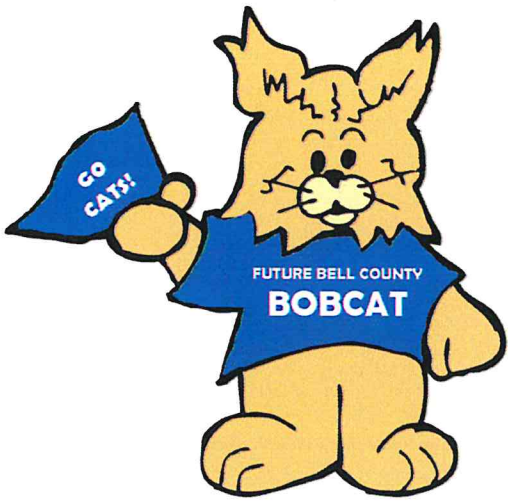


Bell County Schools

Kindergarten Registration

2022-2023 school year is going on now!

April 11th-May 15th, 2022

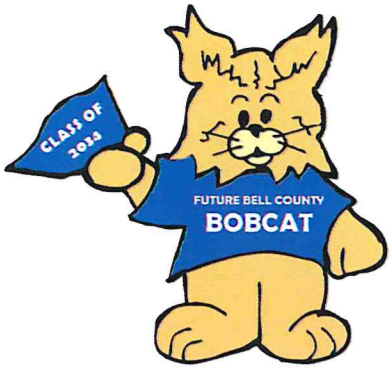
Registration can be completed online at the following link

https://forms.gle/9Yq4Vh37WCyBz2vaA

or via scanning with your cell phone the Q reader below:

To be eligible to attend Kindergarten for the 2022-2023 school year, children must be five years old on or before August 1, 2022.

Questions regarding Kindergarten Registration can be answered by calling your local school or the Bell County Board of Education/ Dr, Mitch Bailey at (606) 337-7051, Extension #132.



Bell County School System Kindergarten Registration Information 2022-2023

Dear Parent/Guardian of a future Bell County Bobcat:

Welcome to our school district. Thank you for providing us an opportunity to teach and love your future Bell County Bobcat. Your child will need the following documents on file before he/she begins their journey of becoming a "Bobcat" in the Class of 2035. Please use this check list to prepare for your child's registration.

Check List:

- ☐ Bell County School District Kindergarten Enrollment Information Form
- ☐ Preventative Health Care Examination Form (Completed by Physician, APRN, PA or EPSDT)
- ☐ Kentucky Eye Examination Form (Completed by either an Optometrist/Ophthalmologist)
- ☐ Kentucky Dental Screening/Examination Form (Completed by a Dentist, Dental Hygienist, Physician, Registered Nurse, APRN or PA)
- ☐ A current Commonwealth of Kentucky Immunization Certificate
- ☐ Copy of Social Security Card
- ☐ Birth Certificate (State Issued-Certified) or other reliable* proof of age and identification

*Examples of "other reliable proof:" Types of "other reliable proof" of a student's identity and age may include but not be limited to: Social Security card; passport; military identification or immigration card; baptismal certificate; copy of the record of baptism – notarized or duly certified and which reflects the date of the student's birth; recording of student's name and birth in a family Bible or other religious text; notarized statement from the parents or another relative or guardian as to the date of the student's birth; prior school record indicating the date of the student's birth; driver's license or learner's permit; adoption record; any religious record authorized by a religious official; affidavit of identity and age; any government document or court record reflecting the date of the student's birth; oral proof when the native language of a parent or guardian is not a written language.

Bell County School District
Kindergarten
Enrollment Information
2022-23 School Year

For School Use:
Home Room Teacher

_____

Legal Custodial Document On File

☐ YES

Student Information

School Center: _____ **Date:** _____

Grade: _____ **Enrolling Parent/Guardian:** _____

Legal Name of Student (**As it Appears on the Birth Certificate**):

(Last) _____ Suffix: (Jr., III, etc.) _____ (First) _____ (Middle) _____

Social Security Number _____

Date of Birth: (Month) _____ (Day) _____ (Year) _____ Birthplace: (County) _____ (State) _____

[ ] Male [ ] Female

Race (See below): [ ] White [ ] Black [ ] Hispanic [ ] Asian/Pacific Islander [ ] American Indian/Alaskan Native [ ] Other

