MONTGOMERY COUNTY SCHOOLS

Student Registration Form

Date_____ Grade_____

School_____ Homeroom Teacher_____

PERSONAL INFORMATION

Student's Legal Name: _____ / / __

(Last) (First) (Middle) SS# (optional)

Residence Address: _____

(Street) (Apt. #) (City) (Zip Code)

Mailing Address (if different from residence):_____

(Include P.O. Box # if applicable)

Home Phone: _____ **Birth Date:** _____ **Age:** _____ **Sex:** ☐ M ☐ F

Ethnicity: *Select one* ☐ Hispanic ☐ Non-Hispanic

Race: *Select all that apply* ☐ Caucasian/White ☐ African American/Black ☐ Asian

☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander

Last School Attended: _____ **City/ State:** _____

Has your child been diagnosed with a disability or special need? ___Y ___N - If yes please provide name of diagnosis, date, where diagnosed, and any additional information helpful for your child _____

_____

_____ _____

Person Completing this form – Must be parent or legal guardian (*please print*) **Date Completed**

FAMILY INFORMATION: PLEASE PROVIDE THE FOLLOWING INFORMATION:

Student Lives With: (check all that apply)

☐ Mother/Father ☐ Mother ☐ Father ☐ Grandparents ☐ Guardian

☐ Foster Parents ☐ Stepfather/Mother ☐ Stepmother/Father ☐ Other

Biological/Adoptive Parent Information:	**Biological/Adoptive Parent Information:**	**Legal Guardian (if not biological/adoptive parent)**
Name:_____	Name:_____	Name:_____
Address:_____	Address:_____	Address:_____
_____	_____	_____
Cell Phone:_____	Cell Phone:_____	Cell Phone:_____
Work Place:_____	Work Place:_____	Work Place:_____
Work Phone:_____	Work Phone:_____	Work Phone:_____
Email:_____	Email:_____	Email:_____
Step parent (if applicable):_____	Step parent (if applicable):_____	Step parent (if applicable):_____
_____	_____	_____

CONTINUE ON BACK

It is the responsibility of the parent or guardian to provide accurate information and to inform the school as changes occur to the information on this document.

VERY IMPORTANT - Please List ALL children living in the household- use separate sheet to list additional children if needed

Name	Birthdate	School Attending (if applicable)

REQUIRED CONTACT INFORMATION – List at least two contacts (OTHER THAN PARENTS) who may pick up your child in the event you cannot be reached:

Name:_____Phone:_____Alt. Phone: _____

Name:_____Phone:_____Alt. Phone: _____

Name:_____Phone:_____Alt. Phone: _____

Name:_____Phone:_____Alt. Phone: _____

Parent/Guardian signature_____ Date_____

Pick up restrictions: (Note: If biological parent(s) is restricted, court documentation is required to be on file at the school.)

BUS RIDER INFORMATION

In general as a matter of routine:

I ride the bus twice daily ___Yes ___No

I ride the bus once daily ___Yes ___No

I do not ride the bus ___Yes ___No

If known:

Bus number that picks you up_____ Bus number that drops you off_____

STUDENT RESIDENCY STATEMENT

This form is intended to address the requirements of the McKinney-Vento Act (Title X, Part C of the No Child Left Behind Act). The questions below are to assist in determining if the student meets the eligibility criteria for services provided under the McKinney-Vento Act. **Information provided on this form is confidential.**

Where does the student stay at night:

- ☐ In a shelter (family shelter, domestic violence shelter, or transitional living program);
- ☐ In a motel, hotel, or weekly-rate housing;
- ☐ In a house with parent(s);
- ☐ In a house or apartment with more than one family because of economic hardship or loss;
- ☐ In an abandoned building, a car, at a campground, or on the street;
- ☐ In a temporary foster care or with an adult who is not the parent or legal guardian;
- ☐ In substandard housing (no electricity, no water, and/or no heat);
- ☐ With friends or family because student is a runaway or unaccompanied youth; or
- ☐ Other (please specify):_____

I certify the above named student qualifies for the child Nutrition Program under the provisions of the McKinney-Vento Act.

