Dear Prospective Preschool Parent/Guardian:

Thank you for inquiring how a child qualifies for the Boone County Preschool Program and how the application process works.

**WHO is eligible?**
Must reside in Boone County School District and meet one or more of the following criteria:

- Be financially eligible (160% poverty level) and 4 by Aug. 1st of the school year. **NO income consideration for 3 year olds.**
- 3 and 4 year olds may qualify as a child with an educational disability (having a delay in one or more areas of development)

For suspected educational disability, a screening will be scheduled.

**WHAT does Screening mean?** (*Due to COVID-19 virus, screenings are not being scheduled. We will contact you when screening dates are reinstated.*)
Identifying any potential areas of concern in a child’s development. Developmental skills that are screened; cognitive, fine and gross motor, speech/language, social and self-help skills. If there are concerns, interventions will be recommended.

If the household income meets the state’s requirements (looks at income and amount of people in the home=160% poverty level and 4 years of age by Aug. 1st of school year), the child will be eligible for preschool services. A screening will take place once in the classroom. If the household’s income is over the allowable amount, we then offer a screening for your child. *Screenings take place several times throughout the school year.

Based on the outcome of the screening, your child may or may not require interventions. After the screening results are scored, the interventionists will discuss this further with you. If your child needs interventions, at their conclusion, the interventionists will discuss further steps if any are necessary.

**HOW the Preschool Application Process Works:**
Complete the application & provide copies of documents as identified in red in the What We Need section below. *(Incomplete applications received will not be processed.)*

After receiving your child’s completed application with ALL required documents, we will contact you with next steps. We will inform you if your child qualifies for income eligibility. If your household is not income eligible, we can schedule a screening date and time. We screen children throughout the school year.

**WHAT WE NEED:**
Complete **& Provide the following items in red below:** (*The items in black may be turned in after eligibility is determined OR if the child starts preschool in which case you can turn those items into their school office where their file will be.)

| 1- Student Enrollment/Emergency card (2 pages) (signed & dated) | 4- Copy of KY Certification of Immunization, completed by Physician (must be current) |
| 2- Preschool Transportation card (2 pages) (signed & dated) | 5- Copy of Birth Certificate |
| 3- Household Income Verification form (2 pages, signed & dated) & copies of supporting documents (last 2-3 pay stubs or tax return) (only fill out if child is 4 yrs old by August 1; do not complete if 3 yrs old). *IF you are receiving unemployment, copies of statements.* | 6- Copy of Social Security Card OR Completed Statement of Non-Disclosure of Social Security Number |
| 7- Copy of Proof of Residence (copy of bill with your name/address on it or copy your lease) |
### Application

<table>
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<tr>
<th>Item</th>
<th>Description</th>
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<tr>
<td>8- Copy of Custody / Guardianship Papers / Foster Parent Documents</td>
<td>*Preventative Health Care Examination Form (both sides) completed by a Physician (NOT due at time of preschool application. Turn into child’s school office once they begin school)</td>
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<td>9- Permission to Videotape / Photography/ Publish form (signed)</td>
<td>*KY Eye Examination Form (NOT due at time of preschool application). Turn into child’s school office once they begin school)</td>
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<td>10- Adjudication form (signed)</td>
<td>*KY Dental Screening/Examination Form (NOT due at time of preschool application). Turn into child’s school office once they begin school)</td>
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<td>11- Other Reports/Evaluations: Speech/language evals, Physical Therapy reports, Occupational Therapy reports, IEP, etc. (if applicable)</td>
<td>*Copy of Medicaid Card/ Medicaid Release Information Form (if you have one) NOT due at time of preschool application. Turn in to child’s school office once they begin.)</td>
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### HOW TO SUBMIT PRESCHOOL APPLICATION:

*incomplete applications will not be reviewed*

You may return your child’s COMPLETED APPLICATION to us in one of 3 ways:

1. **U.S. Mail:** Preschool Department - Application, 8270 US Hwy 42, Florence, KY 41042.

2. **Drop off:** Monday - Friday 7:30AM - 3:30PM at the Learning Support Services building, *(last building on right on Ockerman Drive behind Ockerman Elementary School)* OR

3. **Email:** michael.shires@boone.kyschools.us

We ask for your patience during high peak seasons, the end and beginning of the school year.

