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 *(must be 4 years old by August 1 for income consideration)* 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,

[Signature]

Dr. Michael J. Shires
Director of Preschool Services
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) ____________________________ Suffix ________

Grade: ______ Date of Birth: ___________ ☐ Male ☐ Female  SS# (Optional): ______

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

Birthplace: (Country) ____________________________ (State) ______ Phone #: ( ) ______

Student Address: (Street) ____________________________ (City) ______ (State) ______ (Zip) ______

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: ____________________________

Last School Attended: ____________________________

Last Date Attended: ____________________________

School Address: (City) ____________________________ (County) ______ (State) ______

Prior Boone County Schools attended and years: ____________________________

Parents/Guardians Living in Same Household as Student

| Legal Name: ____________________________ Suffix: ________ | Legal Name: ____________________________ Suffix: ________ |
| Relationship to Student: ____________________________ | Relationship to Student: ____________________________ |
| Phone: Home ( ) Work: ( ) | Phone: Home ( ) Work: ( ) |
| Cell Phone: ( ) | Cell Phone: ( ) |
| E-Mail: | E-Mail: |

Siblings Living in Same Household as Student

| Legal Name: ____________________________ Suffix: ________ | Legal Name: ____________________________ Suffix: ________ |
| Birth Date ____________ Sex: ______ Grade: ____________ | Birth Date ____________ Sex: ______ Grade: ____________ |
| Name of Boone County School: ____________________________ | Name of Boone County School: ____________________________ |

| Legal Name: ____________________________ Suffix: ________ | Legal Name: ____________________________ Suffix: ________ |
| Birth Date ____________ Sex: ______ Grade: ____________ | Birth Date ____________ Sex: ______ Grade: ____________ |
| Name of Boone County School: ____________________________ | Name of Boone County School: ____________________________ |

Parents/Guardians Living at an Address Different from Student

| Does this parent/guardian have joint custody? | Does this parent/guardian have joint custody? |
| Should this parent/guardian receive school information? | Should this parent/guardian receive school information? |
| Is this person legally restricted access to this student? | Is this person legally restricted access to this student? |
| (A copy of the court order MUST be provided to the school.) | (A copy of the court order MUST be provided to the school.) |
| Legal Name: ____________________________ Suffix: ________ | Legal Name: ____________________________ Suffix: ________ |
| Relationship to Student: ____________________________ | Relationship to Student: ____________________________ |
| Address: | Address: |
| City: ____________ State: ______ Zip: ______ | City: ____________ State: ______ Zip: ______ |
| Phone: Home ( ) Work: ( ) | Phone: Home ( ) Work: ( ) |
| Cell Phone: ( ) | Cell Phone: ( ) |
| E-Mail: | E-Mail: |
Special Services
Does this student have special needs, or receive special education services? □ Yes □ No
Does this student have a 504 plan? □ Yes □ No Does this student receive Title I services? □ Yes □ No
Does this student receive services for speech? □ Yes □ No
Has this student been formally identified as Gifted/Talented? □ Yes □ No

Transportation
Primary Transportation to School (check all that applies): □ Car Rider □ Walker □ School Bus Bus #: _______ (assigned by school district staff)
Transportation by BCS: □ A.M. □ P.M. □ Both A.M & P.M. □ More Than 1 Mile □ Less Than 1 Mile □ None Daycare: __________________________

Language
Is English most frequently spoken in the home? ___ Yes ___ No, what language? __________________________
Did your child learn English when he/she first began to talk? ___ Yes ___ No, what language? __________________________
Does your child most frequently speak English at home? ___ Yes ___ No, what language? __________________________
Is English most frequently spoken to the child at home? ___ Yes ___ No, what language? __________________________
(If any answers above are other than English, please complete the "Home Language Survey")

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

*Per state regulation, any student with a health condition (such as asthma, allergies, diabetes, seizures, etc.) must have a health care 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

Name of Student

Parent(s)

Home Address

Emergency Phone Number

Mother’s Work Phone

Mother’s Cell Phone

Special Bus Equipment needed: Wheelchair Lift  Other

Date of Birth

Home Phone

City

Father’s Work Phone

Father’s Cell Phone

EMERGENCY MEDICAL INFORMATION:

Student’s Doctor

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.