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 (not Hispanic)—**A person having origins in any of the black racial groups of Africa
- **Hispanic—**A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture of origin regardless of race
- **Asian or Pacific Islander—**A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands
- **American Indian or Alaskan Native—**A person having origins in any of the original peoples of North America and who maintains culture identification through tribal affiliation or community recognition
- **Other**

Student's Physical Address: **911** (Street) _____ (City) _____ (State) _____ (Zip) _____

Student's Mailing Address (If different): (Street) _____ (City) _____ (State) _____ (Zip) _____

Citizenship: [ ] U.S. Citizen [ ] U.S. Resident [ ] Non-Resident Alien [ ] Other: _____

Does your child have special needs, or does he/ she receive special education services? [ ] Yes [ ] No

Does your child have a 504 plan? [ ] Yes [ ] No

Current School of Attendance: _____

School Address: _____ Telephone No.: _____

Household Information

Parents/Guardians Living Within Household with the Student
Legal Name-As it Appears on the Social Security Card

Father's Last Name: _____ Suffix (Jr., II,): _____ First Name: _____ MI:_____

Father's DOB_____ Sex: _____ Relationship to Student: Biological/Step/Other _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Place of Employment:_____

Work Phone: ( ) _____ E-Mail Address: _____

Mother's Last Name: _____ Suffix: _____ First Name: _____ MI:_____

Mother's DOB_____ Sex: _____ Relationship to Student: Biological/Step/Other _____

Home Phone: ( )_____ Cell Phone: ( )_____ Place of Employment:_____

Work Phone: _____ E-Mail Address: _____

Sibling Information

Siblings Living Within Household (Please note N/A if No Siblings)

Last Name: _____ _____First Name: _____ MI: _____

Birthdate: _____ / _____ / _____ Sex: _____ Grade: _____

Currently attending a school in the Bell County School District? [ ] Yes [ ] No Name of School: _____

Last Name: _____ Suffix: _____First Name: _____ MI: _____

Birthdate: _____ / _____ / _____ Sex: _____ Grade: _____

Currently attending a school in the Bell County School District? ? [ ] Yes [ ] No Name of School: _____

Last Name: _____ Suffix: _____First Name: _____MI: _____

Birthdate: _____ / _____ / _____ Sex: _____ Grade: _____

Currently attending a school in the Bell County School District? [ ] Yes [ ] No Name of School: _____

Last Name: _____ Suffix: _____First Name: _____ MI: _____

Birthdate: _____ / _____ / _____ Sex: _____ Grade: _____
Currently attending a school in the Bell County School District? [ ] Yes [ ] No Name of School: _____

Non-Household Information

Parents/Guardians Living at Another Address
Legal Name-As it Appears on the Social Security Card

Does this parent/guardian have joint custody? [ ] Yes [ ] No Should this parent/guardian receive school mailings? [ ] Yes [ ] No

Last Name: _____ First Name: _____ MI: _____

Address: (Street) _____ (City) _____ (State) _____ (Zip) _____

Home Phone: ( ) _____ Cell Phone: ( ) _____Work Phone: ( ) _____

Place of Employment: _____ E-Mail Address: _____

Is there a court order restricting this parent/guardian's access to the student? [ ] Yes [ ] No

(If YES, a copy of the court order MUST be provided and kept on file at the school.)

Transportation

Primary Transportation to School: [ ] Car Driver [ ] Car Passenger [ ] School Bus

Transportation by Bell County School Bus: [ ] One Way [ ] Both Ways [ ] More Than 1 Mile [ ] Less Than 1 Mile

Bus Number_____

Language

Child's Birth Country: _____

What is the language most frequently spoken at home? _____

Which language did your child learn when he or she first began to speak? _____

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

What language do you most frequently speak to your child? _____

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

Childcare

Name of Day Care/Babysitter: _____

Address: _____ Telephone No.: ( ) _____

Medical and Emergency Information

Family Physician: _____ Telephone No.: ( ) _____

Dentist: _____ Telephone No.: ( ) _____

List and identify problems and/or medical conditions (such as allergies) that should be known to school personnel:

_____

Per state regulation, any child with a health condition (such as asthma, allergies, diabetes, seizures, etc.) must have a Primary Care Authorization form on file.