Please note: If you wish to re-apply in the next school year, you will need to fill out a new enrollment card, preschool transportation card and up to date KY immunization record to insure we have current, up to date information. Children cannot start school or interventions without a current shot record.

Should you have any additional questions, please feel free to contact me at 859-334-3794.

Thank you for being an advocate on behalf of your child. We look forward to serving you and your family.

Respectfully,

**Dr. Michael J Shires**

Dr. Michael J. Shires  
Director of Early Childhood Learning  
Boone County School District  
Learning Support Services  
8270 US Hwy 42 *(mailing address)*  
8270 Ockerman Drive *(physical address, off Hwy 42, last building on right)*  
Florence, KY 41042  
859-334-3794
Frequently Asked Questions about PRESCHOOL

1. How do students qualify for Preschool in Kentucky?
   - Income Eligible- Age 4 (by August 1 of the school year) and have a family income at or below 160% of the federal poverty level.
   - Age 3 or 4 and have an educational disability due to delays in development, regardless of family income.

2. Do English Language Learners automatically qualify for Preschool in the state of Kentucky?
   - English Language Learners do not automatically qualify for Preschool. All students have to meet the stated qualifications listed above.

3. Do Preschool students have to start Preschool at the beginning of the school year?
   - Students can qualify and start enrollment into Preschool at any time of the school year.

4. How many years can students be in Preschool?
   - Depending on a student’s birthday and how they qualify, some students can spend up to 3 school years in Preschool.

5. If I feel my student is not ready for Kindergarten, can they spend another year in Preschool?
   - If a student is 5 years old by August 1, they may not spend another year in Preschool. It is recommended that they attend Kindergarten.

6. How many days a week is Preschool?
   - Preschool is Monday-Thursday for half a day. Students that qualify are enrolled in either the AM session or the PM session. AM and PM sessions are determined by your address.

7. Does the bus pick up my child and drop off my child?
   - Transportation is provided in a Preschool bus that has a seat belt. There is an adult driver and an adult monitor on the bus to help the Preschool children. Bus transportation is free.
Boone County Schools
Student Enrollment / Emergency Information

Legal Name of Student (PLEASE PRINT) ___________________________ (Last Name) _______ (First) _______ (Middle) _______ Suffix: _______

Grade: _______ Date of Birth: ____________ □ Male □ Female Social Security # (optional): ____________

Has your child repeated a grade? □ Yes □ No. If yes, which grade? _______

Birthplace: (Country) ___________________________ (County) ___________________________ (State) _______ Phone #: (______)

Student Address: (Street) ___________________________ (Apt #) _______ (City) ___________________________ (State) _______ (Zip) _______

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

Student Mailing Address: (if different) ___________________________ (City) _______ (State) _______ (Zip) _______

(Street or PO Box and Apt #)

□ There are no changes to student’s address or phone number. Parents/Guardians, please initial here _______

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: _______

Kentucky School: □ Yes □ No _______

Last Date Attended: _______

School Telephone #: (______)

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

Prior Boone County Schools attended and years:

Parents/Guardians Living in Same Household as Student

Legal Name: ___________________________ (Last) _______ (First) _______ (Middle) _______ Suffix: _______

Relationship to Student: _______

Home Phone: (______) Work: (______) Cell Phone: (______) E-Mail: _______

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: _______

Parents/Guardians Living at an Address Different from Student

Does this parent/guardian have joint custody? □ Yes □ No _______

Should this parent/guardian receive school information? □ Yes □ No _______

Is this person legally restricted access to this student? □ Yes □ No _______

(A copy of the court order MUST be provided to the school.)

Legal Name: ___________________________ Suffix: _______

Relationship to Student: _______

Address: City: _______ State: _______ Zip: _______

Home Phone: (______) Work: (______) Cell Phone: (______) E-Mail: _______

Does this parent/guardian have joint custody? □ Yes □ No _______

Should this parent/guardian receive school information? □ Yes □ No _______

Is this person legally restricted access to this student? □ Yes □ No _______

(A copy of the court order MUST be provided to the school.)

