WELCOME TO
BOONE COUNTY SCHOOLS
A Distinguished District

Student Name: ____________________________________________

Registration Date: ________________________________________

The following is a list of information that will be needed to enroll your child in
our school district. These items are needed in addition to the registration forms
provided:

_____ *Student Enrollment/Emergency Information Form

_____ Certified Birth Certificate (within 30 days)

_____ *Immunization Certificate (new students only)

_____ Preventive Health Care Examination Form (within 30 days)

_____ Kentucky Eye Exam (first time entering a public school, for ages 3-6)

_____ Kentucky Dental Screening Form (first time entering a public school, ages 5-6)

_____ *Legal Custody Papers (if applicable)

_____ *Proof of Residency at enrolling address in parent/guardians name
  a. Drivers license
  b. Lease, contract, mortgage, etc.
  c. Utility bill

_____ *Adjudication/Expulsion Affidavit Form (most will check #4 and sign)

_____ Transportation Card (prior to riding bus)

_____ Social Security Card or waiver

_____ Permission to Videotape/Photograph/Publish Release Form

*Required at time of enrollment

The Boone County School District does not discriminate against any person on the basis of race, sex, color, religion, national origin, citizenship
status, age or disability in any of its educational or employment programs or activities.
Boone County Schools
Student Enrollment/Emergency Information

Legal Name of Student (Please Print) ___________________________ Suffix ___________________________

Grade: _____ Date of Birth: ___________ Sex: Male □ Female □ SS# (Optional) ___________________________

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

Birthplace: (Country) ___________________________ Phone #: ( ) ___________________________

Student Address: (Street) ___________________________ (County) ___________________________ (City) ___________ (State) ___________ (Zip) ___________________________

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

Ethnicity: Is your child Hispanic/Latino? □ Yes □ No Student Race: (Check all that apply) □ White □ Black or African American □ Native Hawaiian or other Pacific Islander

□ American Indian or Alaska Native □ Migrant □ Immigrant □ Refugee: (Country) ___________

U.S. Citizen: □ Yes □ No If no, country of residence: ___________________________________________

Last School Attended: ___________________________________________ Phone: Home ( ) Work: ( )

Last Date Attended: ___________________________________________ Cell Phone: ( ) E-Mail: ___________

School Address: (City) ___________________________ (County) ___________ (State) ___________ (Zip) ___________________________

Prior Boone County Schools attended and years: ___________________________________________

Parents/Guardians Living in Same Household as Student

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First)</td>
</tr>
<tr>
<td>Relationship to Student: ___________________________</td>
<td></td>
</tr>
<tr>
<td>Phone: Home ( ) Work: ( )</td>
<td></td>
</tr>
</tbody>
</table>
| Cell Phone: ( ) E-Mail: ___________

Siblings Living in Same Household as Student

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First)</td>
</tr>
<tr>
<td>Birth Date</td>
<td>Sex: ___ Grade: ___</td>
</tr>
</tbody>
</table>
| Name of Boone County School: ___________________________

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First)</td>
</tr>
<tr>
<td>Birth Date</td>
<td>Sex: ___ Grade: ___</td>
</tr>
</tbody>
</table>
| Name of Boone County School: ___________________________

Parents/Guardians Living at an Address Different from Student

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First)</td>
</tr>
<tr>
<td>Relationship to Student: ___________________________</td>
<td></td>
</tr>
<tr>
<td>Address: ___________________________________________</td>
<td></td>
</tr>
<tr>
<td>City: ___________ State: ___________ Zip: ___________</td>
<td></td>
</tr>
</tbody>
</table>
| Phone: Home ( ) Work: ( ) Cell Phone: ( ) E-Mail: ___________

Does this parent/guardian have joint custody? ______
Should this parent/guardian receive school information? ______
Is this person legally restricted access to this student? ______
(A copy of the court order MUST be provided to the school.)

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First)</td>
</tr>
<tr>
<td>Relationship to Student: ___________________________</td>
<td></td>
</tr>
<tr>
<td>Address: ___________________________________________</td>
<td></td>
</tr>
<tr>
<td>City: ___________ State: ___________ Zip: ___________</td>
<td></td>
</tr>
</tbody>
</table>
| Phone: Home ( ) Work: ( ) Cell Phone: ( ) E-Mail: ___________

Does this parent/guardian have joint custody? ______
Should this parent/guardian receive school information? ______
Is this person legally restricted access to this student? ______
(A copy of the court order MUST be provided to the school.)
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 BCS:  ☐ A.M.  ☐ P.M.  ☐ Both A.M. & P.M.  ☐ More Than 1 Mile  ☐ Less Than 1 Mile  ☐ None  Daycare: ____________________________

Language

Is English most frequently spoken in the home?  ☐ Yes  ☐ No, what language?
Did your child learn English when he/she first began to talk?  ☐ Yes  ☐ No, what language?
Does your child most frequently speak English at home?  ☐ Yes  ☐ No, what language?
Is English most frequently spoken to the child at home?  ☐ Yes  ☐ No, what language?

