Dear Preschool Parent:

Welcome to the Boone County Preschool Program! You are receiving the first step in determining the eligibility of your child for preschool. **It is important to note that our preschools are designed for children who:**

- have a potential for a delay OR
- are eligible based on household income OR
- have a disability/IEP (if your child already has an IEP, there will be no screening necessary)

All potential preschool children must be screened to begin the eligibility process. To have the screening scheduled, we ask that you complete and return the pieces in red as noted below as soon as possible. When we receive this information, we will contact you to schedule a screening time and date for your child.

Please complete the information noted in red below and return to the preschool office at 8270 US Hwy 42 in Florence. **(Please note our building is physically located on Ockerman Drive, the last building on the right, #8270 - Learning Support Services behind Ockerman Elementary School.)** The pieces in black may be submitted after eligibility is determined. You may contact me at 859-334-3794.

**Complete and Return the following:**

- Student Enrollment/Emergency card (both sides)
- Preschool Transportation card (both sides)
- Household Income Verification Form (both sides) and supporting documents
- KY Certification of Immunization, completed by Physician (must be current)
- Copy of Birth Certificate
- Copy of Social Security Card OR Completed Statement of Non-Disclosure of Social Security Number
- Proof of residence (copy of a bill with your address on it)
- Custody or Guardianship Papers (if appropriate)
- Permission to Videotape/Photography/Publish Adjudication form
- Other reports: Speech/language evaluations
- Preventative Health Care Examination Form (both sides) completed by a Physician
- KY Eye Examination Form
- KY Dental Screening/Examination Form
- Copy of Medicaid Card/ Medicaid Release Information Form (if you have one)

The screening is the first step toward eligibility. Based on the outcome of the screening your child may or may not require interventions. This will be further explained to you after the screening has taken place.

Your support in completing and returning the identified pieces is the first important step in providing a high quality preschool program for your child.

Respectfully,

Thomas E. Siler
Preschool Coordinator
Learning Support Services
Boone County School District
8270 US Hwy 42 (mailing address)
8270 Ockerman Drive (physical address, off Hwy 42; last building on right)
Florence, KY 41042
859-334-3794
Boone County Schools
Student Enrollment/Emergency Information

Legal Name of Student (Please Print) ___________________________ (Last) ___________________________ (First) ___________________________ (Middle) ___________________________ (Jr., III, etc) ___________________________ Suffix ___________________________

Grade: _____ Date of Birth: ________ ☐ Male ☐ Female SSN (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) ___________________________

(Check only if applicable) ☐ Shelter ☐ Motel ☐ House or apartment shared with friends or family members ☐ Friends/Family member 

*If applicable, please complete a Residency Questionnaire (704 KAR 7/050)

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

Ethnicity: Is your child Hispanic/Latino? ☐ Yes ☐ No

Student Race: (Check all that apply) ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaskan Native

U.S. Citizen: ☐ Yes ☐ No If no, country of residence: ___________________________ ☐ Migrant ☐ Immigrant ☐ Refugee: (Country) ___________________________

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

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

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

Prior Boone County Schools attended and years: ___________________________

Parents/Guardians Living in Same Household as Student

<table>
<thead>
<tr>
<th>Legal Name: ___________________________ (Last) ___________________________ (First) ___________________________ (Middle) ___________________________ (Jr., III, etc) ___________________________ Suffix: ___________________________</th>
<th>Legal Name: ___________________________ (Last) ___________________________ (First) ___________________________ (Middle) ___________________________ (Jr., III, etc) ___________________________ Suffix: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Student: ___________________________</td>
<td>Relationship to Student: ___________________________</td>
</tr>
<tr>
<td>Phone: Home ( ) Work ( )</td>
<td>Phone: Home ( ) Work ( )</td>
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<tr>
<td>Cell Phone: ( )</td>
<td>Cell Phone: ( )</td>
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<tr>
<td>E-Mail: ___________________________</td>
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</tbody>
</table>

