

BOONE COUNTY SCHOOLS
Student Enrollment Checklist

FOR OFFICE USE ONLY

Enrolling School

Student Name: _____ Grade _____

Date of Registration: _____ Previous School _____

(XX) FORMS OR DOCUMENTS TO BE PROVIDED BY PARENT/GUARDIAN

(X) FORMS PROVIDED BY THE SCHOOL

REQUIRED FORMS	PARENT ACTION	OFFICE VERIFICATION
XX Immunization (Upon entry) (on Kentucky form) (Parents get form from Health Care provider or Health Department)		
XX Physical Examination (within 30 days) (given within 1 year prior to initial entry and/or within 1 year prior to entry into sixth grade)		
XX Kentucky Eye Examination Form for School Entry (By January 1 of the year of enrollment, ages 3, 4, 5 and 6 only)		
XX Proof of Residence (Copy of utility bill, lease/rental agreement, realtor purchase agreement, home title, etc.)		
XX Birth Certificate (within 30 days)		
XX Custody Papers (in case of divorce/shared custody (if name is different than on Birth Certificate card or does not live with both natural parents)		
XX Social Security Card (optional) (Required for KEES only)		
X District Enrollment form SR 1		
X Records Request SR 3		
X Photography/Video Release Form		
X Parent/Guardian Home Language Survey (required if indicated by Enrollment form)		
X Federal Lunch Program Form (optional)		
X KRS.158.155 Form Adjudication/Expulsion Form SR 4		
X Alternate Location Request Form (if needed)		
X Student Transportation Form		
Withdrawal Form from Previous School (optional)		
Transcript (optional)		

Documents to be given to Parents for Information

Student Code of Conduct
Student Fees Information
Transportation Regulations

District Social Security Waiver SR 6 (needed for KEES
money)
School Calendar

OFFICE STAFF

Transcript Requested _____ Transcript Received _____ Fees Paid Yes ___ No ___
Records Requested _____ Records Received _____ Date _____

If any of the Student Services sections of the Student Enrollment form is completed, a copy of the form has
been sent to the Student Services Center. _____

2010-2011 Boone County Schools

Student Enrollment/Emergency Information

Office Use Only

School: _____
 Start Date: _____
 Teacher: _____

Legal Name of Student (Please Print) _____ (Last) _____ (First) _____ (Middle) _____ Suffix _____ (Jr., III, etc)

Grade: _____ Date of Birth: _____ ☐ Male ☐ Female SS# (Optional) _____

Birthplace: (Country) _____ (County) _____ (State) _____ Phone #: () _____

Student Address: (Street) _____ (Apt #) _____ (City) _____ (State) _____ (Zip) _____

(Check only if applicable*) ☐ Shelter ☐ Motel ☐ House or apartment shared with friends or family members ☐ Friends/Family member (other than parent/guardian)
**If applicable, please complete a Residency Questionnaire (704 KAR 7:090)*

Student Mailing Address: (if different) _____ (City) _____ (State) _____ (Zip) _____
 (Street or PO Box and Apt #)

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: _____ ☐ Migrant ☐ Immigrant ☐ Refugee: (Country) _____

Last School Attended: _____ Kentucky School: ☐ Yes ☐ No

Last Date Attended: _____ School Telephone #: () _____

School Address: (City) _____ (County) _____ (State) _____

Parents/Guardians Living in Same Household as Student

Legal Name: _____ Suffix: _____
 (Last) (First) (M. I.)

Relationship to Student: _____

Phone: Home () _____ Work: () _____

Cell Phone: () _____ E-Mail : _____

Place of Employment: _____

Occupation: _____ DOB _____

Legal Name: _____ Suffix: _____
 (Last) (First) (M. I.)

Relationship to Student: _____

Phone: Home () _____ Work: () _____

Cell Phone: () _____ E-Mail : _____

Place of Employment: _____

Occupation: _____ DOB _____

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: _____

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? _____

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.)