Legal Name: ___________________________ Suffix: _______

Relationship to Student: _______

Address: City: _______ State: _______ Zip: _______

Home Phone: (______) Work: (______) Cell Phone: (______) 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 apply): □ Car rider   □ Walker   □ School Bus   □ Bus #: ________ (assigned by school district staff)
Transportation by BC Schools: □ A.M. □ P.M. □ Both A.M. & P.M. □ More than 1 mile □ Less than 1 mile □ Daycare: ________________

Language

Is English most frequently spoken in the home? □ Yes □ No, what language spoken? ________________________________
Did your child learn English when he/she first began to talk? □ Yes □ No, what language spoken? ________________________________
Does your child most frequently speak English at Home? □ Yes □ No, what language spoken? ________________________________
Is English most frequently spoken to the child at home? □ Yes □ No, what language spoken? ________________________________
(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 #: _____________________________

Name: _____________________________ Relationship to student: _____________________________ Telephone #: _____________________________

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 __________

Revised 02/2016
BOONE COUNTY SCHOOLS
PRESCHOOL TRANSPORTATION
CONFIDENTIAL EMERGENCY INFORMATION

Start Date ___________ Session ___________

Date ___________________ School ___________________

Name of Student ___________________ Date of Birth ___________________

Parent(s) ___________________ Home Phone ___________________

Home Address ___________________ City ___________________ Zip ___________

Emergency Phone Number ___________________

Mother’s Work Phone ___________________ Father’s Work Phone ___________________

Mother’s Cell Phone ___________________ Father’s Cell Phone ___________________

Special Bus Equipment needed: Wheelchair Lift ___________________ Other ___________________

**EMERGENCY MEDICAL INFORMATION:**

Student’s Doctor ___________________ Phone ___________________

Hospital Preference ___________________

Address ___________________

Insurance ___________________


**PLEASE CHECK BOXES, as needed:**

☐ Verbal ☐ Non Verbal ☐ Seizure Disorder ☐ Hearing Impaired

☐ Ambulatory ☐ Non Ambulatory ☐ Visually Impaired

Allergies ___________________

Medication ___________________ Dosage ___________________ Side Effects ___________________

**ON THE BACK OF THIS CARD PLEASE WRITE STEPS TO BE TAKEN BY DRIVER/ASSISTANT IN THE EVENT OF ILLNESS, SEIZURES, ETC, WHILE RIDING THE BUS.

**ON THE BACK OF THIS CARD PLEASE WRITE ANY SPECIAL INSTRUCTIONS FOR CONTROLLING STUDENT’S BEHAVIOR.

**ALL CHILDREN WILL RIDE THE BUS IN A SAFETY VEST OR SAFETY SEAT.

**ALTERNATIVE PICK-UP AND/OR DROP-OFF LOCATION:**

If pick-up and/or drop off location is other than the home address, complete the following information:

All alternative locations must be within the school boundary. They will be designated as the authorized location for pick-up & drop-off, 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 office

AM (pick-up) information:

Bus # _________ Stop Location ___________________

PM (pick-up) information:

Bus # _________ Stop Location ___________________

Program Director ___________________ Parent ___________________

This information is maintained in accordance with the Family Education Rights and Privacy Act.
• PLEASE WRITE STEPS TO BE TAKEN BY DRIVER/ASSISTANT IN THE EVENT OF ILLNESS, SEIZURES, ETC., WHILE RIDING THE BUS, AS NECESSARY.

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

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

SAFETY IS OUR PRIMARY CONCERN WHEN TRANSPORTING YOUR CHILDREN.

THEREFORE BELOW, PLEASE LIST THE NAMES & PHONE NUMBERS 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 TO CHILD</th>
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PARENT/GUARDIAN SIGNATURE __________________________ DATE ____________
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

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Household and Income Form for Preschool Eligibility

Letter to Families
Page 1 of 1
INSTRUCTIONS FOR APPLYING

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

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

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

If you have FOSTER CHILD(REN) ONLY, follow these instructions. You do not need to fill out a separate form for each foster child in your household. (If there are both foster children and non-foster children in your household, follow the instructions below for All Other Households).

If all children in the household are marked as foster children in Part 1:
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Sign the form.

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

Part 2: Skip this part.
Part 3: Follow these instructions to report total household income from this month or last month.