Siblings Living in Same Household as Student

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

<table>
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<th>Legal Name: ___________________________ Suffix: ___________________________</th>
<th>Legal Name: ___________________________ Suffix: ___________________________</th>
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</thead>
<tbody>
<tr>
<td>Relationship to Student: ___________________________</td>
<td>Relationship to Student: ___________________________</td>
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<tr>
<td>Address: ___________________________</td>
<td>Address: ___________________________</td>
</tr>
<tr>
<td>Phone: Home ( ) Work ( )</td>
<td>Phone: Home ( ) Work ( )</td>
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<tr>
<td>Cell Phone: ( )</td>
<td>Cell Phone: ( )</td>
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<tr>
<td>E-Mail: ___________________________</td>
<td>E-Mail: ___________________________</td>
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</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 applies): □ Car Rider □ Walker □ School Bus Bus #: ________ (assigned by school district staff)
Transportation by BCS: □ A.M. □ P.M. □ Both A.M. & P.M. □ More Than 1 Mile □ Less Than 1 Mile □ None Daycare: __________________________

Language

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

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

Medical Information

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

*Per state regulation, any student with a health condition (such as asthma, allergies, diabetes, seizures, etc.) must have a health care 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 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 ___________________________
Emergency Phone Number ___________________________ Father's Work Phone ___________________________
Mother's Work Phone ___________________________ Father's Cell Phone ___________________________
Mother'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 P/IU and D/O, 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 official

AM (pick-up) information:
Bus # ___________________________ Stop Location:_________________________

PM (drop-off) 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 NEEDED

PLEASE WRITE ANY SPECIAL INSTRUCTIONS FOR CONTROLLING STUDENT’S BEHAVIOR, AS NEEDED.

SAFETY IS OUR PRIMARY CONCERN WHEN TRANSPORTING YOUR CHILDREN

PLEASE LIST NAME AND PHONE NUMBER 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</th>
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PARENT/GUARDIAN SIGNATURE ___________________________ DATE ____________

School Year
Dear Parent/Guardian:

Thank you for beginning the process for determining if your child is eligible to attend the state funded preschool program. The state funded preschool program is an intervention program, provided to families who meet income eligibility guidelines and/or whose child is identified with a developmental delay or disability. Each family interested in their child attending the state funded preschool program, based on household income, must complete a household income verification form.

1. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD? You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children and who pay a pro-rated share of expenses), do not include them.

2. 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.

3. WE ARE IN THE MILITARY. DO WE INCLUDE OUR HOUSING ALLOWANCE AS INCOME? If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.

4. MY SPOUSE IS DEPLOYED TO A COMBAT ZONE. IS HIS/HER COMBAT PAY COUNTED AS INCOME? No, if the combat pay is received in addition to his/her basic pay because of his/her deployment and it wasn't received before s/he was deployed, combat pay is not counted as income. Contact your school for more information.

5. WHAT DOCUMENTS CAN I PROVIDE TO VERIFY MY INCOME? Individual Income Tax Form 1040, W-2 forms, pay stubs dated within the last month, written statements from employers, or documentation showing current status of recipients of public assistance.

If you have other questions or need help, call 859-334-3794.

Sincerely,

Thomas E. Siler
Preschool Coordinator
Boone County School District
8270 US Hwy 42 (mailing address)
8270 Ockerman Drive (physical address, off Hwy 42; last building on right)
Florence, KY 41042

Household Income Verification Form for Preschool Eligibility
School Year 2018-2019
Letter to Families
Page 1 of 1
# INSTRUCTIONS FOR APPLYING

**Part 1:** All Household Members (a household member is any child or adult living with you): All applicants should complete this part. List the name of each household member, the name of the school each child attends and the child's grade. If the child is a foster child, check the box for foster child. If a household member has no income, check the box for no income. All household members, including foster children, should be included here. If you need additional space, attach a separate piece of paper.

**IF YOUR CHILD IS HOMELESS, A MIGRANT OR A RUNAWAY, FOLLOW THESE INSTRUCTIONS.**

- **Part 2:** Check the appropriate category.
- **Part 3:** Skip this part.
- **Part 4:** Sign the form.

**IF YOU HAVE FOSTER CHILD(REN) ONLY, FOLLOW THESE INSTRUCTIONS. YOU DO NOT NEED TO FILL OUT A SEPARATE FORM FOR EACH FOSTER CHILD IN YOUR HOUSEHOLD. (IF THERE ARE BOTH FOSTER CHILDREN AND NON-FOSTER CHILDREN IN YOUR HOUSEHOLD, FOLLOW THE INSTRUCTIONS BELOW FOR ALL OTHER HOUSEHOLDS).**

If all children in the household are marked as foster children in Part 1:

- **Part 2:** Skip this part.
- **Part 3:** Skip this part.
- **Part 4:** Sign the form.