Legal Name: _____ Suffix: _____

Relationship to Student: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home () _____ Work: () _____

Cell Phone: () _____ E-Mail: _____

Place of Employment: _____ DOB _____

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.)

Legal Name: _____ Suffix: _____

Relationship to Student: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home () _____ Work: () _____

Cell Phone: () _____ E-Mail: _____

Place of Employment: _____ DOB _____

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

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 1 services? ☐ Yes ☐ No

Has this student been formally identified as Gifted/Talented? ☐ Yes ☐ No

Transportation

Primary Transportation to School (check all that applies): ☐ 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

What is the language most frequently spoken at home? _____

Which language did this student learn when he or she first began to talk? _____

What language does this student most frequently speak? _____

What languages do the parents of this student speak? _____

(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:** _____

Office Use Only

New Enrollment _____
Revised Enrollment _____
Office Personnel _____
Date _____

PREVENTATIVE HEALTH CARE EXAMINATION FORM - INITIAL ENTRY [headstart - fourth (4) grade]

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. Local school boards may extend this time not to exceed two (2) months. The administration shall have an approved program of continuous health supervision which shall include evidence of having been screened for vision and hearing.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Social Security Number: _____ Date of Birth: _____

Parent or Guardian Name: _____

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

Seizures: _____

Chronic Illness: _____

Allergies: _____

Medications: _____

Significant Historical Information: _____

Physical Exam:

N.	Abn.		Hgt:_____ Wgt:_____ BP:_____ / _____
_____	_____	General Appearance	Hearing: R _____ L _____
_____	_____	HEENT	Vision: R _____ / _____ L _____ / _____
_____	_____	Skin	STRABISMUS/AMBLYOPIA SCREEN <input type="checkbox"/> ABNORMAL
_____	_____	Neck	Optional-----HCT/HGB: _____ (required for headstart)
_____	_____	Chest	Optional-----UA: _____
_____	_____	Heart	
_____	_____	Abd - Genitalia	
_____	_____	Extremities-Back	
_____	_____	Neuro_	

Explain Abnormal Exam: _____

Recommendations:

_____ No Restrictions: Normal Exam

_____ RESTRICTIONS AND SUGGESTIONS TO SCHOOL: _____

Age appropriate and suggested anticipatory guidance (health assessments)

- ☐ Discuss injury prevention with parents
- ☐ Bicycle Safety ☐ Car Seat Belts ☐ Memorization of Name, Address and Phone Number
- ☐ Advise the child not to go with or accept anything from strangers and feel free to say "NO" to strangers.
- ☐ Emphasize the importance of dental care.
- ☐ Discuss mental health issues.

Signed: _____ Date: _____
Physician/ARNP/PA/EPSTD Provider

Address: _____ Telephone: _____

PREVENTATIVE HEALTH CARE EXAMINATION FORM - Sixth (6th) Grade Form (for grades 5-12)

All local boards of education shall require a second and third preventative health care examination of each child within one (1) year prior to entry into the sixth (6th) grade or subsequent grades. Each board shall have an approved program of continuous health supervision in accordance with current statutes and regulations, vision, hearing and scoliosis scheduled screening tests. Local school districts shall establish a plan for implementation and compliance with the sixth (6th) grade examination.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Grade: 5th 6th 7th 8th 9th 10th 11th 12th (Circle appropriate grade)

Student Name: _____

Social Security Number: _____ Date of Birth: _____

Parent or Guardian Name: _____

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

MEDICAL HISTORY

Seizures: _____

Chronic Illness: _____

Allergies: _____

Medications: _____

Significant Historical Information _____

Physical Exam:

N.	Abn.		
_____	_____	General Appearance	Hgt: _____ Wgt: _____ BP: _____ / _____
_____	_____	HEENT	Hearing: R _____ L _____
_____	_____	Skin	Vision: R _____ / _____ L _____ / _____
_____	_____	Neck	Optional-----HCT/HGB: _____
_____	_____	Chest	Optional-----UA: _____
_____	_____	Heart	
_____	_____	Abd-Genitalia	
_____	_____	Extremities-Back (including scoliosis screen for 6 th grade)	
_____	_____	Neuro	

