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?** *Due to COVID-19 virus, screenings are not being scheduled. We will contact you when screening dates are reinstated.*

**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 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.*)

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1- Student Enrollment/Emergency card (2 pages, signed &amp; dated)</td>
<td></td>
<td>5- Copy of Birth Certificate</td>
</tr>
<tr>
<td></td>
<td>2- Preschool Transportation card (2 pages, signed &amp; dated)</td>
<td></td>
<td>6- Copy of Social Security Card <strong>OR</strong> 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 <em>(copy of a bill with your name &amp; address on it or copy of your lease)</em></td>
</tr>
<tr>
<td></td>
<td>4- Copy of KY Certification of Immunization completed by Physician <em>(must be current)</em></td>
<td></td>
<td>8- Copy of Custody/Guardianship Papers/Foster Parent Documents <em>(if applicable)</em></td>
</tr>
</tbody>
</table>
### Application Information

<table>
<thead>
<tr>
<th>No.</th>
<th>Requirement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>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>
</tr>
<tr>
<td>10</td>
<td>Adjudication form (signed)</td>
<td>KY Eye Examination Form (NOT due at time of preschool application)</td>
</tr>
<tr>
<td>11</td>
<td>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>
</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 Department - Screening Documentation, 8270 US Hwy 42, Florence, KY 41042.

2. **Drop off:** Monday - Friday 7:30AM - 3:30PM at the Learning Support Services building, *(last building on right on Ockerman Drive behind Ockerman Elementary School)* OR

3. **Email:** michael.shires@boone.kyschools.us

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

**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 shot record.

Should you have any additional questions, please feel free to contact me at 859-334-3794.

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  
Learning Support Services  
8270 US Hwy 42 *(mailing address)*  
8270 Ockerman Drive *(physical address, off Hwy 42; last building on right)*  
Florence, KY 41042  
859-334-3794
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?
   - 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

Legal Name of Student (PLEASE PRINT) ___________________________ (Last Name) ___________________________ (First Name) ___________________________ (Middle Name) ___________________________ (Suffix)

Grade: _____ Date of Birth: _____________ □ Male □ Female Social Security # (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) ___________________________

(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: ___________________________

Last School Attended: ___________________________ Kentucky School: □ Yes □ No

Last Date Attended: ___________________________ School Telephone #: (____) ________

School Address: (City) ___________________________ (County) ___________________________ (State) ___________________________ (Zip) ___________________________

Prior Boone County Schools attended and years: ___________________________ ___________________________

 Parents/Guardians Living in Same Household as Student

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Relationship to Student</th>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First) (Middle) (Suffix)</td>
<td>(<strong><strong>)</strong></strong>___</td>
<td>(<strong><strong>)</strong></strong>___</td>
<td>(<strong><strong>)</strong></strong>___</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Relationship to Student</th>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First) (Middle) (Suffix)</td>
<td>(<strong><strong>)</strong></strong>___</td>
<td>(<strong><strong>)</strong></strong>___</td>
<td>(<strong><strong>)</strong></strong>___</td>
</tr>
</tbody>
</table>

 Siblings Living in Same Household as Student

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

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

 Parents/Guardians Living at an Address Different from Student

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Relationship to Student</th>
<th>Address</th>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First) (Middle) (Suffix)</td>
<td>(<strong><strong>)</strong></strong>___</td>
<td>(<strong><strong>)</strong></strong>___</td>
<td>(<strong><strong>)</strong></strong>___</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Relationship to Student</th>
<th>Address</th>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First) (Middle) (Suffix)</td>
<td>(<strong><strong>)</strong></strong>___</td>
<td>(<strong><strong>)</strong></strong>___</td>
<td>(<strong><strong>)</strong></strong>___</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 rider ☐ 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
Start Date __________ Session __________

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>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PARENT/GUARDIAN SIGNATURE ___________________________ DATE ___________

School Year
Apply online

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 www.schoollunchapp.com. Please allow 2 weeks for processing and benefit information.

For a paper copy or other questions you may contact the Food Service Department by phone at 859-282-2367

"The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) USDA is an equal opportunity provider and employer."
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: ____________________________
BOONE COUNTY SCHOOLS  
Permission to Videotape/Photography/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 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:

<table>
<thead>
<tr>
<th>Height</th>
<th>ft</th>
<th>inches</th>
<th>Weight</th>
<th>BMI</th>
<th>BMI%</th>
<th>B/P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td></td>
<td></td>
<td>Passed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Failed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Referred</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hearing - Right</td>
<td>Passed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Failed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Referred</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hearing - Left</td>
<td>Passed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Failed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Referred</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Optional: Hct/Hgb: ____________________________________________________________________________________________

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: ____________________________
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

<table>
<thead>
<tr>
<th>Unaided Acuity</th>
<th>OD</th>
<th>OS</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best Corrected Acuity</th>
<th>OD</th>
<th>OS</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Signed: ____________________________ Optometrist/Ophthalmologist

Date: ____________________________

Address: ____________________________ Telephone: ( ) ____________________________
Kentucky Dental Screening/Examination Form for School Entry

Kentucky law, KRS 156.160(l), 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.

<table>
<thead>
<tr>
<th>Student Name: _______________________</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth date: <strong>/</strong>/____</td>
<td>Gender: □ 0 Male □ 1 Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent or Guardian: __________________</td>
<td>Name</td>
<td>Relationship</td>
<td></td>
</tr>
<tr>
<td>Address: ___________________________</td>
<td>City: ____________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number: ______________________</td>
<td>School: __________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Exam/Screening <strong>/</strong>/____</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Untreated Decay: (Check one)</th>
<th>Treated Decay: (Check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0 No untreated cavities</td>
<td>□ 0 No treated cavities</td>
</tr>
<tr>
<td>□ 1 Untreated cavities</td>
<td>□ 1 Treated cavities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pattern of Early Childhood Cavities: (Check one)</th>
<th>Treatment Urgency: (Check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0 No Early Childhood Cavities</td>
<td>□ 0 No obvious problem</td>
</tr>
<tr>
<td>□ 1 Early Childhood Cavities Present</td>
<td>□ 1 Early dental care needed</td>
</tr>
<tr>
<td></td>
<td>□ 2 Referral for Urgent Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test Type (check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Screening</td>
</tr>
<tr>
<td>□ Exam</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screener's Name: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screener's Address: __________________</td>
</tr>
<tr>
<td>Phone Number: ______________________</td>
</tr>
<tr>
<td>Screening Date: ____________________</td>
</tr>
<tr>
<td>Screener's Signature: __________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional affiliation: (Please check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Dentist</td>
</tr>
<tr>
<td>□ Dental Hygienist</td>
</tr>
<tr>
<td>□ Physician Assistant</td>
</tr>
<tr>
<td>□ Registered Nurse with training</td>
</tr>
<tr>
<td>□ APRN</td>
</tr>
<tr>
<td>□ Physician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
</table>

OH-12
3/16/2015