**ALL OTHER HOUSEHOLDS,** including WIC households, households with non-foster children and households with both foster children and non-foster children, follow these instructions:

- **Part 2:** Skip this part.
- **Part 3:** Follow these instructions to report total household income from this month or last month.
  
  - **Section 1—Name:** List all household members who have income.
  
  - **Section 2—Gross Income and How Often It Was Received:** List the income for each household member. Check the box to tell us how often the person receives the income—weekly, every other week, twice a month, or monthly.
    
    - **Earnings from work:** List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. Net income should only be reported for self-owned business, farm, or rental income.
    
    - **Welfare, Child Support, Alimony:** List the amount each person receives and check the box to tell us how often.
    
    - **Pensions, Retirement, Social Security, Supplemental Security Income (SSI), Veteran’s benefits (VA benefits) and disability benefits:** List the amount each person receives and check the box to tell us how often they receive it.
    
    - **All Other Income:** List Worker’s Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household and any other income received weekly, every other week, twice a month or monthly. Do not include income from KTAP, SNAP, WIC, federal education benefits and foster care payments received by your family from the placing agency.
    
    - **If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.**

- **Part 4:** An adult household member must sign the form. Please include your address and phone number in the event the Preschool Coordinator has a question about your information.

---

**Household Income Verification Form for Preschool Eligibility**

School Year 2018-2019

Instructions for Completing

Page 1 of 1
HOUSEHOLD INCOME VERIFICATION FORM

The State Funded Preschool Program is available to children who are 4 years old on or before August 1 and whose family income is 160% poverty or less; and children who are 3 or 4 years old with an identified disability. To determine income eligibility, please complete, sign and return this application to Tom Siler along with other completed paperwork.

PART 1. ALL HOUSEHOLD MEMBERS

<table>
<thead>
<tr>
<th>Names of all people living in your household (First, Middle Initial, Last)</th>
<th>School the child attends, or indicate “NA” if household member is not in school</th>
<th>Grade Level</th>
<th>Check if a foster child (legal responsibility of welfare agency or court) if all children listed below are foster children, skip to Part 4 to sign this form.</th>
<th>Check if NO income</th>
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PART 2. HOMELESS, MIGRANT, RUNAWAY STATUS

IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT OR A RUNAWAY, CHECK THE APPROPRIATE BOX.

HOMELESS ☐ MIGRANT ☐ RUNAWAY ☐

PART 3. TOTAL HOUSEHOLD GROSS INCOME (BEFORE DEDUCTIONS). List all income on the same line as the person who receives it. Check the box for how often it is received. RECORD EACH INCOME ONLY ONCE.

1. NAME
(List only household members with income)

2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED

<table>
<thead>
<tr>
<th>Earnings from work before deductions.</th>
<th>Weekly</th>
<th>Every 2 Weeks</th>
<th>Monthly</th>
<th>Welfare, child support, alimony</th>
<th>Weekly</th>
<th>Every 2 Weeks</th>
<th>Monthly</th>
<th>Pensions, retirement, Social Security, SSI, VA benefits</th>
<th>Weekly</th>
<th>Every 2 Weeks</th>
<th>Monthly</th>
<th>All Other income (indicate frequency, such as “weekly” “every 2 weeks”, “monthly”)</th>
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</thead>
<tbody>
<tr>
<td>(Example) Jane Smith</td>
<td>$200</td>
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</table>

PART 4. SIGNATURE (ADULT HOUSEHOLD MEMBER MUST SIGN)

An adult household member must sign the form.

I certify (promise) that all information on this form is true and that all income is reported. I understand that the school will get state and federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose benefits.

Sign here: ___________________________________________ Print name: ___________________________________________ Date: __________________________

Address: ___________________________________________ City: ___________________________ State: __________ Zip Code: __________

Phone Number: ______________________________________ Cell Phone Number: ___________________________

Household Income Verification Form for Preschool Eligibility
School Year 2018-2019
Household and Income Data
Page 1 of 2
Privacy Notice
The Kentucky Department of Education is requiring schools to collect the information on this form. You do not have to give this information, but if you do not, we cannot determine your child’s eligibility for additional benefits under state and federal programs. We will hold the information you provide us as private and confidential to the extent required by law. However, we will share your socioeconomic status with various state and federal programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

Non-Discrimination Statement: In accordance with Federal Law and U.S. Department of Education policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write U.S. Department of Education, Office for Civil Rights, The Wanamaker Building, 100 Penn Square East, Suite 515, Philadelphia, PA 19107-3323 or call (215) 656-8541 (Voice). Individuals who are hearing impaired or have speech disabilities may contact U.S. DOE through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). The U.S. Department of Education is an equal opportunity provider and employer.