School Year
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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<tbody>
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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 wishing for their child to attend the state funded preschool program must complete a household and income 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 me at 859-334-3794 or my assistant, Angie Becknell at 859-282-2619.

Sincerely,

Dr Michael J. Shires
Director of Preschool Services
Boone County School District
8270 US Hwy 42 (mailing address)
8270 Ockerman Drive (physical address, off Hwy 42; last building right - behind Ockerman Elementary School)
Florence, KY 41042

*Household and Income Form for Preschool Eligibility*
School Year 2019-2020
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.
     o 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.
     o Welfare, Child Support, Alimony: List the amount each person receives, and check the box to tell us how often.
     o 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.
     o 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 payments received by your family from the placing agency.
     o 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 AND INCOME 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, the program is available to children who are 3 or 4 years old with an identified disability. To determine income eligibility, please complete, sign and return this application to: Dr. Michael Shires, Director of Preschool Services at Boone County School District.

**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>Indicate if 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>Indicate 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>Weekly</th>
<th>Every 2 Weeks</th>
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<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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<tr>
<td>(Example) Jane Smith</td>
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Household and Income Form for Preschool Eligibility  
School Year 2019-2020  
Letter to Families  
Page 1 of 2
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: ____________________

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.

Check List

1. Have you included all your children as household members?
2. For each household member receiving income, is the frequency indicated?
3. 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: ____________________

Household and Income Form for Preschool Eligibility
School Year 2019-2020
Letter to Families
Page 2 of 2
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."
BOONE COUNTY SCHOOLS FREE AND REDUCED PRICE MEALS

Dear Parent/Guardian:
Children need healthy meals to learn. Boone County School offers healthy meals every school day. Breakfast costs $1.00; lunch costs $2.25 for elementary and $2.50 for middle and high school students. Your children may qualify for free meals or for reduced-price meals. Reduced-price is $0.00 for breakfast and $0.00 for lunch. This packet includes an application for free or reduced-price meal benefits, as well as a set of detailed instructions. Below are some common questions and answers to help you with the application process.

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

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Yearly Income</th>
<th>Monthly Income</th>
<th>Weekly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$23,107</td>
<td>$1,926</td>
<td>$445</td>
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<tr>
<td>2</td>
<td>$31,284</td>
<td>$2,607</td>
<td>$602</td>
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<tr>
<td>3</td>
<td>$39,461</td>
<td>$3,289</td>
<td>$759</td>
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<tr>
<td>4</td>
<td>$47,638</td>
<td>$3,970</td>
<td>$917</td>
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<tr>
<td>5</td>
<td>$55,815</td>
<td>$4,652</td>
<td>$974</td>
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<tr>
<td>6</td>
<td>$63,992</td>
<td>$5,333</td>
<td>$1,231</td>
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<tr>
<td>7</td>
<td>$72,169</td>
<td>$6,015</td>
<td>$1,388</td>
</tr>
<tr>
<td>8</td>
<td>$80,346</td>
<td>$6,696</td>
<td>$1,546</td>
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<tr>
<td>Each additional person:</td>
<td>+$8,177</td>
<td>+$682</td>
<td>+$158</td>
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</table>

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

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

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

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

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

7. MY CHILD'S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT ANOTHER ONE? Yes. Your child's application is only good for that school year and for the first few days of this school year through September 25, 2019. You must send in a new application unless the school told you that your child is eligible for the new school year.
year. If you do not send in a new application that is approved by the school or you have not been notified that your child is eligible for free meals, your child will be charged the full price for meals.

8. I GET WIC. CAN MY CHILD(REN) GET FREE MEALS? Children in households participating in WIC may be eligible for free or reduced-price meals. Please fill out an application.

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

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

11. WHAT IF I DISAGREE WITH THE SCHOOL'S DECISION ABOUT MY APPLICATION? You should talk to school officials. You also may ask for a hearing by writing to Barbara Kincalid, 8830 US Hwy 42, Florence, KY 41042 or calling 859-282-2367.