Explain Abnormal Exam: _____

Recommendations:

_____ No Restrictions: Normal Exam

_____ RESTRICTIONS AND SUGGESTIONS TO SCHOOL: _____

Age Appropriate and Suggested Anticipatory Guidance (Health Assessments)

1. How have things been going for you at school? With your peers?
2. How do you rate your own health?
3. What concerns do you have about your own development?

Advise adolescents about the following good health habits and self-care. – See sample reference on back of form.

☐ Risk behaviors were discussed and addressed

☐ Risk behaviors were not addressed today

Signed: _____ Date _____
Physician/ARNP/PA/EPSTD Provider

Address: _____ Telephone: _____

Guidelines Only - Please do not mark risk factors on this form.

	Low Risk	Moderate Risk	High Risk
Body Mass Index	Between 15-85% Normal weight/height per the growth chart	Between 5-15%/85-95% (Just over or just under the normal range)	<5%/>95% (Much over or much under normal weight)
Weight perception	Feels good about weight	Feels “fat” even though weight is normal on the chart	Skips meals, vomits, takes medicine, or exercises too much to control weight
Nutrition	Eats 3 meals/day; and eats fruits, vegetables, and foods with fiber	Eats less than 3 meals/day; or vegetarian without milk or eggs	Eats a lot of snacks with fat and sugar, eats few regular meals
Exercise	5 times/week for at least 20 min each, with increased heart rate and sweating	Exercises less than 5 times/week, not strenuously	No regular exercise to increase heart rate
Tobacco use	No smoke or chew	Smoke or chew less than daily; or Stopped less than 6 weeks ago	Smoke or chew regularly
Drug use	Never used	Previously used; not in the past 3 months	Recently used or currently uses marijuana, huffing, LSD, cocaine, heroin, etc.
Alcohol use	Has only tasted it, or used for religious purpose	Social only, not more than once/week; less than 3 beers or 2 liquor drinks at a time	Drunkenness, blackouts; drinking interferes w/school, family, etc.; 4 or more drinks at a time
Sexual activity	Never, or is married and faithful	Not in last 6 months; safe sex with condoms	Sex <u>without</u> regular use of condoms; first intercourse before age 16
School	B/C average or better, steady improvement in grades	Grades slipping; detention problem	Failing grades; suspension; often skips school
Depression	Usually happy	Often feels discouraged or down; cries a lot	Unhappy <u>most</u> of the time; feels hopeless; thought of suicide
Abuse	No physical or sexual abuse	Abuse reported and counseling received	Abuse still occurring or not treated with counseling
Safety	Uses seat belt/helmet, never rides with drunk driver	Usually uses seat belt/helmet; rarely rides with drunk driver	Does not use seat belt/helmet; has driven drink; sometimes rides with drunk driver
Violence	No fights, no threats, does not carry a knife, gun, or rifle, no legal troubles	Threatens others; previous illegal acts (stealing, etc.) but not in past 3 months	Damages own or others’ property; carries a gun, knife, or rifle; physical fights with peers; has had contact with police
Family relationships and responsibility	Gets along with family, completes chores or work duties	Often argues with family; does not complete chores or work duties	Physical and/or intense verbal fights with family
Friends and Recreation	Has male and female friends; involved in clubs, activities, or hobbies	Has few friends; does things alone; has friends who often get into trouble	Has no friends; or belongs to gang or cult
Good qualities and Future plans	Can name 3 good qualities about self; has plans for the future	Hard to think of good qualities about self; has few interests; does not have future	No good qualities about self; no interests or activities
Immunizations	Second MMR; tetanus within ten years; hepatitis series; had varicella or been vaccinated	Lacks any one item	Lacks two or more items

Kentucky Eye Examination Form for School Entry

8/2000

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 AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

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

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 / _____
	Normal Abnormal Not able 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: () _____

STATEMENT OF NON-DISCLOSURE OF SOCAL SECURITY NUMBER

DATE: _____

PARENT NAME AND 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 **(KEES) 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 your child.