Date: _____ McKinney-Vento Liaison Signature: _____

It is the responsibility of the parent or guardian to provide accurate information and to inform the school as changes occur to the information on this document.

Revised 3/28/19

Montgomery County School District

HOME LANGUAGE SURVEY

Student Name: _____ Birth Date: _____ Sex: ❑ Male ❑ Female

Parent/Guardian Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

School: _____ Grade: _____ Date: _____

Federal and state laws require the following information be collected about the primary and home language of every student upon enrollment in the school district. Please complete a survey for each child you are enrolling in the school district.

1. What language did your child learn when he/she first began to talk? _____

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

3. What language is spoken by you and your family most of the time at home? _____

If a language other than English is indicated for any of the above questions, the school district will test your child's English language proficiency to determine eligibility for initial and continuing placement in an English language development program. You will be notified about the results of this testing.

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

_____ _____

Parent or Guardian's Signature Date

OFFICE USE ONLY			
Student ID #	Date Distributed	Date Received	

Publication Consent Form

School _____

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 public awareness or fund-raising purposes. 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 posting a likeness of your child on the school or District Web site.

Under 09.14 AP.12, the District has designated student photographs as "directory information." Consistent with that annual notice, a photograph of an individual student may be released to others and/or reproduced in school yearbooks as long as the parent or adult student has not submitted written notice (by returning form 09.14 AP.12) indicating that they do not wish photographs of the student to be released.

This form covers permission for the District to record and use the recorded image, voice, or work of the student (photographed, filmed, taped, or digitally recorded) for public awareness purposes, including publication on the school and/or District's web site and in school yearbooks.

Please review this form carefully, sign and date the form, and submit the form to the school.

Once signed and dated, this form shall remain in effect for your child's enrollment in any of our 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 (*PLEASE PRINT*)

Montgomery County School District permission to release my/our child's name, photograph, and/or audio/video reproduction for publication to the general public concerning school functions and activities, including academic and athletic activities.

Name of Parent(s)/Guardian(s) (**PLEASE PRINT**) _____

_____ _____

Parent/Guardian's Signature ***Date***

NOTE: If the recorded image, voice, or work of a student is to be included in a publication as part of a commercial or for-profit fund-raising endeavor, affirmative authorization of the parent/guardian or eligible student must be obtained.

Review/Revised:7/26/2016

Electronic Access/User Agreement Forms

AUP FORM FOR STUDENTS

STUDENT'S NAME (LAST) _____ **(FIRST)** _____ **(INITIAL)** _____

STUDENT'S ADDRESS _____

STUDENT'S AGE ____ **DATE OF BIRTH** _____ **SEX** ___ **PHONE NUMBER** _____

SCHOOL _____

GRADE _____ **HOMEROOM/CLASSROOM** _____

As a user of the **Montgomery County School District's** computer network, I hereby agree to comply with the District's Internet and electronic mail rules and to communicate over the network in a responsible manner while abiding by all relevant laws and restrictions. I further understand that violation of the regulations is unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked and school disciplinary action and/or legal action may be taken.

Student's Signature _____ Date _____

Prior to the student's being granted independent access privileges, the following section must be completed for students under 18 years of age:

As the parent or legal guardian of the student (under 18) signing above, I grant permission for my child to access networked computer services such as electronic mail and the Internet. I understand that this access is designed for educational purposes; however, I also recognize that some materials on the Internet may be objectionable, and I accept responsibility for guidance of Internet use by setting and conveying standards for my child to follow when selecting, sharing, researching, or exploring electronic information and media.

