WELCOME TO
BOONE COUNTY SCHOOLS
A Distinguished District

Student Name: _________________________________

Registration Date: ____________________________

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

_____ *Student Enrollment/Emergency Information Form

_____ Certified Birth Certificate (within 30 days)

_____ *Immunization Certificate (new students only)

_____ Preventative Health Care Examination Form (within 30 days)

_____ Kentucky Eye Exam (first time entering a public school, for ages 3-6)

_____ Kentucky Dental Screening Form (first time entering a public school, ages 5-6)

_____ *Legal Custody Papers (if applicable)

_____ *Proof of Residency at enrolling address in parent/guardians name
   a. Drivers license
   b. Lease, contract, mortgage, etc.
   c. Utility bill

_____ *Adjudication/Expulsion Affidavit Form (must will check #4 and sign)

_____ Transportation Card (prior to riding bus)

_____ Social Security Card or waiver

_____ Permission to Videotape/Photograph/Publish Release Form

*Required at time of enrollment

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

Legal Name of Student (Please print) [Last] [First] [Middle] [Suffix]

Grade: _____ Date of Birth: ___________ □ Male □ Female SSH (Optional)

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

Birthplace: (Country) ___________ (County) ___________ (State) _______ Phone #: (___)

Student Address: (Street) __________________ (Apartment) _______ (City) ___________ (State) _______ (Zip) _______

□舍 □ Motel □ House or apartment shared with friends or family members □ Friends/Family member

*If applicable, please complete a Residency Questionnaire (704 380 6770)

Student Mailing Address: (if different) __________________ (City) ___________ (State) _______ (Zip) _______

Ethnicity/City: 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 □ Temporary □ Refugee (Country)

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

Last Date Attended: __________________ School Telephone #: (___)

School Address: (City) ___________ (State) _______

Prior Boone County Schools attended and years:

Parents/Guardians Living in Same Household as Student

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

siblings living in same household as student

<table>
<thead>
<tr>
<th>Legal Name: ___________ [Suffix]</th>
<th>Legal Name: ___________ [Suffix]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date _______ Sex: _______ Grade: _______</td>
<td>Birth Date _______ Sex: _______ Grade: _______</td>
</tr>
<tr>
<td>Name of Boone County School: __________________</td>
<td>Name of Boone County School: __________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal Name: ___________ [Suffix]</th>
<th>Legal Name: ___________ [Suffix]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date _______ Sex: _______ Grade: _______</td>
<td>Birth Date _______ Sex: _______ Grade: _______</td>
</tr>
<tr>
<td>Name of Boone County School: __________________</td>
<td>Name of Boone County School: __________________</td>
</tr>
</tbody>
</table>

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: _______ [Suffix] | Relationship to Student: _______ |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: __________________</td>
<td>Phone: Home (<em><strong>) Work: (</strong></em>)</td>
</tr>
<tr>
<td>City: ___________ State: _______ Zip:</td>
<td>Cell Phone: (___) E-Mail: _______</td>
</tr>
</tbody>
</table>

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: _______ [Suffix] | Relationship to Student: _______ |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: __________________</td>
<td>Phone: Home (<em><strong>) Work: (</strong></em>)</td>
</tr>
<tr>
<td>City: ___________ State: _______ Zip:</td>
<td>Cell Phone: (___) E-Mail: _______</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 BCS: ☐ A.M. ☐ P.M. ☐ Both A.M. & P.M. ☐ More Than 1 Mile ☐ Less Than 1 Mile ☐ None Daycare: __________________________

Language

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

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

Medical Information

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

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

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

Physician Name: __________________________ Telephone: __________________________

I give school officials permission to contact the named Health Care Provider: __________________________ [Parent/Guardian Signature]

Emergency Information

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

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

Name: __________________________ Relationship to student __________________________ Telephone No. (___) ___________

Name: __________________________ Relationship to student __________________________ Telephone No. (___) ___________

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

Name: __________________________ Relationship to student __________________________

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

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

Parent/Guardian Signature __________________________ Date: __________________________

Revised 07/2016
Boone County Schools
2020-2021 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 # ______________
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:

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 ____________________________
Kentucky has a statewide immunization registry (KIR) that medical practices use to help keep track of their patient’s immunizations. They use this system to record vaccines given to patients and to access information about their patients’ immunization histories, including vaccines given at other medical offices. KYIR makes it easy to keep track of a patient’s Immunization status, even if the patient visits more than one medical practice. It also helps ensure doctors and nurses give the right vaccines at the right time, and allows them to remind their patients when vaccines are due or overdue.

The information in KYIR is CONFIDENTIAL-only authorized users may access the system. Authorized users include health departments, medical practices, schools, childcare facilities, WIC Programs, and health care plans.

Some records in KYIR may be incomplete or missing because an Immunization was given in another state, or because the medical practice did not enter it into the system. Your child’s school wishes to help improve our community’s records by providing missing Immunization information to KYIR, but requires your permission to do so, in accordance with the Family Educational Rights and Privacy Act (FERPA).

By signing below, you can make your child’s Immunization history more complete, helping to ensure appropriate and timely future Immunization.

Please sign this form if you agree to grant permission for your child’s school to provide your child’s Immunization history to KYIR. This may include creating a new record, or updating an existing record. Please use a separate form for each additional child.

My Name: ____________________________

My Child’s Name: ____________________________

My Child’s Date of Birth: ____________________________

Signature: ____________________________

My Telephone Number: ______________ Date Signed: ______________

Please submit this form to your school administrator/nurse- thank you!
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. (182 IMAR 1:160)

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: ___________________________ Gender: M F Grade: ____________

Date of Birth: _______________ Age: ___ yr ___ months Preferred Language: ____________

Parent or Guardian Name: ____________________________________________________________

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, RPD 330.

