evaluations: Speech/language evals, Physical Therapy reports, Occupational Therapy reports, IEP, etc. (if applicable)</td>
<td>*KY Dental Screening/Examination Form (NOT due at time of preschool application)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Copy of Medicaid Card/ Medicaid Release Information Form (if you have one) (NOT due at time of preschool application)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HOW TO SUBMIT PRESCHOOL SCREENING DOCUMENTATION:** You may return your child’s completed forms and copies of other document to us at the screening OR ahead of time in one of 3 ways:

1. **U.S. Mail:** Preschool Achievement Center (PAC), 7627 Ewing Blvd., Florence, KY 41042. **OR**
2. **Drop off:** Monday - Friday 7:30AM - 3:30PM at the above address **OR**
3. **Email:** angela.becknell@boone.kyschools.us

We ask for your patience during high peak seasons, the end and beginning of the school year, and pandemics.

**Please note:** If you wish to re-apply in the next school year, you will need to fill out a new enrollment card, preschool transportation card and up to date KY immunization record to insure we have current, up to date information. Children cannot start school or interventions without a current Kentucky immunization record.

Should you have any additional questions, please feel free to contact me at 859-283-3251.

Thank you for being an advocate on behalf of your child. We look forward to serving you and your family.

Respectfully,

**Dr. Michael J Shires**

Dr. Michael J. Shires  
Director of Early Childhood Learning  
Boone County School District  
Preschool Achievement Center (PAC)  
7627 Ewing Boulevard  
Florence, KY 41042  
859-283-3251 (main phone)  
859-282-0019 (fax)
Frequently Asked Questions about
PRESCHOOL

1. How do students qualify for Preschool in Kentucky?
   - Income Eligible- Age 4 (by August 1 of the school year) and have a family income at or below 160% of the federal poverty level.
   - Age 3 or 4 and have an educational disability due to delays in development, regardless of family income.

2. Do English Language Learners automatically qualify for Preschool in the state of Kentucky?
   - English Language Learners do not automatically qualify for Preschool. All students have to meet the stated qualifications listed above.

3. Do Preschool students have to start Preschool at the beginning of the school year?
   - Students can qualify and start enrollment into Preschool at any time of the school year.

4. How many years can students be in Preschool?
   - Depending on a student’s birthday and how they qualify, some students can spend up to 3 school years in Preschool.

5. If I feel my student is not ready for Kindergarten, can they spend another year in Preschool?
   - If a student is 5 years old by August 1, they may not spend another year in Preschool. It is recommended that they attend Kindergarten.

6. How many days a week is Preschool? *(NORMAL SCHEDULE WHEN NO COVID)*
   - Preschool is Monday-Thursday for half a day. Students that qualify are enrolled in either the AM session or the PM session. AM and PM sessions are determined by your address.

7. Does the bus pick up my child and drop off my child?
   - Transportation is provided in a Preschool bus that has a seat belt. There is an adult driver and an adult monitor on the bus to help the Preschool children. Bus transportation is free.
**Boone County Schools**

**Student Enrollment / Emergency Information**

<table>
<thead>
<tr>
<th>Legal Name of Student (PLEASE PRINT)</th>
<th>(Last Name)</th>
<th>(First)</th>
<th>(Middle)</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade:</td>
<td>Date of Birth:</td>
<td>☐ Male ☐ Female</td>
<td>Social Security # (optional):</td>
<td></td>
</tr>
<tr>
<td>Has your child repeated a grade? ☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthplace: (Country)</td>
<td>(County)</td>
<td>(State)</td>
<td>Phone #:</td>
<td></td>
</tr>
<tr>
<td>Student Address: (Street)</td>
<td>(Apt #)</td>
<td>(City)</td>
<td>(State)</td>
<td>Zip</td>
</tr>
<tr>
<td>Student Address: (if different)</td>
<td>(City)</td>
<td>(State)</td>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Student Mailing Address: (if different)</td>
<td>(City)</td>
<td>(State)</td>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>☐ There are no changes to student’s address or phone number. Parents/Guardians, please initial here</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity: Is your child Hispanic/Latino? ☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student Race: (Check all that apply) ☐ White ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Asian ☐ American Indian or Alaskan Native</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Citizen: ☐ Yes ☐ No</td>
<td>☐ Migrant ☐ Immigrant ☐ Refugee: (Country)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last School Attended:</td>
<td>Kentucky School: ☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Date Attended:</td>
<td>School Telephone #:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Address: (City)</td>
<td>(County)</td>
<td>(State)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Boone County Schools attended and years:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Parents/Guardians Living in Same Household as Student

