MONTGOMERY COUNTY SCHOOLS

Student Registration Form

Date_____ Grade_____

School_____ Homeroom Teacher_____

PERSONAL INFORMATION

Student's Legal Name: _____ / / __

(Last) (First) (Middle) SS# (optional)

Residence Address: _____

(Street) (Apt. #) (City) (Zip Code)

Mailing Address (if different from residence):_____

(Include P.O. Box # if applicable)

Home Phone: _____ **Birth Date:** _____ **Age:** _____ **Sex:** ☐ M ☐ F

Ethnicity: *Select one* ☐ Hispanic ☐ Non-Hispanic

Race: *Select all that apply* ☐ Caucasian/White ☐ African American/Black ☐ Asian

☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander

Last School Attended: _____ **City/ State:** _____

Has your child been diagnosed with a disability or special need? ___Y ___N - If yes please provide name of diagnosis, date, where diagnosed, and any additional information helpful for your child _____

_____

_____ _____

Person Completing this form – Must be parent or legal guardian (*please print*) **Date Completed**

FAMILY INFORMATION: PLEASE PROVIDE THE FOLLOWING INFORMATION:

Student Lives With: (check all that apply)

☐ Mother/Father ☐ Mother ☐ Father ☐ Grandparents ☐ Guardian

☐ Foster Parents ☐ Stepfather/Mother ☐ Stepmother/Father ☐ Other

Biological/Adoptive Parent Information:	**Biological/Adoptive Parent Information:**	**Legal Guardian (if not biological/adoptive parent)**
Name:_____	Name:_____	Name:_____
Address:_____	Address:_____	Address:_____
_____	_____	_____
Cell Phone:_____	Cell Phone:_____	Cell Phone:_____
Work Place:_____	Work Place:_____	Work Place:_____
Work Phone:_____	Work Phone:_____	Work Phone:_____
Email:_____	Email:_____	Email:_____
Step parent (if applicable):_____	Step parent (if applicable):_____	Step parent (if applicable):_____
_____	_____	_____

CONTINUE ON BACK

It is the responsibility of the parent or guardian to provide accurate information and to inform the school as changes occur to the information on this document.

VERY IMPORTANT - Please List ALL children living in the household- use separate sheet to list additional children if needed

Name	Birthdate	School Attending (if applicable)

REQUIRED CONTACT INFORMATION – List at least two contacts (OTHER THAN PARENTS) who may pick up your child in the event you cannot be reached:

Name:_____Phone:_____Alt. Phone: _____

Name:_____Phone:_____Alt. Phone: _____

Name:_____Phone:_____Alt. Phone: _____

Name:_____Phone:_____Alt. Phone: _____

Parent/Guardian signature_____ Date_____

Pick up restrictions: (Note: If biological parent(s) is restricted, court documentation is required to be on file at the school.)

BUS RIDER INFORMATION

In general as a matter of routine:

I ride the bus twice daily ___Yes ___No

I ride the bus once daily ___Yes ___No

I do not ride the bus ___Yes ___No

If known:

Bus number that picks you up_____ Bus number that drops you off_____

STUDENT RESIDENCY STATEMENT

This form is intended to address the requirements of the McKinney-Vento Act (Title X, Part C of the No Child Left Behind Act). The questions below are to assist in determining if the student meets the eligibility criteria for services provided under the McKinney-Vento Act. **Information provided on this form is confidential.**

Where does the student stay at night:

- ☐ In a shelter (family shelter, domestic violence shelter, or transitional living program);
- ☐ In a motel, hotel, or weekly-rate housing;
- ☐ In a house with parent(s);
- ☐ In a house or apartment with more than one family because of economic hardship or loss;
- ☐ In an abandoned building, a car, at a campground, or on the street;
- ☐ In a temporary foster care or with an adult who is not the parent or legal guardian;
- ☐ In substandard housing (no electricity, no water, and/or no heat);
- ☐ With friends or family because student is a runaway or unaccompanied youth; or
- ☐ Other (please specify):_____

I certify the above named student qualifies for the child Nutrition Program under the provisions of the McKinney-Vento Act.