Regular Medication: _____ Dosage: _____

A notarized Authorization to Give Medication Form must be on file for any medication to be given to a student during the school day.

Page 3 Legal Name of Student: (Last) _____ (First) _____ (Middle) _____

Emergency Contact Information

In case of an accident or emergency of any kind, when parent/guardian cannot be contacted please call one of the following individuals:

Name: _____ Relationship: _____

Home Phone :( )_____ Work Phone :( )_____ Cell Phone :( )_____

Name: _____ Relationship: _____

Home Phone :( )_____ Work Phone :( )_____ Cell Phone :( )_____

Parent's/Guardian's Signature: _____ Date: _____

Name: _____ Relationship: _____

Home Phone :( )_____ Work Phone :( )_____ Cell Phone :( )_____

Parent's/Guardian's Signature: _____ Date: _____

 Legal Name of Student: (Last) ____________________ (First) ____________________ (Middle) ____________

Persons Who Can Check Your Child Out of School
(In Addition To Emergency Contacts Listed Above)

NO INDIVIDUAL WILL BE PERMITTED TO CHECK-OUT/PICK-UP A CHILD WHOSE NAME AND **PHOTO ID** ARE NOT RECORDED ON THIS FORM!

Name: ____________________ Relationship: ____________________
(Aunt, Uncle, Friend, etc.)

Home Phone :( )__________ Work Phone :( )__________ Cell Phone :( )__________

Copy of driver's license or other photo ID:

Name: ____________________ Relationship: ____________________
(Aunt, Uncle, Friend, etc.)

Home Phone :( )__________ Work Phone :( )__________ Cell Phone :( )__________

Copy of driver's license or other photo ID:

Name: ____________________ Relationship: ____________________
(Aunt, Uncle, Friend, etc.)

Home Phone :( )__________ Work Phone :( )__________ Cell Phone :( )__________

Copy of driver's license or other photo ID:

Name: ____________________ Relationship: ____________________
(Aunt, Uncle, Friend, etc.)

Home Phone :( )__________ Work Phone :( )__________ Cell Phone :( )__________

Copy of driver's license or other photo ID:

Name: ____________________ Relationship: ____________________
(Aunt, Uncle, Friend, etc.)

Home Phone :( )__________ Work Phone :( )__________ Cell Phone :( )__________

Copy of driver's license or other photo ID:

Name: ____________________ Relationship: ____________________
(Aunt, Uncle, Friend, etc.)

Home Phone :( )__________ Work Phone :( )__________ Cell Phone :( )__________

Copy of driver's license or other photo ID:

Directions to Home: ____
____
____
____
____
____
____

Pre-K Information on Early Learning

From list below select where your child received early care services for the past 12 months prior to enrollment, you may choose all that apply.

[ ] 01: State-funded preschool – state-funded preschool program, which, as defined in 704 KAR 3:410, provides preschool services to at-risk 4-year-olds and 3- and 4-year olds with identified special needs

[ ] 02: Out-of-state state-funded preschool

[ ] 03: Head Start – Head Start, which provides early childhood services to 3- and 4-year-old children who are at risk

[ ] 04: Out of state Head Start

[ ] 05: Child care – any child care or private preschool setting that is licensed by the Division of Regulated Child Care and includes Type I, Type II and family certified homes

[ ] 06: Out of state child care

[ ] 07: Home – home care with a parent/guardian before entering school

[ ] 08: Private sitter

[ ] 09: Kin Care

[ ] 10: Therapy

[ ] 11: Other (explain) _____

Do Not Write Below This Line

OFFICE USE ONLY

Household Name: _____
Records Requested: [ ]Yes [ ] No Date: _____
Student ID No.: _____
Address Verification: _____
Teacher/Room No.: _____
Entry Date/Code: _____
Transfer Student: [ ] Yes [ ] No

Bus No.: _____
Transportation Code: _____
ESL Services: [ ] Yes [ ] No
ECE Program: _____
504 Plan: _____
Withdrawal Code: _____
Immunization Certificate [ ] Vision Exam [ ]

COMMONWEALTH OF KENTUCKY
CERTIFICATE OF IMMUNIZATION STATUS

Certificate Issuing Office Name and Address

Name of Child: _____ **Birthdate:** _____
(Last) (First) (Middle) (Suffix) (MM/DD/YYYY)