<table>
<thead>
<tr>
<th>Legal Name:</th>
<th>(Last)</th>
<th>(First)</th>
<th>(M.I.)</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Student:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Phone: (___)</td>
<td>Work: (___)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cell Phone: (___)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-Mail:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Siblings Living in Same Household as Student

<table>
<thead>
<tr>
<th>Legal Name:</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Name of Boone County School:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal Name:</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Name of Boone County School:</td>
<td></td>
</tr>
</tbody>
</table>

### Parents/Guardians Living at an Address Different from Student

<table>
<thead>
<tr>
<th>Legal Name:</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Student:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Work:</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td></td>
</tr>
<tr>
<td>E-Mail:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal Name:</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Student:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Work:</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td></td>
</tr>
<tr>
<td>E-Mail:</td>
<td></td>
</tr>
</tbody>
</table>
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 apply): □ Car ride □ Walker □ School Bus Bus #: _________ (assigned by school district staff)
Transportation by BC Schools: □ A.M. □ P.M. □ Both A.M & P.M. □ More than 1 mile □ Less than 1 mile □ Daycare: ______________

Language

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

(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 #: ____________________________

Name: ____________________________ Relationship to student: ____________________________ Telephone #: ____________________________

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: ____________________________

Revised 02/2016
BOONE COUNTY SCHOOLS
PRESCHOOL TRANSPORTATION
CONFIDENTIAL EMERGENCY INFORMATION

Date ____________________ School ____________________

Name of Student ____________________ Date of Birth ____________________

Parent(s) ____________________ Home Phone ____________________

Home Address ____________________ City ____________________ Zip ____________________

Emergency Phone Number ____________________

Mother’s Work Phone ____________________ Father’s Work Phone ____________________

Mother’s Cell Phone ____________________ Father’s Cell Phone ____________________

Special Bus Equipment needed: Wheelchair Lift ____________________ Other ____________________

EMERGENCY MEDICAL INFORMATION:

Student’s Doctor ____________________ Phone ____________________

Hospital Preference ____________________

Address ____________________

Insurance ____________________

PLEASE CHECK BOXES, as needed:

☐ Verbal ☐ Non Verbal ☐ Seizure Disorder ☐ Hearing Impaired

☐ Ambulatory ☐ Non Ambulatory ☐ Visually Impaired

Allergies ____________________

Medication ____________________ Dosage ____________________ Side Effects ____________________

**ON THE BACK OF THIS CARD PLEASE WRITE STEPS TO BE TAKEN BY DRIVER/ASSISTANT IN THE EVENT OF ILLNESS, SEIZURES, ETC, WHILE RIDING THE BUS.

**ON THE BACK OF THIS CARD PLEASE WRITE ANY SPECIAL INSTRUCTIONS FOR CONTROLLING STUDENT’S BEHAVIOR.

**ALL CHILDREN WILL RIDE THE BUS IN A SAFETY VEST OR SAFETY SEAT.

ALTERNATIVE PICK-UP AND/OR DROP-OFF LOCATION:

IF pick-up and/or drop off location IS OTHER THAN THE HOME ADDRESS, complete the following information:

ALL alternative locations must be within the school boundary. They will be designated as the authorized location for pick-up & drop-off, with District approval, and NOT subject to change.