Date: _____ McKinney-Vento Liaison Signature: _____

It is the responsibility of the parent or guardian to provide accurate information and to inform the school as changes occur to the information on this document.

Revised 3/28/19

Montgomery County School District

HOME LANGUAGE SURVEY

Student Name: _____ Birth Date: _____ Sex: ❑ Male ❑ Female

Parent/Guardian Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

School: _____ Grade: _____ Date: _____

Federal and state laws require the following information be collected about the primary and home language of every student upon enrollment in the school district. Please complete a survey for each child you are enrolling in the school district.

1. What language did your child learn when he/she first began to talk? _____

2. What language does your child most frequently speak at home? _____

3. What language is spoken by you and your family most of the time at home? _____

If a language other than English is indicated for any of the above questions, the school district will test your child's English language proficiency to determine eligibility for initial and continuing placement in an English language development program. You will be notified about the results of this testing.

4. If available, in what language would you prefer to receive information from the school? _____

_____ _____

Parent or Guardian's Signature Date

OFFICE USE ONLY			
Student ID #	Date Distributed	Date Received	

Publication Consent Form

School _____

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 public awareness or fund-raising purposes. 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 posting a likeness of your child on the school or District Web site.

Under 09.14 AP.12, the District has designated student photographs as "directory information." Consistent with that annual notice, a photograph of an individual student may be released to others and/or reproduced in school yearbooks as long as the parent or adult student has not submitted written notice (by returning form 09.14 AP.12) indicating that they do not wish photographs of the student to be released.

This form covers permission for the District to record and use the recorded image, voice, or work of the student (photographed, filmed, taped, or digitally recorded) for public awareness purposes, including publication on the school and/or District's web site and in school yearbooks.

Please review this form carefully, sign and date the form, and submit the form to the school.

Once signed and dated, this form shall remain in effect for your child's enrollment in any of our 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 (*PLEASE PRINT*)

Montgomery County School District permission to release my/our child's name, photograph, and/or audio/video reproduction for publication to the general public concerning school functions and activities, including academic and athletic activities.

Name of Parent(s)/Guardian(s) (**PLEASE PRINT**) _____

_____ _____

Parent/Guardian's Signature ***Date***

NOTE: If the recorded image, voice, or work of a student is to be included in a publication as part of a commercial or for-profit fund-raising endeavor, affirmative authorization of the parent/guardian or eligible student must be obtained.

Review/Revised:7/26/2016

Electronic Access/User Agreement Forms

AUP FORM FOR STUDENTS

STUDENT'S NAME (LAST) _____ **(FIRST)** _____ **(INITIAL)** _____

STUDENT'S ADDRESS _____

STUDENT'S AGE ____ **DATE OF BIRTH** _____ **SEX** ___ **PHONE NUMBER** _____

SCHOOL _____

GRADE _____ **HOMEROOM/CLASSROOM** _____

As a user of the **Montgomery County School District's** computer network, I hereby agree to comply with the District's Internet and electronic mail rules and to communicate over the network in a responsible manner while abiding by all relevant laws and restrictions. I further understand that violation of the regulations is unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked and school disciplinary action and/or legal action may be taken.

Student's Signature _____ Date _____

Prior to the student's being granted independent access privileges, the following section must be completed for students under 18 years of age:

As the parent or legal guardian of the student (under 18) signing above, I grant permission for my child to access networked computer services such as electronic mail and the Internet. I understand that this access is designed for educational purposes; however, I also recognize that some materials on the Internet may be objectionable, and I accept responsibility for guidance of Internet use by setting and conveying standards for my child to follow when selecting, sharing, researching, or exploring electronic information and media.

