ROCKCASTLE COUNTY SCHOOLS 2019-2020

Enrollment Information

Enrollment Date_____

Student Name: _____

STUDENT INFORMATION

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

❑ Male ❑ Female Social Security Number: _____ Grade: _____ Teacher Name: _____

Date of Birth: _____ Race/Ethnicity (check all that apply): Hispanic/Latino: ❑ Yes ❑ No

❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander

Student's Physical Address: Street:_____City:_____State:_____ Zip:_____

Student's Mailing Address *(if different from above)*: Street/PO Box:_____City:_____State:_____ Zip:_____

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

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

Does your child have a 504 plan? ❑ Yes ❑ No Does your child receive gifted and talented services? ❑ Yes ❑ No

Has your child been enrolled in another school district in Kentucky? ❑ Yes ❑ No

Last School Attended: _____

School Address: _____ Telephone No.:( ) _____

PARENTS/GUARDIANS LIVING IN SAME HOUSEHOLD AS STUDENT

Last Name: _____First Name: _____ MI:____
Sex: ❑ Male ❑ Female Relationship to Student: _____
Phone: (Home) ( ) _____ (Cell) ( )_____
Place of Employment:_____ (Phone) ( )_____
E-Mail Address: _____
I want a Parent Portal account: ❑ Yes ❑ No

Last Name: _____ First Name: _____ MI:____
Sex: ❑ Male ❑ Female Relationship to Student: _____
Phone: (Home) ( ) _____ (Cell) ( )_____
Place of Employment:_____ (Phone)( ) _____
E-Mail Address: _____
I want a Parent Portal account: ❑ Yes ❑ No

SIBLINGS/OTHERS LIVING IN SAME HOUSEHOLD

Last Name: _____First Name: _____ MI:____
Sex: ❑ Male ❑ Female Birthdate: _____
Grade:_____ Relationship to Student: _____
Currently attending a Rockcastle County School? ❑ Yes ❑ No
Name of School: _____

Last Name: _____ First Name: _____ MI:____
Sex: ❑ Male ❑ Female Birthdate: _____
Grade:_____ Relationship to Student: _____
Currently attending a Rockcastle County School? ❑ Yes ❑ No
Name of School: _____

Last Name: _____First Name: _____ MI:____
Sex: ❑ Male ❑ Female Birthdate: _____
Grade: ____ Relationship to Student: _____
Currently attending a Rockcastle County School? ❑ Yes ❑ No
Name of School: _____

Last Name: _____ First Name: _____ MI:____
Sex: ❑ Male ❑ Female Birthdate: _____
Grade:_____ Relationship to Student: _____
Currently attending a Rockcastle County School? ❑ Yes ❑ No
Name of School: _____

PARENTS/GUARDIANS LIVING AT ANOTHER ADDRESS

Does this parent/guardian have joint custody? ❑ Yes ❑ No
Last Name: _____ First Name: _____ MI: _____
Sex: ❑ Male ❑ Female Relationship to Student: _____
Address: _____
_____
Phone: (Home)( ) _____ (Cell) ( )_____
Place of Employment:_____ (Phone)( ) _____
E-Mail Address: _____
Is there a court order restricting this parent's/guardian's access to the student? ❑ Yes ❑ No ***(If yes, a copy of the court order MUST be provided.)***

Does this parent/guardian have joint custody? ❑ Yes ❑ No
Last Name: _____ First Name: _____ MI: _____
Sex: ❑ Male ❑ Female Relationship to Student: _____
Address: _____
_____
Phone: (Home)( ) _____ (Cell) ( )_____
Place of Employment:_____ (Phone)( ) _____
E-Mail Address: _____
Is there a court order restricting this parent's/guardian's access to the student? ❑ Yes ❑ No ***(If yes, a copy of the court order MUST be provided.)***

Teacher Name: _____

Please complete other side.

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

TRANSPORTATION

Primary Transportation to School: ❑ School Bus ❑ Walk ❑ Parent Pickup Bus #.: _____ Parent Pickup #.:_____

Transportation provided by Rockcastle County Schools: ❑ One Way ❑ Both Ways ❑ More than 1 mile ❑ Less than 1 mile

Detailed Directions to Student's Home: _____

_____

_____

_____

NON-ENGLISH SPEAKERS

What is the primary language spoken in the student's home? _____

What language did your child learn when he or she first began to talk?_____

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

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

CHILDCARE

Name of Day Care or Babysitter: _____

Address: _____Telephone No.: ( ) _____

In case of an accident/emergency or when parent /guardian is not available, my child may be released to one of the following:

Name: _____ Relationship: _____Telephone No. ( )_____

Name: _____ Relationship: _____Telephone No. ( )_____

Name: _____ Relationship: _____Telephone No. ( )_____

Name: _____ Relationship: _____Telephone No. ( )_____

MEDICAL AND EMERGENCY INFORMATION

Family Physician: _____Telephone No.: ( ) _____

Dentist: _____Telephone No.: ( ) _____

Please mark the following conditions that that have been diagnosed by a healthcare provider:

☐ Anaphylactic Reaction/Severe Allergic Episode ☐ Diabetes ☐ Asthma ☐ Seizures ☐ Other _____

Per state regulation, any child with a health condition (such as asthma, diabetes, seizures) must have a Primary Care Provider Authorization Form on file. For more information or to obtain a form, please contact your child's school.