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

Part 4: An adult household member must sign the form. Please include your address and phone number in the event the Preschool Coordinator has a question about your information.
HOUSEHOLD 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 a foster child (legal responsibility of welfare agency or court)</th>
<th>Indicate if NO income</th>
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</table>

**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**

| Earnings from work before deductions. | Weekly | Every 2 Weeks | Twice Monthly | Monthly | Welfare, child support, alimony | Weekly | Every 2 Weeks | Twice Monthly | Monthly | Pensions, retirement, Social Security, SSI, VA benefits | Weekly | Every 2 Weeks | Twice Monthly | Monthly | All Other Income (indicate frequency, such as “weekly” “every 2 weeks”, “monthly”) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (Example) Jane Smith | $200 | ☑ | ☐ | ☐ | $150 | ☑ | ☑ | ☐ | ☐ | $0 | ☐ | ☐ | ☐ | ☐ | ☐ | $50 / monthly |
| $ | | | | | $ | | | | | | | | | | | | |
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Household and Income Form for Preschool Eligibility

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 child(ren) 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, 400 W. Van Buren St., Room 5020, Chicago, IL 60607 or call (800) 364-9892 (voice) or (800) 877-8393 (TDD). 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: □ 150% poverty □ Special Education □ Head Start □ Over Income
Reason (180% poverty; Special Education; Head Start [if applicable]; Over Income): ___________________________
Preschool Coordinator: ___________________________ Date: ___________________________
Secondary Signature: ___________________________ Date: ___________________________

Household and Income Form for Preschool Eligibility
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."
STATEMENT OF NON-DISCLOSURE OF SOCIAL SECURITY NUMBER

DATE: ________________________________

PARENT NAME & ADDRESS:

____________________________________

____________________________________

____________________________________

STUDENT’S NAME: __________________________ DOB: ____________

SCHOOL ATTENDING: _____________________

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 social security number 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

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 of 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 use/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. (702 KAR 1:160)

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION
Student Name: ____________________________________________ Gender: M F Grade: __________________________
Date of Birth: ____________________________ Age: ___ yrs ___ months Preferred Language: __________________________
Parent or Guardian Name: ____________________________________________

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

MEDICAL HISTORY
Allergies: ____________________________________________________________
Current Prescribed Medications to be taken daily at school: ____________________________
Significant Historical Information: ____________________________________________

SCREENING RESULTS:

<table>
<thead>
<tr>
<th>Height: ft inches</th>
<th>Weight</th>
<th>BMI:</th>
<th>BMI%:</th>
<th>B/P:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>Right 20/___</td>
<td>Passed</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Left 20/___</td>
<td>Failed</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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/Throat ☐ 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

☐ 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
  - Seat belts
  - 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 cycloplegia? (Please indicate one.)  

- YES  
- NO

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

Type of Examination  

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

Diagnosis:  

- Normal  
- Myopia  
- Hyperopia  
- Astigmatism  
- Strabismus  
- Amblyopia

Other: ________________________________________________

Recommendations:  

1. Glasses prescribed:  

- YES  
- NO

2. ________________________________________________

3. ________________________________________________

Age appropriate and suggested anticipatory guidance (health assessments):  

- Educate (parents/patients) about eye/vision disorders and needed vision care  
- Counsel (parents/patients) regarding eye safety  
- Stress importance of early, preventative eye care  
- Recommend re-examination, as appropriate

Signed: ________________________________

Optometrist/Ophthalmologist

Date: ________________________________

Address: ________________________________

Telephone: ( ) ________________________________
### Kentucky Dental Screening/Examination Form for School Entry

**Student Name:**

**Gender:**
- Male [ ]
- Female [ ]

**Birth Date:**
- [ ]

**Parent or Guardian:**

**Address:**

**City:**

**Country:**

**Phone Number:**

**School:**

**Screening Date:**

**Screening Site:**

**Screening Type:**
- Exam [ ]
- Screening [ ]

**Test Type (check one):**

**Professional Affiliation:**
- Physician [ ]
- APRN [ ]
- Nurse Practitioner [ ]
- Registered Nurse [ ]
- Physician Assistant [ ]
- Dental Hygienist [ ]
- Dentist [ ]

**Treatable Caries:**
- Yes [ ]
- No [ ]

**Untreatable Caries:**
- Yes [ ]
- No [ ]

**No Obvious Problem:**
- Yes [ ]
- No [ ]

**1 Early Dental Care Needed:**
- Yes [ ]
- No [ ]

**2 Referral for Urgent Care Needed:**
- Yes [ ]
- No [ ]

**Patient of Early Childhood Caries:**
- Yes [ ]
- No [ ]

**Comments:**

**Emergency Contact:**

**Signature:**

**Date:**

---

**NOTE:** Common required.

**KDESH0205**

**OAS/DS2**

3/16/2016

OH-12