Pick-up Location ____________________

Drop-off Location ____________________

Parent/Guardian Signature ____________________

STUDENT BUS INFORMATION

To be completed by school office ____________________

AM (pick-up) information:

Bus # ____________________ Stop Location ____________________

PM (pick-up) information:

Bus # ____________________ Stop Location ____________________

Program Director ____________________ Parent ____________________

This information is maintained in accordance with the Family Education Rights and Privacy Act.
• PLEASE WRITE STEPS TO BE TAKEN BY DRIVER/ASSISTANT IN THE EVENT OF ILLNESS, SEIZURES, ETC., WHILE RIDING THE BUS, AS NECESSARY.

• PLEASE WRITE ANY SPECIAL INSTRUCTIONS FOR CONTROLLING STUDENT'S BEHAVIOR, AS NECESSARY.

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

SAFETY IS OUR PRIMARY CONCERN WHEN TRANSPORTING YOUR CHILDREN.

THEREFORE BELOW, PLEASE LIST THE NAMES & PHONE NUMBERS OF PERSONS OTHER THAN YOURSELF WHO WILL BE MEETING THE BUS. WE WILL REQUIRE A PHOTO ID FOR YOUR CHILD TO BE RELEASED.

<table>
<thead>
<tr>
<th>NAME</th>
<th>PHONE</th>
<th>RELATIONSHIP TO CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

PARENT/GUARDIAN SIGNATURE __________________________ DATE ________________

School Year
APPLY ONLINE FOR BENEFITS

FREE OR REDUCED

BREAKFAST AND LUNCH

www.schoollunchapp.com

- CONVENIENT ACCESS
- FASTER PROCESSING

- FASTER BENEFIT
- SAFE & SECURE

The online meal application is available in English and Spanish at schoollunchapp.com. Please allow 2 weeks for processing and benefit information.

For a paper copy or other questions please contact Food Services at 859-282-2367.

USDA is an equal opportunity provider and employer.
BOONE COUNTY SCHOOLS FREE AND REDUCED PRICE MEALS

Dear Parent/Guardian:

Children need healthy meals to learn. Boone County School offers healthy meals every school day. Breakfast costs $1.25; lunch costs $2.50 for elementary and $2.75 for middle and high school students. Your children may qualify for free meals or for reduced-price meals. **Reduced-price is $0.30 for breakfast and $0.40 for lunch.** This packet includes an application for free or reduced-price meal benefits, as well as a set of detailed instructions. Below are some common questions and answers to help you with the application process.

1. **WHO CAN GET FREE MEALS?**
   a. All children in households receiving benefits from SNAP or KTAP can get free meals regardless of your income.
   
   Categorical eligibility for free meal benefits is extended to all children in a household when the application lists a case number for SNAP or KTAP for any household member. Households with any member who is receiving SNAP or KTAP benefits may submit an application with abbreviated information as indicated on the application and instructions.
   
   b. Children receiving Medicaid when the Medicaid office reports to the Kentucky Department of Education that the household composition and income levels are within the free income eligibility guidelines are eligible for free meals. (Reporting participation in Medicaid on a household application does not provide benefits).
   
   c. Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals.
   
   d. Children participating in their school’s Federal Head Start Program are eligible for free meals.
   
   e. Children who meet the definition of homeless, runaway, or migrant are eligible for free meals.
   