MEDICAL HISTORY

Allergies: ____________________________________________________________

______________________________________________________________

Current Prescribed Medications to be taken daily at school: ________________________________

______________________________________________________________

Significant Historical Information: __________________________________________________

______________________________________________________________

SCREENING RESULTS:

Height: ___ ft ___ inches Weight: __________ BMI: __________ BMI%: __________ BP: __________

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right 20/20</th>
<th>Passed</th>
<th>Failed</th>
<th>Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left 20/20</td>
<td>Passed</td>
<td>Failed</td>
<td>Referred</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oculars:</th>
<th>Head/HC:</th>
<th>Lead:</th>
<th>Urinalysis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross dental (teeth and gums)</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Refer/Ex</td>
</tr>
<tr>
<td>Head/Exopthalmos</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Refer/Ex</td>
</tr>
<tr>
<td>Ears/Ears/Neck/Throat</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Refer/Ex</td>
</tr>
<tr>
<td>Chest/Lungs/Heart</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Refer/Ex</td>
</tr>
<tr>
<td>Aidsenren</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Refer/Ex</td>
</tr>
<tr>
<td>Scoliosis assessment</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Refer/Ex</td>
</tr>
</tbody>
</table>

(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 restrictions/adaptation. (Specify reason and restriction)

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☐ SCHOOL READINESS
  • Establish routines
  • Pre- and post-school cultural activities
  • Praise
  • 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 dental visits
  • Brushing/Flossing
  • Fluoride

☐ SAFETY
  • Sexual safety
  • Pedestrian safety
  • Safety belts
  • 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/SPSST Provider

Address: ___________________________  Telephone: ___________________________
KRS 156.160 (1) 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: _______________________________________

Family Ocular and Medical History: Amblyopia, Strabismus, Glaucoma, Diabetes

Other: ____________________________________________________________

Other Patient Information: _____________________________________________

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

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

Type of Examination

Heterophoria (eye and adnexa)
Internal Exam (medial, lateral,alus, etc)
Neurological integrity (pupils)
Pupillary Function (acetone)
Accommodation and convergence
Color Vision

Diagnosis:

□ Normal □ Myopia □ Hyperopia □ Astigmatism □ Strabismus □ Amblyopia

Other: ____________________________________________________________

Recommendations:

□ Glasses prescribed: YES NO

□ □ □

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 Telephone: ( )

Address: ____________________________________________
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.

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender:</td>
<td>□ 0 Male</td>
<td>□ 1 Female</td>
<td></td>
</tr>
<tr>
<td>Parent or Guardian:</td>
<td>Name</td>
<td>Relationship</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
<td>School:</td>
<td></td>
</tr>
<tr>
<td>Date of Exam/Screening:</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>Screener's Signature:</td>
</tr>
<tr>
<td>Professional affiliation: (Please check one)</td>
</tr>
<tr>
<td>□ Dentist</td>
</tr>
<tr>
<td>□ Dental Hygienist</td>
</tr>
<tr>
<td>□ Physician Assistant</td>
</tr>
<tr>
<td>□ LHD Registered Nurse with KIDS Smiles training</td>
</tr>
<tr>
<td>□ APRN</td>
</tr>
<tr>
<td>□ Physician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DH-12</td>
</tr>
</tbody>
</table>
BOONE COUNTY SCHOOLS

PARENTAL CONSENT FOR RECORD RELEASE

To Principal of: ________________________________

(Name of School)

______________________________

(Address)

______________________________

(City, State, Zip)

I am the parent/legal guardian of ________________________________

(Name of Student) (DOB)

You are authorized to:

☐ Release the checked information
☐ Release all information

☐ 1. Cumulative Records
☐ 2. General identifying data (Name, Address, DOB, Grade Level Completed, Grades, Class Standing, Attendance Record)
☐ 3. Standardized Achievement and Aptitude Test Scores
☐ 4. Medical/Health Records
☐ 5. Special Education Due Process File

☐ 6. Gifted File
☐ 7. Title I File
☐ 8. BSS File
☐ 9. Limited English Proficiency/English as Second Language File
☐ 10. Record of Extra-Curricular Activities
☐ 11. Other (Specify) ________________________________

To: __________________________________________

The reason for this request is:

☐ Transfer to school due to change in residence
☐ Other – Specify ________________________________

Signature of Parent or Legal Guardian

Address ________________________________ City ________________________________

Date ________________________________ Phone Number ________________________________
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: ______________________
Home Language Survey

Dear Parent/Guardian:

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

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

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

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

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

**Student Information (required):**

Name: ___________________________  Grade: _________

**Student Language Background (required):**

1. What is the language most frequently spoken at home? ___________________________

2. Which language did your child learn when they first began to talk? ___________________________

3. What language does your child most frequently speak at home? ___________________________

4. What language do you most frequently speak to your child? ___________________________

**Language for School Communication (not required):**

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

**Parent/Guardian Signature:** ___________________________  **Date:** _________

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

---

**For School Use Only**

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

Name: ___________________________  **Date:** _________
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 or may tape the event.

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

As the parent(s)/guardians(s) of ____________________________________________, I/we give the 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) __________________________________

_________________________________________ Date

Parent/Guardian’s Signature

_________________________________________ Date

Parent/Guardian’s Signature

_________________________________________ Date

Principal/Designee’s Signature

Revised 2/2008