CONSENT FOR USE

By signing this form, you hereby accept and agree that your child's rights to use the electronic resources provided by the District and/or the Kentucky Department of Education (KDE) are subject to the terms and conditions set forth in District policy/procedure. Please also be advised that data stored in relation to such services is managed by the District pursuant to policy 08.2323 and accompanying procedures. You also understand that the e-mail address provided to your child can also be used to access other electronic services or technologies that may or may not be sponsored by the District, which provide features such as online storage, online communications and collaborations, and instant messaging. Use of those services is subject to either standard consumer terms of use or a standard consent model. Data stored in those systems, where applicable, may be managed pursuant to the agreement between KDE and designated service providers or between the end user and the service provider. Before your child can use online services, he/she must accept the service agreement and, in certain cases, obtain your consent.

Name of Parent/Guardian (Please print) _____

Signature of Parent/Guardian _____

STUDENTS: Return this form to your school.

Review/Revised:4/26/2016

MONTGOMERY COUNTY SCHOOL HEALTH UNIT CONSENT FOR SERVICES 2019-20

Student Name: _____ Grade: ____ School: _____

The School Health Unit will provide care for all students P-12. This includes, but is not limited to, illness/injury assessments, medication administration, emergency first aid and/or monitoring/education for chronic disease such as asthma or diabetes. However, we cannot provide services to your child without this signed consent (except for emergency first aid). Consent can be withdrawn at any time by the parent or guardian.

Please review this form carefully and complete all information that is requested and return to your child's homeroom teacher or directly to the school nurse.

The school nurse ensures health screenings are completed including height, weight, vision & hearing as required, and that legal guardians are notified of any abnormal findings.

All medications sent from home must have proper parent/guardian consent and taken to the school nurse immediately upon arrival to school for proper storage and administration. Per protocol, non-prescription medications are only given for three days consecutively without a physician's order. The Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available for me to read. **To ensure my child's safety, school health services may share educationally relevant health information with school staff or medical professionals having direct involvement with my child, or may contact the healthcare provider for necessary health information or medication and treatment clarification.**

☑ Please CHECK MARK the following items for which you give consent:

❒ **Acetaminophen** (generic name for **Tylenol®**)—**GIVEN ONLY WITH SPECIFIC PARENT CONSENT OR PERSONAL SUPPLY**

❒ **Ibuprofen** (generic for Motrin®) --**GIVEN ONLY WITH SPECIFIC PARENT CONSENT OR PERSONAL SUPPLY**

❒ **Antacids** (generic)–AS AGE APPROPRIATE

❒ **Cough Drops** (generic) –AS AGE APPROPRIATE

❒ **Peppermint Hard/Soft Candy –**AS AGE APPROPRIATE

❒ **Benadryl®** (generic)-AS AGE APPROPRIATE

❒ **Sore Throat Spray** (generic)—AS AGE APPROPRIATE

❒ **Anti-diarrheal** (generic for Imodium—7th-12th grades)

❒ **Sterile Eye Drops/Artificial Tears** (generic)

❒ **Saltine Crackers**

❒ **Lemon/Lime Caffeine free Soda**

❒ **Aloe Vera Gel**

❒ **Orajel®** (generic oral pain relief)

❒ **Anti-Itch/Sting Kill** (generic)

❒ **Triple Antibiotic Ointment** (generic)

❒ **Vaseline/Lip Lubricant/Carmex** (generic)

By signing below, **I understand** that a school nurse in accordance with Montgomery County School Health Protocols may administer the above over the counter (OTC) products, after she/he has evaluated my child's complaint. **I give my consent** for my child listed above to receive the above checked medications/comfort measures as indicated above. **I understand** that the nurse will delegate necessary medication for field trips when indicated by school health consent, IHP, parental note or emergency. **I understand** that school personnel will make the determination, in case of emergency, to contact 911/EMS for emergency treatment**. I understand** that with all accidents, the student's healthcare coverage is filed and billed first, as the school's accident insurance is a secondary insurance.

Known Allergies: _____

Other Medical Conditions: _____

Current Medications: _____

By signing this consent I release Montgomery County Schools from any liability related to the administration of medications or treatment as long as Reasonable and Customary care is provided. This consent is given voluntarily and with full knowledge of its significance.