   f. Children can get free or reduced-price meals if your household’s gross income is within the limits on the Federal Income Eligibility Guidelines. Your children may qualify for free or reduced-price meals if your household income falls at or below the limits on this chart.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Yearly Income</th>
<th>Monthly Income</th>
<th>Weekly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$23,606</td>
<td>$1,968</td>
<td>$454</td>
</tr>
<tr>
<td>2</td>
<td>$31,894</td>
<td>$2,668</td>
<td>$614</td>
</tr>
<tr>
<td>3</td>
<td>$40,182</td>
<td>$3,349</td>
<td>$773</td>
</tr>
<tr>
<td>4</td>
<td>$48,470</td>
<td>$4,040</td>
<td>$933</td>
</tr>
<tr>
<td>5</td>
<td>$56,758</td>
<td>$4,730</td>
<td>$1,02</td>
</tr>
<tr>
<td>6</td>
<td>$55,046</td>
<td>$5,421</td>
<td>$1,251</td>
</tr>
<tr>
<td>7</td>
<td>$73,334</td>
<td>$6,112</td>
<td>$1,411</td>
</tr>
<tr>
<td>8</td>
<td>$81,622</td>
<td>$6,802</td>
<td>$1,570</td>
</tr>
<tr>
<td>Each additional person:</td>
<td>+$8,288</td>
<td>+$691</td>
<td>+$160</td>
</tr>
</tbody>
</table>

2. **HOW DO I KNOW IF MY CHILDREN QUALIFY AS HOMELESS, MIGRANT, OR RUNAWAY?** Do the members of your household lack a permanent address? Are you staying together in a shelter, hotel, or other temporary housing arrangement? Does your family relocate on a seasonal basis? Are any children living with you who have chosen to leave their prior family or household? If you believe children in your household meet these descriptions and have not been told your children will get free meals, please call Student Services at 859-334-445 or email mark.raleigh@boone.kyschools.us.

3. **CAN I INCLUDE FOSTER CHILDREN AS PART OF MY HOUSEHOLD ON MY APPLICATION?** Yes. A foster child may be included in the household on an application when applying for benefits for any non-foster children residing in a household.

4. **DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD?** No. Use one Free and Reduced-Price School Meals Application for all students in your household. We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: your child’s school or Food Service Dept., at 8330 US Hwy 42, Florence, Ky 41042

5. **SHOULD I FILL OUT AN APPLICATION IF I RECEIVED A LETTER THIS SCHOOL YEAR SAYING MY CHILDREN ARE APPROVED FOR FREE MEALS?** No, but please read the letter you got carefully. If any children in your household were missed from your eligibility notification, contact the Food Service at 859-282-2367 or email holly.buchanan@boone.kyschools.us immediately.

6. **CAN I APPLY ONLINE?** Yes! You are encouraged to complete an online application instead of a paper application if you are able. The online application has the same requirements and will ask you for the same information as the paper application. Visit [www.schoollunchapp.com](http://www.schoollunchapp.com) to begin or contact Food Service Dept., 859-282-2367 for more information.

7. **MY CHILD’S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT ANOTHER ONE?** Yes. Your child’s application is only good for that school year and for the first few days of this school year through **October 06, 2020**. You must send in a new application unless the school told you that your child is eligible for the new school...
8. **I GET WIC. CAN MY CHILD(REN) GET FREE MEALS?** Children in households participating in WIC may be eligible for free or reduced-price meals. Please fill out an application.

9. **WILL THE INFORMATION I GIVE BE CHECKED?** Yes. We may also ask you to send written proof of the household income you report.

10. **IF I DON'T QUALIFY NOW, MAY I APPLY LATER?** Yes, you may apply at any time during the school year. For example, children with a parent or guardian who becomes unemployed may become eligible for free and reduced-price meals if the household income drops below the income limit.

11. **WHAT IF I DISAGREE WITH THE SCHOOL'S DECISION ABOUT MY APPLICATION?** You should talk to school officials. You may ask for an agency by writing to: Stephanie Caldwell, 8830 US Hwy 42, Florence, KY 41042 or calling 859-282-2367.

12. **MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN?** Yes. You, your children, or other household members do not have to be U.S. citizens to apply for free or reduced-price meals.

13. **DO I HAVE TO PROVIDE MY SOCIAL SECURITY NUMBER ON THE APPLICATION?** No. Only the last 4 digits of the Social Security Number of the household's primary wage earner or another adult household member is needed when submitting an application. It must be indicated on the application if no adult household member has a Social Security Number.