CONSENT FOR USE

By signing this form, you hereby accept and agree that your child's rights to use the electronic resources provided by the District and/or the Kentucky Department of Education (KDE) are subject to the terms and conditions set forth in District policy/procedure. Please also be advised that data stored in relation to such services is managed by the District pursuant to policy 08.2323 and accompanying procedures. You also understand that the e-mail address provided to your child can also be used to access other electronic services or technologies that may or may not be sponsored by the District, which provide features such as online storage, online communications and collaborations, and instant messaging. Use of those services is subject to either standard consumer terms of use or a standard consent model. Data stored in those systems, where applicable, may be managed pursuant to the agreement between KDE and designated service providers or between the end user and the service provider. Before your child can use online services, he/she must accept the service agreement and, in certain cases, obtain your consent.

Name of Parent/Guardian (Please print) _____

Signature of Parent/Guardian _____

STUDENTS: Return this form to your school.

Review/Revised:4/26/2016

MONTGOMERY COUNTY SCHOOL HEALTH UNIT CONSENT FOR SERVICES 2020-21

Student Name: _____ Grade: _____ School: _____

Student's Health Care Provider: _____

The School Health Unit will provide care for all students P-12. This includes, but is not limited to, illness/injury assessment, medication administration, emergency first aid and/or monitoring/education for chronic disease such as asthma or diabetes. However, we cannot provide services to your child without this signed consent (except for emergency first aid). The parent/guardian may withdraw/rescind consent at any time in writing. The school also ensures health screenings including height, weight, vision & hearing are completed as required, and legal guardians are notified of any abnormal findings.

Please review this form carefully, and complete all information requested and return to your child's homeroom teacher or directly to the school nurse.

All medications sent from home must have proper parent/guardian consent, be in the original container with proper label and taken to the school nurse immediately upon arrival to school for proper storage and administration. Per protocol, non-prescription medications are not for more than three days *consecutively* without a physician's order. **All medications must be provided by the parent/guardian.**

The Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available to read. To ensure student safety, school health services may share educationally relevant health information with school staff or medical professionals having direct involvement with my child, or may contact the healthcare provider for necessary health information or medication and treatment clarification.

The school nurse (RN) will delegate necessary daily or as needed medication (provided by the parent) for field trips when indicated by school health consent, IHP, parental note or emergency. And that during off campus events, school personnel will make the determination, in case of emergency, to contact 911/EMS for emergency treatment**.** With all accidents, the student's healthcare coverage is processed first, as the school's accident insurance is a secondary insurance policy.

I understand that a school nurse or trained staff member, in accordance with the Kentucky Department of Education and Montgomery County School Health Protocols, may provide comfort measures such as **saltine crackers**, **lemon lime caffeine free soda**, **peppermint disks** or **soft peppermint** as age appropriate after she/he has evaluated my child's complaint. The health unit also has first aid items, including but not limited to **eye wash/artificial tears**, **aloe vera gel** & **Vaseline**.

Do NOT give my child the listed comfort measures: _____

Known Allergies: _____

Known Medical Conditions & Current Medications @ home: _____

_____

My child may require **over-the-counter medication provided by me**, as needed for symptoms of his/her health condition.

OTC Medication: _____ Given For: _____ Dosage: _____
OTC Medication: _____ Given For: _____ Dosage: _____

By signing this consent, I release Montgomery County Schools from any liability related to the administration of medications or treatment as long as reasonable and customary care is given. This consent is given voluntarily and with full knowledge of its significance.

_____ _____ _____
Parent/Legal Guardian Signature* Relationship to child Date

Health and Emergency Information Form

Students Name: _____ Birth date: _____

Grade_____ School: _____

Legal Home Street Address _____

#1 Legal Guardian Name_____ Contact # (___) _____

#2 Legal Guardian Name_____ Contact # (___) _____

Please mark the following CURRENT HEALTH conditions diagnosed by a healthcare provider:

□ ADD/ADHD □ANAPHYLAXIS (EPI PEN) □ ASTHMA □ CARDIAC/ HEART CONDITION □ DIABETES

□ METABOLIC DISORDER □MIGRAINES □SEIZURES OTHER-PLEASE SPECIFY: _____

List ALL Medication your child takes at school or at home _____

LIST ALL Known Allergies: _____

An individualized health plan (IHP) must be completed for all current health conditions. *A student may not carry a medication (insulin, asthma inhalers, Epi-pens etc) with them UNLESS written permission from their health care provider and parent is provided.