_____ _____ _____

Parent/Legal Guardian Signature* Relationship to child Date

Health and Emergency Information Form

Students Name: _____ Birth date: _____

Grade_____ School: _____

Street Address _____ Legal Guardian(s): _____

#1 Name_____ Home # (___) _____ Cell # (_____) _____

#1 Name_____ Home # (___) _____ Cell # (_____) _____

Please mark the following CURRENT HEALTH conditions diagnosed by a healthcare provider:

☐**ADD/ADHD** ☐**ANAPHYLAXIS (EPI PEN)** ☐**ASTHMA** ☐**CARDIAC/ HEART CONDITION** ☐**DIABETES**

☐**METABOLIC DISORDER** ☐**MIGRAINES** ☐**SEIZURES OTHER-PLEASE SPECIFY: _____**

List ALL Medication your child takes at school or at home _____

LIST ALL Known Allergies: _____

An individualized health plan (IHP) must be completed for all current health conditions. *A student may not carry a medication (insulin, asthma inhalers, Epi-pens etc) with them UNLESS written permission from their health care provider and parent is provided.

The School Health Unit will provide care for all students. This includes, but is not limited to, illness/injury assessments, medication administration, emergency first aid and/or monitoring/education for chronic disease such as asthma or diabetes and referrals for further medical assessment. The school nurse cannot provide services to your child without this signed consent (except for emergency first aid). The school nurse ensures health screenings are completed including height, weight, vision & hearing as required, and that I will be notified of any abnormal findings.

All medications sent from home must be in the original container, accompanied by proper parent/guardian consent and must be given to the nurse, the staff member designated to provide health services or the supervising teacher/sponsor/coach for proper storage. (Includes field trips) Prescription meds must have written authorization of prescribing healthcare provider and OTC medications must have written approval of parent/guardian. Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available to read.

In order to ensure my child's safety, school health services may share educationally relevant health information with others having direct involvement with my child. Medication may be delegated by the nurse for field trips when indicated by school health consent, IHP, parental note or emergency situation; based on health information on file in the health unit at the time of departure. By signing below, I give my child consent to participate in **EDUCATIONAL/SPORTS/CLUB** school-related student trip(s).

I understand that I am responsible to provide all medications and treatment supplies related to my child's health conditions indicated above. I authorize trained school personnel to assist my child with his/her medication as my child's healthcare provider or I have directed if needed. **Teachers/Sponsors are responsible to provide specific information and have specific consent for each trip. Form 09.36 AP.211 is required for any overnight or out of state travel. S**chool personnel will make the determination, in the event of accident or sudden illness while at school or on a school-sponsored trip, to have EMS transport my child to the nearest hospital and authorize treatment as deemed necessary for the health of said child.

EMERGENCY CONTACTS: Please name two (2) persons other than the legal guardian that may take responsibility for your child or make decisions for health care:

1) _____ Phone #_____
2) _____ Phone #_____

Child's Healthcare Provider: _____ Child's Insurance Coverage & Policy Number: _____

The following comfort measures are available as needed while at school: Antacid, Benadryl (allergic reaction), Cough Drop, Peppermint Candy, Saltine Cracker, Lemon/Lime caffeine free Soda, Anti-itch Cream/Spray, Sore Throat Spray, Orajel, Artificial Tears/Eye Wash, Triple Antibiotic Ointment, Vaseline or Lip Lubricant or Aloe Vera Gel. Tylenol and Ibuprofen are only administered with a MD/APRN order or specific parent/guardian consent.

IF YOU DO NOT WANT YOUR CHILD TO HAVE AN ABOVE COMFORT MEASURE PLEASE LIST HERE: ____

_____ _____

Parent/Legal Guardian Signature ***Date***

Review/Revised:4/25/2017

Sterling Health Solutions

School Based Health Consent for Services
Sterling Health Solutions, Inc.