14. **WHAT IF MY INCOME IS NOT ALWAYS THE SAME?** List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only made $900, put down that you made $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

15. **WHAT IF SOME HOUSEHOLD MEMBERS HAVE NO INCOME TO REPORT?** Household members may not receive some types of income we ask you to report on the application, or may not receive income at all. Whenever this happens, please write a C in the field. However, if any income fields are left empty or blank, those will also be counted as zeroes. Please be careful when leaving income fields blank, as we will assume you meant to do so.

16. **WE ARE IN THE MILITARY. DO WE REPORT OUR INCOME DIFFERENTLY?** Your basic pay and cash bonuses must be reported as income. If you get any cash value allowances for off-base housing, food, or clothing, it must also be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income. Any additional combat pay resulting from deployment is also excluded from income.

17. **WHAT IF THERE ISN'T ENOUGH SPACE ON THE APPLICATION FOR MY FAMILY?** List any additional household members on a separate piece of paper, and attach it to your application. Contact Food Service Dept., 8830 US Hwy 42, Florence, KY 41042 or call 859-282-2367 to receive a second application.

18. **MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR?** To find out how to apply for SNAP or other assistance benefits, call 1-855-306-8959 or visit www.benefind.ky.gov.

If you have any questions or need help, please call the Food Service Department at 859-282-2367.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.
STATEMENT OF NON-DISCLOSURE OF SOCIAL SECURITY NUMBER

DATE: ________________________

PARENT NAME & ADDRESS:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

STUDENT'S NAME: ______________________ DOB: ______________________

SCHOOL ATTENDING: ______________________

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 (KEES) Kentucky Educational Excellence Scholarship funds for their college education.

I also understand that any programs requiring my child’s social security number for participation within the Boone County School District and/or the Kentucky Department of Education will not be available to your child.

Parent Signature: ______________________ Date: ______________________
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 of 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 use/preferences by notifying the Principal in writing of your request.

As the parent(s)/guardian(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
Commonwealth of Kentucky
Kentucky Department of Education
Boone County Board of Education

-Adjudication Form-

K.R.S. 158.000 requires that a parent or guardian of a child who has been adjudicated guilty or previously expelled from 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 ____________________________ (student's name) who:

1. _____ was adjudicated guilty and/or

2. _____ was previously expelled from ____________________________ (name of 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, that statements and information contained herein are true, factual and complete.

Affiant, Parent/Guardian ___________________________________________ 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 | Hearing - Right | Passed | Failed | Referred | | Left 20/__________ | Failed | Hearing - Left | Passed | Failed | Referred |
|--------------|----------------------|--------|-----------------|--------|--------|----------|

Optional: Hem/Hgb: ____________________________  Lead: ____________________________  Urinalysis: ____________________________

Gross dental (teeth and gums)  Normal: ______  Abnormal: ______  Refer/Tx: ____________________________

Head/skelp/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

☐ 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

☐ ORAL HEALTH
  • 60 minutes of exercise/day
  • 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/EP/SDT Provider

Address: ___________________________  Telephone: ___________________________
KDESHE004

Kentucky Eye Examination Form for School Entry

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 threes (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: getClientQuestion
                                   -clientQuestion
                                   -clientQuestion
Other: ______________________________________________________________________________________
Other Pertinent Information: ________________________________________________________________

Refraction with cycloplegia? (Please indicate one.)  ☑ YES ☑ NO

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<thead>
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<tbody>
<tr>
<td>Unaided Acuity</td>
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<tr>
<td>Best Corrected Acuity</td>
<td>20/</td>
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</tbody>
</table>

Type of Examination

- Normal
- Abnormal
- Notable to Another

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

Signed: __________________________ Optometrist/Ophthalmologist

Address: __________________________ Telephone: ( ) __________________________

Date: __________________________
Kentucky Dental Screening/Examination Form for School Entry

Kentucky law, KRS 156.180(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

Comments:

Note: Comment required if marked.

OH-12

3/15/2015