Parent Signature: _____ Date: _____

Phone Number

Kentucky Dental Screening/Examination Form for School Entry

August 2010

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: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Last First Middle </div>		Student Race/Ethnicity: (Please check one) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> 1 White </div> <div style="width: 50%;"> <input type="checkbox"/> 5 American Indian/Alaska </div> <div style="width: 50%;"> <input type="checkbox"/> 2 Black/African American </div> <div style="width: 50%;"> <input type="checkbox"/> 6 Native Hawaiian/Pacific Islander </div> <div style="width: 50%;"> <input type="checkbox"/> 3 Hispanic /Latino </div> <div style="width: 50%;"> <input type="checkbox"/> 7 Multi-racial </div> <div style="width: 50%;"> <input type="checkbox"/> 4 Asian </div> <div style="width: 50%;"> <input type="checkbox"/> 9 Unknown </div> </div>	
Birth date: _____ Gender: <input type="checkbox"/> 0 Male <input type="checkbox"/> 1 Female		Screener's Name: _____ Screener's Address: _____ _____ Phone Number: _____ Screening Date: _____ _____ Screener's Signature: _____	
Parent or Guardian: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Name Relationship </div>			
Address: _____ City: _____			
Phone Number: _____ School: _____ Date of Enrollment: _____			
Untreated Decay: (Check one) <div style="margin-top: 10px;"> <input type="checkbox"/> 0 No untreated cavities <input type="checkbox"/> 1 Untreated cavities </div>	Treated Decay: (Check one) <div style="margin-top: 10px;"> <input type="checkbox"/> 0 No treated cavities <input type="checkbox"/> 1 Treated cavities </div>	Professional affiliation: (Please check one) <div style="display: flex; flex-wrap: wrap; margin-top: 10px;"> <div style="width: 50%;"> <input type="checkbox"/> Dentist </div> <div style="width: 50%;"> <input type="checkbox"/> Dental Hygienist </div> <div style="width: 50%;"> <input type="checkbox"/> Physician Assistant </div> <div style="width: 50%;"> <input type="checkbox"/> LHD Registered Nurse with KIDS Smiles training </div> <div style="width: 50%;"> <input type="checkbox"/> ARNP </div> <div style="width: 50%;"> <input type="checkbox"/> Physician </div> </div>	
Pattern of Early Childhood Cavities: (Check one) <div style="margin-top: 10px;"> <input type="checkbox"/> 0 No Early Childhood Cavities <input type="checkbox"/> 1 Early Childhood Cavities Present </div>	Treatment Urgency: (Check one) <div style="margin-top: 10px;"> <input type="checkbox"/> 0 No obvious problem <input type="checkbox"/> 1 Early dental care needed <input type="checkbox"/> 2 Urgent care needed NOTE: Comment required if marked. </div>		
		Comments:	



Boone County Schools

Permission to Videotape/Photography/Publish

2010-2011

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)/guardians(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

BOONE COUNTY SCHOOLS
Student Transportation Form

School Name: _____ Code: _____ School Year: _____

Student Name: _____ D.O.B. _____

Gender: _____ Grade: _____

Home Address:

Street Address: _____

City/State/Zip: _____

Parent/Guardian: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact:

Contact Name: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____

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 P/U and D/O, 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 official

AM (pick-up) information:

Bus # _____ Stop Location: _____

PM (drop-off) information:

Bus # _____ Stop Location: _____

This form must be filled out completely and turned into the school office with other enrollment documentation.

Revised 03/09/09

Commonwealth of Kentucky
Kentucky Department of Education
Boone County Board of Education

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