The Medical Providers (Sterling Health Solutions, Inc.) will offer health services that include, but are not limited to acute care, preventive services, school physicals, medications for minor illnesses and emergency treatment as needed. Basic laboratory tests will be provided at the School Based Clinic when requested by a parent or if a child comes to the clinic with symptoms indicating the need for a lab test, or if it's a required part of the physical exam. Please review this form carefully and complete all information that is requested. The Providers cannot/will not provide service to your child without this signed consent. This consent does not cover Immunizations. You must contact the School Based Clinic, or the Providers will contact you for a separate consent for that service. The consent can be withdrawn at any time by the parent or guardian by informing the provider in writing.

Student's School:_____

Last Name: _____ **First Name**:_____ **Middle Name:** _____

Gender: M/F **SSN:**_____ **Birth Date:**_____ **Nickname:**_____

Race: □White □Black/African American □Asian □American Indian/Alaskan Native □Native Hawaiian □Other

Ethnicity: □Hispanic/Latino □Non Hispanic/Non Latino **Primary Language:**_____

Address:_____ **Zip Code**:_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____ **Preferred Communication**: Phone/Email

In case of Emergency, please contact:

Name of Mother/Legal Guardian:_____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:**_____

Name of Father/Legal Guardian:_____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:**_____

Student's doctor: _____ Phone: _____

Student's dentist: _____ Phone: _____

Student's Pharmacy: _____ Phone: _____

INSURANCE INFORMATION:

Primary Insurance: _____ **ID#**_____ **GROUP#**_____
Secondary Insurance: _____ **ID#**_____ **GROUP#**_____
Subscriber Name:_____ **Subscriber Date of Birth**_____
Subscriber Gender: □Female □Male **Subscriber Phone**_____
Subscriber Address if different from Patient:_____

This information is **required** for the student's health record to be complete but will ONLY be billed if services are provided the by Nurse Practitioner. School nurse visits are not billed to insurance.

Student's Medical History:

The following information will aid the School Nurse/Nurse Practitioner in making an accurate assessment of your child in case of illness or emergency.

ALLERGIES

Medications	
Vaccines	
Food	
Other	

CURRENT MEDICATION(S)

Medication Name	Dosage	Directions

****You will be asked to complete a separate Medication Consent form if you desire the School Nurse to administer this medication in the School.**

Any Hospitalizations? ☐Yes ☐No

Reason for Hospitalization	Date of Hospitalization	Facility Where Hospitalized

Any Surgeries? ☐Yes ☐No

Type of Surgery	Date of Procedure	Facility Where Procedure Was Performed

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

Condition	Y	N	Condition	Y	N
Allergies			Ear Infections		
Asthma			Chicken Pox		
Eczema			Urinary Tract Infection		
Seizures			Acne		
Heart Murmur			Serious Injury or Concussion		
Wheezing			Developmental and/or Speech Problems		
Pneumonia			ADHD/ADD		

FAMILY HISTORY

Do any family members have any of the following conditions?

Condition	**Which Relative** (Mom, Dad, Grandparent, Aunt, Uncle, Brother, Sister, etc)	Condition	**Which Relative** (Mom, Dad, Grandparent, Aunt, Uncle, Brother, Sister, etc)
Heart Attack	Age:	Colitis	
High Blood Pressure		Crohn's Disease	
Congestive Heart Failure		Colon Polyps	
Rheumatic Heart Disease		Hepatitis	
Congenital Heart Disease		Stomach Ulcer	
Breast Cancer	Age:	Kidney Disease	
Colon Cancer	Age:	Stroke	
Leukemia		Migraine	
Melanoma (skin cancer)		Seizures	
Ovarian Cancer		Diabetes	
Pancreatic Cancer		Goiter	
Any other Cancer		Bleeding Tendency	
Asthma		Suicide	
Tuberculosis		Mental Illness	
Other		Drug or Alcohol Abuse	

When was the last time your child was seen by a doctor?