Name of Parent: _____
(Last) (First) (Middle) (Suffix)

Address: _____
(Street) (City) (State) (Zip Code)

VACCINE	DOSE 1 MM/DD/YYYY	DOSE 2 MM/DD/YYYY	DOSE 3 MM/DD/YYYY	DOSE 4 MM/DD/YYYY	DOSE 5 MM/DD/YYYY
Hepatitis B	/ /	/ /	/ /	/ /	
Alt. Adult Hepatitis B[1]	/ /	/ /			
DTaP/DTP/DT[2]	/ /	/ /	/ /	/ /	/ /
Hib[3]	/ /	/ /	/ /	/ /	
Pneumococcal (PCV13)	/ /	/ /	/ /	/ /	
Polio	/ /	/ /	/ /	/ /	/ /
Influenza	/ /	/ /			
MMR	/ /	/ /			
Varicella	/ /	/ /	**Had Chickenpox or Zoster Disease Yes No**		/ /
Hepatitis A	/ /	/ /			
Meningococcal	/ /	/ /			
Td	/ /	/ /			
Tdap	/ /	/ /			
Rotavirus	/ /	/ /	/ /		
HPV	/ /	/ /	/ /		
Men B	/ /	/ /	/ /		
Pneumococcal (PPSV23)	/ /	/ /			

[1]Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age. [2]DTaP, DTP, or DT. [3]Hib not required at 5 years of age or more.

☐ This child <u>is current</u> for immunizations until ___/___/____, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

☐ This child <u>is not up-to-date</u> at this time. This certificate is valid until ___/___/____, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

Reason child is not up-to-date:

☐ **Provisional Status** - Child is behind on required immunizations.

☐ **Medical Exemption** - The following immunizations are not medically indicated: _____

_____

If Medical Exemption, can these vaccines be administered at a later date? **No:** _____ **Yes:** _____ **Date:** ___/___/___

☐ **Religious Objection**

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

_____ _____
(Signature of physician, APRN, PA, pharmacist, LHD administrator, RN or LPN designee) (Date)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

Kentucky UNBRIDLED SPIRIT

OFO/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 ☐ Registered Nurse with 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:

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: _____

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: _____

Estado de Kentucky

Rechazo de inmunizaciones obligatorias por motivos religiosos del padre/tutor

Los Centros para el Control y la Prevención de Enfermedades (CDC) y el Departamento para la Salud Pública de Kentucky (KDPH) reconocen que la inmunización es una de las herramientas más eficaces para prevenir enfermedades y reducir los riesgos asociados con la exposición a ciertas enfermedades. KRS 214.036 exige que los padres que se oponen a la inmunización de su hijo(a) proporcionen una declaración jurada por escrito rehusando la inmunización del niño(a) por motivos religiosos.

Escriba una "X" en la casilla a la izquierda de cada enfermedad de la cual usted se opone a que su hijo(a) reciba la inmunización. Escriba sus iniciales y la fecha a la derecha.

