BOONE COUNTY SCHOOLS
Student Transportation Form

School Name:_____ Code:_____ School Year:_____

Student Name:_____ D.O.B. _____

Gender: _____ Grade:_____

Home Address:

Street Address:_____

City/State/Zip:_____

Parent/Guardian:_____ Relationship:_____

Home Phone: _____ Cell Phone:_____

Emergency Contact:

Contact Name:_____

Relationship: _____

Home Phone: _____ Cell Phone:_____

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/U 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:_____

This form must be filled out completely and turned into the school office with other enrollment documentation.
Revised 03/09/09

Commonwealth of Kentucky
Kentucky Department of Education
Boone County Board of Education

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

2013-2014 Boone County Schools
Student Enrollment/Emergency Information

Office Use Only
School: _____
Start Date: _____
Teacher: _____

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

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

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 (other than parent/guardian)
If applicable, please complete a Residency Questionnaire (704 KAR 7:090)

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

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) _____

Race/Ethnic Group Categories
- White (not Hispanic)-A person having origins in any of the original peoples of Europe, North Africa. or the Middle East
- Black/African American (not Hispanic)-A person having origins in any of the black racial groups of Africa
- Hispanic/Latino-A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture of origin regardless of race
- Asian-A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.
- Pacific Islander-A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- American Indian or Alaskan Native-A person having origins in any of the original peoples of North & South America and who maintains culture identification through tribal affiliation or community attachment.

Parents/Guardians Living in Same Household as Student

Legal Name: _____ _____ _____ Suffix:____
(Last) First) (M. I.)
Relationship to Student: _____
Phone: Home (__)_____ Work: (__)_____
Cell Phone: (__)_____ E-Mail : _____
Place of Employment: _____
Occupation: _____DOB_____

Legal Name: _____ _____ _____ Suffix:____
(Last) First) (M. I.)
Relationship to Student: _____
Phone: Home (__)_____ Work: (__)_____
Cell Phone: (__)_____ E-Mail : _____
Place of Employment: _____
Occupation: _____DOB_____

Siblings Living in Same Household as Student

Legal Name: _____ Suffix: _____
Birth Date _____ Sex: _____ Grade: _____
Name of Boone County School:_____

Legal Name: _____ Suffix: _____
Birth Date _____ Sex: _____ Grade: _____
Name of Boone County School:_____

Legal Name: _____ Suffix: _____
Birth Date _____ Sex: _____ Grade: _____
Name of Boone County School:_____

Legal Name: _____ Suffix: _____
Birth Date _____ Sex: _____ Grade: _____
Name of Boone County School:_____

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: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home (__)_____Work: (__)_____
Cell Phone: (__)_____ E-Mail: _____
Place of Employment: _____DOB_____

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: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home (__)_____Work: (__)_____
Cell Phone: (__)_____ E-Mail: _____
Place of Employment: _____DOB_____

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 1 services? ☐ 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: _____

Office Use Only

New Enrollment _____
Revised Enrollment _____
Office Personnel _____
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 INDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____ **Gender: M F Grade:** _____

Date of Birth: _____ **Age:** _____ **yrs** _____ **months Preferred Language:** _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies: _____

_____

_____

_____

Current Prescribed Medications to be taken daily at school: _____

_____

_____

_____

Significant Historical Information: _____

_____

_____

_____

SCREENING RESULTS:

Height: _____ **ft** _____ **inches** _____ **Weight** _____ **BMI:** _____ **BMI%** _____ **B/P:** _____

Vision	**Right 20/_____**	**Passed** ☐ **Failed** ☐ **Referred** ☐	**Hearing – Right**	**Passed** ☐	**Failed** ☐	**Referred** ☐
	Left 20/_____		**Hearing - Left**	**Passed** ☐	**Failed** ☐	**Referred** ☐

Optional: Hct/HGB: _____ **Lead:** _____ **Urinalysis:** _____

Gross dental (teeth and gums)	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Head/scalp/skin	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Eyes/Ears/Nose/Throat	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Chest/Lungs/Heart	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Abdomen	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Scoliosis assessment	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____

(Over)

This child has the following problems that may impact the educational experience:

☐ **Vision** ☐ **Hearing** ☐ **Speech/Language** ☐ **Physical** ☐ **Social/Behavioral** ☐ **Cognitive**

Specify: _____

_____

☐ **This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.**

_____

Recommendations (Attach additional sheet if necessary): _____

_____

(Please Check One)

☐ **This child may participate fully in school activities including physical education.**

☐ **This child may participate in school activities including physical education with the following restriction/adaptation.**

(Specify reason and restriction) _____

_____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☐ **SCHOOL READINESS**
- **Establish routines**
- **After-school care/activities**
- **Friends**
- **Bullying**
- **Communicate with teachers**

☐ **MENTAL HEALTH**
- **Family time**
- **Anger management**
- **Discipline for teaching not punishment**
- **Limit TV, computer**

☐ **NUTRITION AND PHYSICAL ACTIVITY**
- **Healthy weight**
- **Well-balanced diet, including breakfast**
- **Fruits, vegetables, whole grains, dairy**
- **60 minutes of exercise/day**

☐ **ORAL HEALTH**
- **Regular dentist visits**
- **Brushing/Flossing**
- **Fluoride**

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

Additional comments or recommendations: _____

_____

_____

_____

_____

_____

Signed: _____ **Date:** _____

Physician/APRN/PA/EPSDT Provider

Address: _____ **Telephone:** _____

KDE/DSS **Kentucky Eye Examination Form for School Entry** **KDESHS004**

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

	OD	OS
Unaided Acuity	20/	20/
Best Corrected Acuity	20/	20/

Type of Examination	Normal	Abnormal	Notable to Assess
External Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

Diagnosis:

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: ☐ YES ☐ NO
2 _____
3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

- ☐ Educate (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: ( ) _____

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

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. ESS 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

OAS/DSS **Kentucky Dental Screening/Examination Form for School Entry** **KDESHS005**

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.

Student Name: _____
Last First Middle

Birth date: _____/_____/_____ Gender: ☐ 0 Male ☐ 1 Female

Parent or Guardian:_____
Name Relationship

Address:_____ City: _____

Phone Number:_____ School:_____

Date of Exam/Screening _____/_____/_____

Test Type (check one)

☐ Screening

☐ Exam

Screener's Name: _____

Screener's Address: _____

_____

Phone Number:_____Screening Date:_____

Screener's Signature:_____

Professional affiliation: (Please check one)

☐ Dentist ☐ Dental Hygienist

☐ Physician Assistant ☐ LHD Registered Nurse with KIDS Smiles training

☐ APRN ☐ Physician

Untreated Decay: (Check one)

☐ 0 No untreated cavities

☐ 1 Untreated cavities

Treated Decay: (Check one)

☐ 0 No treated cavities

☐ 1 Treated cavities

Pattern of Early Childhood Cavities: (Check one)

☐ 0 No Early Childhood Cavities

☐ 1 Early Childhood Cavities Present

Treatment Urgency: (Check one)

☐ 0 No obvious problem

☐ 1 Early dental care needed

☐ 2 Referral for Urgent Care
NOTE: Comment required if marked.

Comments:

Boone County Schools

Permission to Videotape/Photography/Publish

2013-2014

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*

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***