Doctor's Name: _____ **Reason:** _____ **Date:** _____

Immunization Status:

Is your child up to date on immunizations? ☐Yes ☐No

Where is the child's immunization record on file: _____

☐Yes, I give permission for school nurse to provide a copy of immunization record

Other:

Do you have concerns about your child's health? ☐Yes ☐No

Is your child exposed to second hand smoke? ☐Yes ☐No

Does your child smoke and/or use tobacco products? ☐Yes ☐No

Does your child drink alcohol? ☐Yes ☐No

INCOME: ***Note: Sterling Health Solutions, Inc. Center is dedicated to providing health care to the community. We rely on grant funds to support our school based health programs. By providing the income information requested, this will help us report about the population we serve and is important when applying for grants. THANK YOU FOR YOUR HELP!***

Family Size	Annual Income (*please circle one*)			
1	Below $11,770	$11,771-17,655	$17,656-23,540	Above $23,540
2	Below $15,930	$15,931-23,895	$23,896-31,860	Above $31,860
3	Below $20.090	$20,091-30,135	$30,136-40,180	Above $40,180
4	Below $24,250	$24,251-36,375	$36,376-48,500	Above $48,500
5	Below $28,410	$28,411-42,615	$42,616-56,820	Above $56,820
6	Below $32,570	$32,571-48,855	$48,856-65-140	Above $65,140

Sterling Health Solutions

Sterling Health Solutions, Inc. Center School Based Health
Assignment of Benefits / Consent for Treatment

I consent to the customary tests, procedures that may be deemed necessary for treatment of my child's condition by members of the Medical Staff of Sterling Health Solutions, Inc. Center. Consent is hereby given for such visits to the school nursing office for the purposes of examination, treatment, and procedures rendered by a qualified Nurse Practitioner.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment.

I authorize payment of medical benefits to the supplier for services provided by Sterling Health Solutions, Inc. Center.

I understand that I may be billed separately for services provided by clinic providers for treatment related services. I hereby authorize payment directly to the professional providing these services which would otherwise be payable to me. *Services performed by the school nurse are not billed.

Authorize for Release of Medical Information

I hereby authorize the release of medical information as necessary for settlement of this claim. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records, as well as release of records to my child's primary care provider. Further, I release Sterling Health Solutions, Inc. Center and any related corporations or affiliates from any liability resulting from the release of these medical records and agree to identify and hold them harmless from any such liability. This constitutes permission to release medical information regarding sexually transmitted disease, if applicable, to Third Party Payor pursuant to KRS 214.420.

I have read the above and understand that items above as it applies to me. I verify I have received a Notice of Privacy Practices (45 CFR 164.520 (2) (ii) and Bill of Rights.

_____ _____

Date Signature of the Parent/Legal Guardian

_____ _____

Best **phone number** to reach you **Email** to link you to Patient Portal for child's health record

_____ _____

Date Signature of Witness

If parent/legal guardian signs with (X) or authorized person gives verbal consent, two signatures with names, addresses, and telephone numbers must be entered below.

_____

Date Phone Number Witness Name Address

_____

Date Phone Number Witness Name Address

Sterling
Health Solutions

CONSENT FOR WELL - CHILD EXAMS

As part of overall health care for children, the school requires Kindergarten and 6th Grade Well Child Exams and it is recommended that all children have a Well Child Exam on a yearly basis. The Nurse Practitioner can complete the exam if you want to get your child's check-up through the school clinic. **All you need to do is sign below giving permission if you would like us to complete your child's Well Child Exam or School Grade Entry Exam.**

If your child has already had a well-child exam or the required school check-up at their primary care physician's office, please forward a copy of it to the school as soon as possible. Well Child exams are billable and will be billed to your insurance/medical card. Although, for private insurance NO COPAY will be billed to you because the children's well-child exams are covered 100% by insurance. So it will be NO COST to you.

All exams can be completed at the school clinic EXCEPT for any required immunizations (shots) because we are not able to bring the vaccines to school. **If your child needs a physical that requires vaccination,** the school nurse will help you schedule an appointment with your child's physician or the health department.

____**Yes**, I would like for Sterling Health Solutions, Inc. to complete my child's exam at school.

____My child has already had their required school exam or the well-child exam.

Parent/Guardian Signature:_____

Best Phone Number to reach you: _____