☐	**Hepatitis B:** Según los CDC y el KDPH, los síntomas graves y efectos de esta enfermedad incluyen: ictericia (piel u ojos amarillos), problemas con el hígado de por vida, tales como cicatrización y cáncer del hígado, o muerte.	**Iniciales**_____ **Fecha** _____
☐	**Difteria (DTaP, DT, Tdap, Td):** Según los CDC y el KDPH, los síntomas graves y efectos de esta enfermedad incluyen: insuficiencia cardíaca, parálisis (no poder mover las partes del cuerpo), problemas con la respiración, coma, o muerte.	**Iniciales**_____ **Fecha** _____
☐	**Tétanos (DTaP, DT, Tdap, Td):** Según los CDC y el KDPH, los síntomas graves y efectos de esta enfermedad incluyen: inmovilización de la mandíbula, dificultad para tragar y respirar, convulsiones (espasmos musculares o ausencias), contracción dolorosa de los músculos en la cabeza y el cuello, o muerte.	**Iniciales**_____ **Fecha** _____
☐	**Pertussis (Tos ferina) (DTaP, Tdap):** Según los CDC y el KDPH, los síntomas graves y efectos de esta enfermedad incluyen: ataques de tos severa que pueden causar vómitos y agotamiento, neumonía, convulsiones (espasmos musculares o ausencias), daños cerebrales, o muerte.	**Iniciales**_____ **Fecha** _____
☐	***Haemophilus influenzae* tipo b (Hib):** Según los CDC y el KDPH, los síntomas graves y efectos de esta enfermedad incluyen: meningitis (infección del revestimiento del cerebro y de la médula espinal), neumonía, hinchazón severa en la garganta que dificulta la respiración, infecciones de la sangre, las articulaciones, los huesos y el revestimiento del corazón, o muerte.	**Iniciales**_____ **Fecha** _____
☐	**Infecciones neumocócicas:** Según los CDC y el KDPH, los síntomas graves y efectos de esta enfermedad incluyen: dolor en el pecho con respiración rápida o dificultad para respirar, una fiebre alta, temblores, escalofríos, sudores excesivos, fatiga, confusión, y una tos con flemas que persiste o empeora, neumonía, daños cerebrales, o muerte.	**Iniciales**_____ **Fecha** _____
☐	**Polio:** Según los CDC y el KDPH, los síntomas graves y efectos de esta enfermedad incluyen: parálisis (no poder mover partes del cuerpo), meningitis (infección del revestimiento del cerebro y de la médula espinal), discapacidad permanente, o muerte.	**Iniciales**_____ **Fecha** _____
☐	**Sarampión, Paperas, Rubéola (MMR):** Según los CDC y el KDPH, los síntomas graves y efectos del sarampión incluyen: neumonía, convulsiones (espasmos musculares o ausencias), daños cerebrales, o muerte. Los síntomas graves y efectos de las paperas incluyen: meningitis (infección del revestimiento del cerebro y de la médula espinal), hinchazón dolorosa de los testículos u ovarios, esterilidad, sordera, o muerte. Los síntomas graves y efectos de rubéola incluyen: erupción cutánea, artritis y dolores musculares o de las articulaciones. Si una mujer contrae rubéola cuando está embarazada, podría tener un aborto espontáneo o su bebé podría nacer con defectos de nacimiento graves, tales como sordera, problemas cardíacos o discapacidad de aprendizaje.	**Iniciales**_____ **Fecha** _____
☐	**Varicela (*Chickenpox*):** Según los CDC y el KDPH, los síntomas graves y efectos de esta enfermedad incluyen: severas infecciones cutáneas, neumonía, daños cerebrales, o muerte.	**Iniciales**_____ **Fecha** _____
☐	**Hepatitis A:** Según los CDC y el KDPH, los síntomas graves y efectos de esta enfermedad incluyen: ictericia (piel u ojos amarillos), síntomas gripales, hospitalización, o muerte.	**Iniciales**_____ **Fecha** _____
☐	**Enfermedad meningocócica:** Según los CDC y el KDPH, los síntomas graves y efectos de esta enfermedad incluyen: dolor de cabeza severo, rigidez en el cuello, confusión, convulsiones (espasmos musculares o ausencias), fiebre alta, náusea y vómitos, sensibilidad de los ojos a la luz, pérdida auditiva, neumonía, daños cerebrales, o muerte.	**Iniciales**_____ **Fecha** _____

Debido a mis creencias religiosas, me opongo a que mi hijo(a) reciba las inmunizaciones obligatorias marcadas más arriba.
Soy consciente de que si cambio de idea, puedo revocar esta objeción y obtener las inmunizaciones para mi hijo(a). Iniciales: _____

- *Se dispone de información adicional sobre las enfermedades prevenibles con vacunas, las inmunizaciones y los servicios de inmunización a costo reducido o sin costo en el departamento de salud local en cada condado.*
- *En el caso de que el departamento de salud del condado o el departamento de salud estatal declare un brote de una enfermedad prevenible con vacuna para la cual no se puede proporcionar una prueba de inmunidad en un niño(a), puede que no se permita que el niño(a) asista al cuidado infantil o la escuela por hasta tres (3) semanas, o hasta que termine el período de riesgo.*

Nombre del niño(a) _____, _____
Apellido(s) Primer nombre Segundo nombre

Fecha de nacimiento del niño(a) _____
MM/DD/AAAA

Firma del padre/madre _____

Fecha _____
MM/DD/AAAA

To be completed by Notary Public
Para ser llenado por el* Notary Public *(fedatario)

ESTADO DE)
CONDADO DE)

Suscrito, jurado o afirmado bajo juramento y reconocido ante mí, un *Notary Public* (fedatario) en y para el estado y condado antes mencionados, por _____, este día _____ de _____ del 20_____.