The School Health Unit will provide care for all students. This includes, but is not limited to, illness/injury assessments, medication administration, emergency first aid and/or monitoring/education for chronic disease such as asthma or diabetes and referrals for further medical assessment. The school nurse cannot provide services to your child without this signed consent (except for emergency first aid). The school nurse ensures health screenings are completed including height, weight, vision & hearing as required, and that I will be notified of any abnormal findings.

All medications sent from home must be in the original container, accompanied by proper parent/guardian consent and must be given to the nurse, the staff member designated to provide health services or the supervising teacher/sponsor/coach for proper storage. (Includes field trips) Prescription meds must have written authorization of prescribing healthcare provider and OTC medications must have written approval of parent/guardian. Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available to read.

In order to ensure my child's safety, school health services may share educationally relevant health information with others having direct involvement with my child. Medication may be delegated by the nurse for field trips when indicated by school health consent, IHP, parental note or emergency situation; based on health information on file in the health unit at the time of departure. By signing below, I give my child consent to participate in **EDUCATIONAL/SPORTS/CLUB** school-related student trip(s). I understand that I am responsible to provide all medications and treatment supplies related to my child's health conditions indicated above. I authorize trained school personnel to assist my child with his/her medication as my child's healthcare provider or I have directed if needed. **Teachers/Sponsors are responsible to provide specific information and have specific consent for each trip. Form 09.36 AP.211 is required for any overnight or out of state travel. S**chool personnel will make the determination, in the event of accident or sudden illness while at school or on a school-sponsored trip, to have EMS transport my child to the nearest hospital and authorize treatment as deemed necessary for the health of said child.

EMERGENCY CONTACTS: Please name two (2) persons other than the legal guardian that may take responsibility for your child or make decisions for health care:

1) _____ Phone #_____

2) _____ Phone #_____

Child's Healthcare Provider: _____ Child's Insurance Provider: _____

_____ _____

Parent/Legal Guardian Signature ***Date***

Review/Revised:9/26/2017

MONTGOMERY COUNTY SCHOOLS 2020-2021

Dear Parent/Guardian:

Our school is participating in the Community Eligibility Provision (CEP) under the National School Lunch Program. The CEP provision is available to schools with a high percentage of economically disadvantaged students. Under CEP all students receive a breakfast/lunch at no charge for the entire school year. However, to determine eligibility to receive additional benefits for your child(ren) you will need to complete a household and income form.

1. DO I NEED TO FILL OUT A FORM FOR EACH CHILD? No. *Use one Household and Income Form for all students in your household.* We cannot use a form that is incomplete, so be sure to fill out all required information. Return the completed form to your child(ren)'s school.

2. MY CHILD(REN) ALREADY RECEIVE MEALS AT NO CHARGE. WHY SHOULD I COMPLETE THIS FORM AS WELL? Many state and federal programs use socioeconomic status (that is, household and income information) to determine eligibility for their programs. In addition, the primary state funding calculation uses socioeconomic status. By completing this form your school is able to determine your child(ren)'s eligibility for additional programs. Regardless, your child(ren) will still receive meals at no charge.

3. 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.

4. 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.

5. 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.

6. 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.

If you have other questions or need help, call 859-497-8578

Sincerely,

April Johnson, FRAM Coordinator

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 and call **April Johnson, FRAM Coordinator. 859-497-8578.**
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 FRAM Coordinator has a question about your information.