Please list any medications your child takes at home or school: _____

I give permission for my child to be seen by the school nurse and receive treatment for minor complaints (i.e.. Headache, skin irritations, cough, etc.)	Y	N
I give permission for my child to be photographed or audio/video taped for broadcast or print for Rockcastle County Schools publications or website.	Y	N
I give permission for my child to participate in physical education. (If no, a doctor's statement must be attached.)	Y	N
I give permission to the Rockcastle County Schools to display the product of my child's school related academic, athletic, music and/or art work on the district website and other district publications.	Y	N

I give permission for my child to be screened for vision, hearing, speech, contagions, and parasites by trained school personnel. In case of an emergency and in the event that no one can be reached at the phone numbers listed for my child, I authorize school officials to administer necessary emergency treatment, call the physician listed, and/or call 911 for emergency transportation of my child. I will not hold the school district financially responsible for the emergency care and/or transport of my child.

I verify that all information provided on this form was supplied by me and is accurate.

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

Rockcastle County Schools

245 Richmond Street | Mt. Vernon, KY 40456 | (606) 256-2125

www.rockcastle.kyschools.us

ROCKCASTLE COUNTY EARLY CHILDHOOD
2019-2020 Registration Form

PRIMARY ADULT (PERSON CHILD LIVES WITH)

Legal Name: (Last) _____ (First) _____ (Middle) _____

Marital Status: ❑ Married ❑ Divorced ❑ Other Date of Birth: _____ Member of the US Military: ❑ Yes ❑ No

Employment Status: ❑ Full-time ❑ Part-time ❑ Disabled ❑ Unemployed ❑ Retired ❑ College Student __ Full Time __ Part Time

Education Level: (circle highest grade completed) 1 2 3 4 5 6 7 8 9 10 11 12 GED Years beyond High School: 1 2 3 4 4+

SECONDARY ADULT

Legal Name: (Last) _____ (First) _____ (Middle) _____

Marital Status: ❑ Married ❑ Divorced ❑ Other Date of Birth: _____ Member of the US Military: ❑ Yes ❑ No

Employment Status: ❑ Full-time ❑ Part-time ❑ Disabled ❑ Unemployed ❑ Retired ❑ College Student __ Full Time __ Part Time

Education Level: (circle highest grade completed) 1 2 3 4 5 6 7 8 9 10 11 12 GED Years beyond High School: 1 2 3 4 4+

SERVICES RECEIVED

SNAP (food stamps) ❑ Yes ❑ No

TANF/K-Tap ❑ Yes ❑ No

SSI ❑ Yes ❑ No

WIC ❑ Yes ❑ No

HEALTH/MEDICAL INFORMATION

Health Insurance: ❑ Medicaid ❑ K-Chip ❑ Private ❑ None

Dental Insurance ❑ Yes ❑ No

Social Security # (optional) _____

SCREENING PERMISSION AND RELEASE OF INFORMATION

I give permission for my child, _____ to be given a developmental/behavioral screening, vision screening and hearing screening provided by the Rockcastle County Board of Education and Community Action Council's South Central Head Start.

I understand that registration and screening information will be shared between the Rockcastle County Board of Education and Community Action Council's South Central Head Start to determine eligibility for preschool.

I understand that the following application information will be shared between the Rockcastle County Board of Education and Community Action Council's South Central Head Start: copy of certified birth certificate, copy of social security card, copy of medical, K-Chip or insurance card, medical exam-including lead, dental exam, eye exam and immunization certificate.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Witness Date

Rockcastle County Preschool and Community Action Council's South Central Head Start
AUTHORIZATION TO DISCLOSE HEALTH/DENTAL INFORMATION

Child's Name (print) _____ Date of Birth _____

I_____ give permission to: _____
(Parent / Guardian Name) (Health Care / Dental Provider Name)

To share the following information with **Rockcastle County Schools / Community Action Council's South Central Head Start** so that this person or entity may assist my child with health care needs/issues.

The requested information may be shared for one year after the date on this authorization form or until I revoke the authorization.

I give permission for the following information to be shared: (***Check all boxes that apply***)

- □ Physical Exam/Well Child Exam/Immunizations
- □ Hearing and Vision Exams/Screenings
- □ Lead Screening
- □ Dental Exam/Treatment
- □ Health Information Regarding Behavioral or Mental Health Services
- □ IFSP/IEP
- □ Other _____

This form must be signed by the child's parent/guardian

Signature of Parent/Guardian _____ Date _____

Staff Signature_____ Date_____

I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient named above and may not be protected under Federal laws and regulations regarding the privacy of the protected health information.

This authorization must be signed and dated and may be revoked by notifying the Health Care/Dental Provider at any time except to the extent action has been taken prior to revocation.

Please fax or mail the above requested information to:

Rockcastle Preschool/Head Start
Attn: Dreama Roberts
955 West Main St.
Mt. Vernon, KY 40456
Phone: 606-256-8301
Fax: 606-256-1027