(if any answers above are other than English, please complete the "Home Language Survey")

Medical Information

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

*Per state regulation, any student with a health condition (such as asthma, allergies, diabetes, seizures, etc.) must have a health care plan on file. For more information, please contact the school Nurse or Health Clerk.

Regular Medication: ____________________________ Dosage: ____________________________
An "Authorization to Give Medication" form must be on file for any medication to be given to a student during the school day.
Physician Name: ____________________________ Telephone: ____________________________

I give school officials permission to contact the named Health Care Provider: ____________________________ (Parent/Guardian Signature)

Emergency Information

If needed, what hospital should this student be taken to? ____________________________
IN AN EMERGENCY, if parent/guardian cannot be contacted, please call and/or release my child to one of the following:
Name: ____________________________ Relationship to student ____________________________ Telephone No: (____) ____________
Name: ____________________________ Relationship to student ____________________________ Telephone No: (____) ____________

If there is anyone NOT ALLOWED access to this student, list their name and relationship: (Legal documentation MUST be provided to the school.)
Name: ____________________________ Relationship to student ____________________________

The school is not responsible for students authorized by parent to leave school during school hours or for students in elementary and middle school authorized by parent to privately return to their homes after school.

If there are changes made during the year, please contact the school office IMMEDIATELY.

Parent/Guardian Signature ____________________________ Date: ____________

Revised 02/2016
BOONE COUNTY SCHOOLS
Student Transportation Form

School: ___________________________ School Code: ___________ School Year: ___________

Student Name: ___________________________ D.O.B: __________________

Gender: _______ Grade: ___________ Student ID: ___________________________ Teacher: __________________

(All students will be routed to their home address unless an alternative address is provided.)

Home Address: ___________________________

City/State/Zip: ___________________________

Parent/Guardian: ___________________________ Phone: __________________

Emergency Contact: ___________________________ Phone: __________________

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

□ NO BUS TRANSPORTATION NEEDED
   Car Rider Number: ___________________ Daycare Name and Assigned #: __________________

□ DAY CARE TRANSPORTS? YES: _______ NO: _______ ___________

□ AM TRANSPORTATION ONLY
□ PM TRANSPORTATION ONLY
□ AM & PM TRANSPORTATION NEEDED

□ ALTERNATE PICK-UP AND/OR DROP-OFF LOCATION NEEDED (Must be inside school boundaries)

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

If using an alternate address please provide the following:

Pick-up Location: ___________________________

Drop-off Location: ___________________________

(Leave this area blank if being transported to home address or no transportation is needed)

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

Student Bus Information
(To be completed by school official)

AM Pick-up Information:

Bus #: ___________________ Stop Location: ___________________________

PM Drop-off Information:

Bus #: ___________________ Stop Location: ___________________________
Commonwealth of Kentucky
Kentucky Department of Education
Boone County Board of Education
Adjudication/Expulsion Affidavit

K.R.S. 158.000 requires that a parent or guardian of a child who has been adjudicated guilty or previously expelled for homicide, assault, or violation of state law or school regulations relating to weapons, alcohol or drugs notify a new school of that fact by a sworn statement given to the school at the time of registration.

In compliance with that requirement, I swear or affirm that I am the parent or legal guardian of ____________________________ who:

1. __________ Was adjudicated guilty and/or
2. __________ Was previously expelled from ____________________________ private or public school, either in state or out-of-state and/or
3. __________ Was disciplined for a violation of state law or school regulation relating to weapons, alcohol or drugs.
4. __________ Has never been adjudicated guilty or previously expelled or disciplined for violation of K. R. S. 158.000 as mentioned above.

The facts are as follows:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

(Please attach a separate sheet as needed.)

I swear or affirm that, to the best of my knowledge and belief, the statements and information contained herein are true, factual and complete.

_________________________________________________________________________

Affiant, Parent/Guardian ____________________________ Date ____________________________
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:

Height: ______ ft ______ inches Weight: ______ BMI: ______ BMI%: ______ B/P: ______

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right 20/</th>
<th>Passed</th>
<th>Failed</th>
<th>Left 20/</th>
<th>Passed</th>
<th>Failed</th>
<th>Referred</th>
</tr>
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</tbody>
</table>

Hearing - Right: Passed | Failed | Referred

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 cycloplegia? (Please indicate one.)  YES  NO

<table>
<thead>
<tr>
<th>Unaided Acuity</th>
<th>OS</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/20</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best Corrected Acuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/20</td>
</tr>
</tbody>
</table>

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: ( ) __________________________
Kentucky Dental Screening/Examination Form for School Entry