HOUSEHOLD AND INCOME FORM 2020-2021

Montgomery County School District is participating in the Community Eligibility Provision (CEP) under the National School Lunch Program. Under CEP, **all** children in the school will receive a breakfast/lunch at no charge regardless of income or completion of this form. However, to determine your child(ren)'s eligibility for various additional state and federal program benefits, please complete, sign and return **a single application per household** to your child(ren)'s school.

PART 1. ALL HOUSEHOLD MEMBERS

Names of **ALL** people living in your household (First, Middle Initial, Last)	**School the child attends**, or indicate "NA" if household member is not in school	Grade Level	*Check if a foster child (legal responsibility of the state welfare agency or court). If all children listed below are foster children, **skip to Part 4** to sign this form.*	
			❑	
			❑	
			❑	
			❑	
			❑	
			❑	
			❑	

PART 2. HOMELESS, MIGRANT, RUNAWAY STATUS

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call **April Johnson, 859-497-8578.**

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. If you provided a case number in Part 2, you do **not** need to provide income information. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

☐ **DECLINE TO PROVIDE INCOME** – Check this box if you don't wish to provide your income information; your SES status will automatically be "Paid".

1. NAME (List only household members with income, including any students in the home who have income)	**2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED** Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Public assistance, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, Social Security, SSI, VA benefits, All Other Income	Weekly	Every 2 Weeks	Twice Monthly	Monthly
(Example) Jane Smith	$200	☒	☐	☐	☐	$150	☐	☒	☐	☐	$0	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 4. SIGNATURE (ADULT HOUSEHOLD MEMBER MUST SIGN)

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: ____________________

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, gender identity, age, or disability. To file a complaint of discrimination, write U.S. Department of Education, Office for Civil Rights, The Wanamaker Building, 100 Penn Square East, Suite 515, Philadelphia, PA 19107-3323 or call (215) 656-8541 (Voice). Individuals who are hearing impaired or have speech disabilities may contact U.S. DOE through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). The U.S. Department of Education is an equal opportunity provider and employer.

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, with auditors for program reviews, and with law enforcement officials to help them look into violations of program rules. Regardless, all students enrolled in a Community Eligibility Provision school will receive meals at no charge.

HOUSEHOLD CHECKLIST

- ☐ Have you included all your children as household members?
- ☐ For each household member receiving income, is the frequency checkbox checked?
- ☐ Have you signed the form?

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: _____

Categorical Eligibility: _____ SES Code: Free_____ Reduced_____ Paid_____

FRAM Coordinator: _____ Date: _____

STERLING HEALTH CARE

School Year 2020-2021

School Based Health Consent for Services Sterling Health Care, Inc.

The Medical Providers (Sterling Health Care, Inc.) will offer health services that include, but are not limited to acute care, preventive services, school physicals, medications for minor illnesses and emergency treatment as needed. Basic laboratory tests will be provided at the School Based Clinic when requested by a parent or if a child comes to the clinic with symptoms indicating the need for a lab test, or if it's a required part of the physical exam. Please review this form carefully and complete all information that is requested. **The Providers cannot/will not provide service to your child without this signed consent.** This consent does not cover Immunizations. You must contact the School Based Clinic, or the Providers will contact you for a separate consent for that service. The consent can be withdrawn at any time by the parent or guardian by informing the provider in writing.

Student's School:_____

Last Name: _____ **First Name**:_____ **Middle Name:** _____

Gender: M/F **SSN:**_____ **Birth Date:**_____ **Nickname:**_____

Race: ☐White ☐Black/African American ☐Asian ☐American Indian/Alaskan Native ☐Native Hawaiian ☐ Other

Ethnicity: ☐Hispanic/Latino ☐Non Hispanic/Non Latino **Primary Language:**_____ **Interpreter Needed?** ☐Yes ☐No

Address:_____ **Zip Code**:_____

Contact Phone: _____ **Work Phone:** _____ **Email Address:** _____

Preferred Communication: Phone/Email

In case of emergency, please contact:

Name of Mother/Legal Guardian:_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:**_____