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

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

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

15. WHAT IF SOME HOUSEHOLD MEMBERS HAVE NO INCOME TO REPORT? Household members may not receive some types of income we ask you to report on the application, or may not receive income at all. Whenever this happens, please write a 0 in the field. However, if any income fields are left empty or blank, those will also be counted as zeroes. Please be careful when leaving income fields blank, as we will assume you meant to do so.

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

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

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

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

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and mail to U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.
STATEMENT OF NON-DISCLOSURE OF SOCIAL SECURITY NUMBER

DATE: ____________________________

PARENT NAME AND 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 (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

2019 - 2020

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
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. (792 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:

BP: _______ Height: _______ (ft.) _______ (inches) Weight: _______ lbs. BMI: _______ BMI%: _______

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right 20/_______</th>
<th>Passed</th>
<th>Failed</th>
<th>Referred</th>
<th>Hearing - Right</th>
<th>Passed</th>
<th>Failed</th>
<th>Referred</th>
<th>Hearing - Left</th>
<th>Passed</th>
<th>Failed</th>
<th>Referred</th>
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<td>Left 20/_______</td>
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Optional: Hct/Hgb: ____________________________________________

Lead: ____________________________________________ Urinalysis: ____________________________________________

General appearance: Normal Abnormal Refer/Tx:

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

Head/scalp/skin: Normal Abnormal Refer/Tx:

Eyes/Ear/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

☐ ORAL HEALTH
  • 60 minutes of exercise/day
  • Regular dentist visits
  • Brushing/Flossing
  • Fluoride

☐ SAFETY
  • Sexual safety
  • Pedestrian safety
  • Safety helmets
  • Swimming safety
  • Fire escape plan
  • Smoke/carbon monoxide detectors
  • Guns
  • Sun
  • Appropriately restrained in all vehicles

Additional comments or recommendations:


Signed: ____________________________  Date: __________
Physician/APRN/PA/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>
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</thead>
<tbody>
<tr>
<td>20/20</td>
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<table>
<thead>
<tr>
<th>Type of Examination</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Notable to Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Exam (eye and adnex)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Exam (media, lens, fundus, etc)</td>
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<td></td>
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<tr>
<td>Neurological integrity (pupils)</td>
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<tr>
<td>Binocular Function (stereopsis)</td>
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<td></td>
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<tr>
<td>Accommodation and convergence</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Color Vision</td>
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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: ___________________________ 

Optometrist/Ophthalmologist

Date: ___________________________

Address: ___________________________

Telephone: ( )
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>
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<th>Test Type (check one)</th>
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<tbody>
<tr>
<td></td>
<td>□ Screening</td>
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<tr>
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<td>□ Exam</td>
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<thead>
<tr>
<th>Parent or Guardian: ____________________________</th>
<th>Screener’s Name: ____________________________</th>
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<tbody>
<tr>
<td>Name: _________________________________________</td>
<td>Screener’s Address: ____________________________</td>
</tr>
<tr>
<td>Relationship: ____________________________</td>
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<th>Address: ____________________________</th>
<th>City: ____________________________</th>
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</thead>
<tbody>
<tr>
<td>Phone Number: ________________________</td>
<td>School: ________________________</td>
</tr>
<tr>
<td>Date of Exam/Screening <em><strong>/</strong></em>/______</td>
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<thead>
<tr>
<th>Untreated Decay: (Check one)</th>
<th>Treated Decay: (Check one)</th>
<th>Treatment Urgency: (Check one)</th>
<th>Comments:</th>
</tr>
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<tbody>
<tr>
<td>□ 0 No untreated cavities</td>
<td>□ 0 No treated cavities</td>
<td>□ 0 No obvious problem</td>
<td></td>
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<tr>
<td>□ 1 Untreated cavities</td>
<td>□ 1 Treated cavities</td>
<td>□ 1 Early dental care needed</td>
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<tr>
<th>Pattern of Early Childhood Cavities: (Check one)</th>
<th>Treatment Urgency: (Check one)</th>
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</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>
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<tr>
<td></td>
<td>□ 2 Referral for Urgent Care</td>
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<td>NOTE: Comment required if marked.</td>
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OH-12

3/16/2015