_____
***Notary Public,* Estado en general**

Mi comisión se vence: _____

Commonwealth of Kentucky

Parent or Guardian's Declination on Religious Grounds to Required Immunizations

The Centers for Disease Control and Prevention (CDC) and Kentucky Department for Public Health (KDPH) recognize immunization as one of the most effective tools in preventing disease and reducing the risks associated with exposure to certain diseases. KRS 214.036 requires parents who object to immunization of their child to provide a written sworn statement objecting to immunization of the child on religious grounds.

Place an "X" in a box or boxes to the left of each disease, listed below, for which you object to your child receiving the immunization. Initial and date the box on the right.

☐	**Hepatitis B:** According to the CDC and KDPH, serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), life-long liver problems, such as scarring and liver cancer, or death.	Initials_____ Date _____
☐	**Diphtheria (DTaP, DT, Tdap, Td):** According to the CDC and KDPH, serious symptoms and effects of this disease include: heart failure, paralysis (can't move parts of the body), breathing problems, coma, or death.	Initials_____ Date _____
☐	**Tetanus (DTaP, DT, Tdap, Td):** According to the CDC and KDPH, serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, or death.	Initials_____ Date _____
☐	**Pertussis (Whooping Cough) (DTaP, Tdap):** According to the CDC and KDPH, serious symptoms and effects of this disease include: severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, or death.	Initials_____ Date _____
☐	***Haemophilus influenzae* type b (Hib):** According to the CDC and KDPH, serious symptoms and effects of this disease include: meningitis (infection of the brain and spinal cord covering), pneumonia, severe swelling in the throat that makes it hard to breathe, infections of the blood, joints, bones, and covering of the heart, or death.	Initials_____ Date _____
☐	**Pneumococcal:** According to the CDC and KDPH, serious symptoms and effects of this disease include: chest pain with rapid breathing or difficulty breathing, a high fever, shaking, chills, excessive sweating, fatigue, confusion, and a cough with phlegm that persists or worsens, pneumonia, brain damage, or death.	Initials_____ Date _____
☐	**Polio:** According to the CDC and KDPH, serious symptoms and effects of this disease include: paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, or death.	Initials_____ Date _____
☐	**Measles, Mumps, Rubella (MMR):** According to the CDC and KDPH, serious symptoms and effects of measles include: pneumonia, seizures (jerking and staring), brain damage, or death. Serious symptoms and effects of mumps include: meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, sterility, deafness, or death. Serious symptoms and effects of rubella include: rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, or learning disability.	Initials_____ Date _____
☐	**Varicella (Chickenpox):** According to the CDC and KDPH, serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, or death.	Initials_____ Date _____
☐	**Hepatitis A:** According to the CDC and KDPH, serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), "flu-like" illness, hospitalization, or death.	Initials_____ Date _____
☐	**Meningococcal:** According to the CDC and KDPH, serious symptoms and effects of this disease include: severe headache, stiff neck, confusion, seizures (jerking and staring), high fever, nausea and vomiting, sensitivity of eyes to light, hearing loss, pneumonia, brain damage, or death.	Initials_____ Date _____

Due to my religious beliefs, I object to my child receiving the required immunizations selected above. I am aware that if I change my mind, I can rescind this objection and obtain immunizations for my child. Initials _____

- *Additional information about vaccine preventable diseases, immunizations and reduced or no cost immunization services is available from the local health department in each county.*
- *In the event that the county health department or state health department declares an outbreak of a vaccine-preventable disease for which proof of immunity for a child cannot be provided, he or she may not be allowed to attend childcare or school for up to three (3) weeks, or until the risk period ends.*

Child's Name _____
Last First Middle

Child's Date of Birth _____
MM/DD/YYYY

Parent Signature _____

Date _____
MM/DD/YYYY

To be completed by Notary Public

STATE OF)

COUNTY OF)

Subscribed, sworn to or affirmed under oath and acknowledged before me, a Notary Public in and for the state and county aforesaid by _____, on this the _____ day of _____, 20_____.

_____
Notary Public, State at Large

My Commission Expires:_____

Kentucky UNBRIDLED SPIRIT