Kentucky law, KRS 156.160(i), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth date:</td>
<td>/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender:</td>
<td>☐ 0 Male ☐ 1 Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent or Guardian:</td>
<td>Name</td>
<td>Relationship</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
<td>School:</td>
<td></td>
</tr>
<tr>
<td>Date of Exam/Screening</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test Type (check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Screening</td>
</tr>
<tr>
<td>☐ Exam</td>
</tr>
</tbody>
</table>

| Screener's Name: | |
| Screener's Address: | |
| Screener's Signature: | |
| Phone Number: | Screening Date: |

<table>
<thead>
<tr>
<th>Professional affiliation: (Please check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Dentist</td>
</tr>
<tr>
<td>☐ Dental Hygienist</td>
</tr>
<tr>
<td>☐ Physician Assistant</td>
</tr>
<tr>
<td>☐ LHD Registered Nurse with KIDS Smiles training</td>
</tr>
<tr>
<td>☐ APRN</td>
</tr>
<tr>
<td>☐ Physician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Untreated Decay: (Check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 0 No untreated cavities</td>
</tr>
<tr>
<td>☐ 1 Untreated cavities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treated Decay: (Check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 0 No treated cavities</td>
</tr>
<tr>
<td>☐ 1 Treated cavities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pattern of Early Childhood Cavities: (Check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 0 No Early Childhood Cavities</td>
</tr>
<tr>
<td>☐ 1 Early Childhood Cavities Present</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Urgency: (Check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 0 No obvious problem</td>
</tr>
<tr>
<td>☐ 1 Early dental care needed</td>
</tr>
<tr>
<td>☐ 2 Referral for Urgent Care</td>
</tr>
<tr>
<td>NOTE: Comment required if marked.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
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</table>

OH-12
BOONE COUNTY SCHOOLS

PARENTAL CONSENT FOR RECORD RELEASE

To Principal of: ____________________________

(Name of School)

________________________

(Address)

________________________

(City, State, Zip)

I am the parent/legal guardian of: ____________________________

(Name of Student) (DOB)

You are authorized to:

☐ Release the checked information

☐ Release all information

☐ 1. Cumulative Records

☐ 2. General identifying data (Name, Address, DOB, Grade Level Completed, Grades, Class Standing, Attendance Record)

☐ 3. Standardized Achievement and Aptitude Test Scores

☐ 4. Medical/Health Records

☐ 5. Special Education Due Process File

☐ 6. Gifted File

☐ 7. Title I File

☐ 8. ESS File

☐ 9. Limited English Proficiency/English as Second Language File

☐ 10. Record of Extra-Curricular Activities

☐ 11. Other (Specify) ____________________________

To: __________________________________________

________________________

________________________

The reason for this request is:

☐ Transfer to school due to change in residence

☐ Other – Specify ____________________________

________________________

Signature of Parent or Legal Guardian

Address ____________________________________

City ____________________________

Date ____________________________

Phone Number ____________________________
Statement of Non-Disclosure

Of

Social Security Number

Date: ____________________________

Parent/Guardian Name: ____________________________

Address: ______________________________________

School Attending: ____________________________

Student Name: ____________________________ DOB: ____________________________

In signing this waiver, I acknowledge that I am refusing to provide a copy of my child’s Social Security Card to the Boone County School District. By signing this waiver your child will not be eligible for the Kentucky Educational Excellence Scholarship funds for their college education.

I also understand that any programs requiring my child’s SS# for participation, within the Boone County School District and/or the Kentucky Department of Education, will not be available to my child.

Parent Signature ____________________________ DATE: ____________________________
Boone County Schools
Permission to Videotape/Photography/Publish
2016-2017

PLEASE COMPLETE THIS FORM AND SUBMIT IT TO THE SCHOOL.

Dear Parent/Guardian:

At some time during the school year, school/District personnel or other District-authorized persons may videotape or photograph classroom activities or special projects in which your child participates during or after the school day for staff/student evaluative, educational, or public awareness purposes. Such videotapes or photographs may be viewed by peers, faculty, or administrators. On special occasions such as a videotape or photograph of a class or school play or of an academic or athletic event, the film or photograph may be viewed by a general audience including, but not limited to, publishing pictures in yearbooks, event programs and newsletters, or on the school or District Web site.

Please review this form carefully, sign and date the form, and submit the form to the school. Although we will make efforts to comply with your request, bear in mind that we cannot monitor all adults at all times, especially during the special occasions when other parents may take pictures or may tape the event.

Once signed and dated, this form shall remain in effect for your child’s enrollment in the District schools. However, at any time during the school year, you may amend this form only for future uses/preferences by notifying the Principal in writing of your request.

As the parent(s)/guardian(s) of ___________________________, I/we give the
Student’s Name
Boone County School District permission to release my/our child’s name, photograph, and/or audio/video reproduction for publication concerning school functions and activities, including academic and athletic activities.
Name of Parent(s)/Guardian(s) (Please print.) ___________________________

________________________________________
Parent/Guardian’s Signature

______________________________
Date

________________________________________
Parent/Guardian’s Signature

______________________________
Date

________________________________________
Principal/Designee’s Signature

______________________________
Date

Revised 07/14