CHECKLIST

☐ Have you included all your children as household members?
☐ For each household member receiving income, is the frequency checkbox checked?
☐ Have you signed the application?

DO NOT FILL OUT THIS PART. THIS IS FOR SCHOOL USE ONLY.

Annual Income Conversion: Weekly x 52; Every 2 Weeks x 26; Twice A Month x 24; Monthly x 12

Total Income: __________ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice A Month ☐ Month ☐ Year Household size: ______

Eligibility: 160% poverty ☐ Special Education ☐ Head Start ☐ Over Income ☐

Reason (160% poverty; Special Education; Head Start (if applicable); Over Income): ____________________________________________

Preschool Coordinator: ________________________________________ Date: __________

Secondary Signature: _________________________________________ Date: __________
STATEMENT OF NON-DISCLOSURE OF SOCIAL SECURITY NUMBER

DATE: ____________________________

PARENT NAME AND ADDRESS: ____________________________________________

_____________________________________________________________________

_____________________________________________________________________

SCHOOL ATTENDING: _____________________________________________________

STUDENT NAME: ____________________________ DÔB: ________________________

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 SS# 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

2018-2019

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)/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

Revised 8/2007
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>BP: _______</th>
<th>Height: _______(ft) _______(inches)</th>
<th>Weight ______ lbs</th>
<th>BMI ______</th>
<th>BMI% ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>Passed</td>
<td>Failed</td>
<td>Referred</td>
<td>Hearing - Right</td>
</tr>
<tr>
<td>Right 20/20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left 20/20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Optional: Hct/Hgb: ___________________________ Lead: ___________________________ Urinalysis: ___________________________

General appearance: Normal □ Abnormal □ Refer/Tx: ___________________________

Gross dental (teeth and gums): Normal □ Abnormal □ Refer/Tx: ___________________________

Hair/scalp/skin: Normal □ Abnormal □ Refer/Tx: ___________________________

Eyes/Ears/Nose/Throat: Normal □ Abnormal □ Refer/Tx: ___________________________

Chest/Lungs/Heart: Normal □ Abnormal □ Refer/Tx: ___________________________

Abdomen/Genitalia: Normal □ Abnormal □ Refer/Tx: ___________________________

Extremities/back: Normal □ Abnormal □ Refer/Tx: ___________________________

Neuro: 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  Telephone: ____________________________

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:  Astigmatism  Strabismus  Glaucoma  Diabetes

Other: __________________________

Other Pertinent Information: __________________________

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

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

Type of Examination

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Notable to Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Exam (eye and adnexa)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Exam (media, lens, fundus, etc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological Integrity (pupils)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binocular Function (stereopsis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation and convergence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Color Vision</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Diagnosis:

 Normal  Myopia  Hyperopia  Astigmatism  Strabismus  Amblyopia

Other: __________________________

Recommendations:

1 Glasses prescribed:  YES  NO

2 __________________________

3 __________________________

Age appropriate and suggested anticipatory guidance (health assessments):

 Educate (parents/patients) about eye/vision disorders and needed vision care

 Counsel (parents/patients) regarding eye safety

 Stress importance of early, preventative eye care

 Recommend re-examination, as appropriate

Signed: __________________________ Date: __________________________

Optometrist/Ophthalmologist

Address: __________________________ Telephone: ( ) __________________________
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.

<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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent or Guardian:</th>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Exam/Screening:</td>
<td></td>
<td></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>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Screener's Address:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td>Screening Date:</td>
</tr>
<tr>
<td>Screener's Signature:</td>
<td></td>
</tr>
</tbody>
</table>

Professional affiliation: (Please check one)
- □ Dentist
- □ Dental Hygienist
- □ Physician Assistant
- □ LHD Registered Nurse with KIDS Smiles training
- □ APRN
- □ Physician

<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>

Pattern of Early Childhood Cavities: (Check one)
- □ 0 No Early Childhood Cavities
- □ 1 Early Childhood Cavities Present

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

Comments:

NOTE: Comment required if marked.

OH-12