Name of Father/Legal Guardian:_____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:**_____

Student's Doctor: _____ **Student's Dentist:**_____ **Pharmacy:**_____

Would you like your student's visit note sent to their doctor? ☐Yes ☐No

INSURANCE INFORMATION:

Do you have insurance? ☐Yes ☐No

Primary Insurance: _____ **ID#**_____ **GROUP#**_____

Secondary Insurance: _____ **ID#**_____ **GROUP#**_____

Policy Holder Name:_____ **Policy Holder Date of Birth:**_____

Policy Holder Gender: ☐Female ☐Male **Policy Holder Phone:**_____ **Policy Holder SSN:**_____

Policy Holder Address if different from Patient:_____

Birth Mother's Full Name:_____ **DOB:**_____ **SSN:**_____

*Only required if Birth Mother is still on student's insurance.

This information is **required** for the student's health record to be complete but will ONLY be billed if services are provided the by Nurse Practitioner. School nurse visits are not billed to insurance.

Student's Medical History:

The following information will aid the School Nurse/Nurse Practitioner in making an accurate assessment of your child in case of illness or emergency.

ALLERGIES: Please list all medications, vaccines, food or any other allergies

CURRENT MEDICATION(S)

Medication Name	Dosage	Directions

****You will be asked to complete a separate Medication Consent form if you desire the School Nurse to administer this medication in the School.**

Any Hospitalizations? ☐Yes ☐No

Reason for Hospitalization	Date of Hospitalization	Facility Where Hospitalized

Any Surgeries? ☐Yes ☐No

Type of Surgery	Date of Procedure	Facility Where Procedure Was Performed

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

Condition	Y	N	Condition	Y	N	Condition	Y	N
Allergies			Heart Murmur			Chicken Pox		
Asthma			Wheezing			Urinary Tract Infection		
Eczema			Pneumonia			Acne		
Seizures			Ear Infections			Serious Injury or Concussion		
Developmental and/or Speech Problems						ADHD/ADD		
Diabetes						Other		
If Other Please Explain:								

FAMILY HISTORY: Do any family members have any of the following conditions?

Condition	Relative	Condition	Relative	Condition	Relative
Heart Attack	Age:	Pancreatic Cancer		Migraine	
High Blood Pressure		Any other Cancer		Seizures	
Congestive Heart Failure		Colitis		Diabetes	
Rheumatic Heart Disease		Crohn's Disease		Goiter	
Congenital Heart Disease		Colon Polyps		Bleeding Tendency	
Breast Cancer	Age:	Hepatitis		Suicide	
Colon Cancer	Age:	Stomach Ulcer		Mental Illness	
Leukemia		Kidney Disease		Tuberculosis	
Melanoma (skin cancer)		Stroke		Other	
Ovarian Cancer		Asthma		Drug or Alcohol Abuse	

When was the last time your child was seen by a doctor?
Doctor's Name: _____ **Reason:** _____ **Date:** _____

Immunization Status: Is your child up to date on immunizations? ☐Yes ☐No
Where is the child's immunization record on file: _____

☐Yes, I give permission for school nurse to provide a copy of immunization record
Other:

Do you have concerns about your child's health? ☐Yes ☐No Does your child smoke and/or use tobacco products? ☐Yes ☐No

Does your child drink alcohol? ☐Yes ☐No Is your child exposed to second hand smoke? ☐Yes ☐No

INCOME: ***Note: Sterling Health Care, Inc. Center is dedicated to providing health care to the community.***
We rely on grant funds to support our school based health programs. By providing the income information requested, this will help us report about the population we serve and is important when applying for grants. THANK YOU FOR YOUR HELP!

Household Size: _____ **Family Income:** _____

Sterling Health Care, Inc. Center School Based Health Assignment of Benefits / Consent for Treatment

I consent to the customary tests, procedures that may be deemed necessary for treatment of my child's condition by members of the Medical Staff of Sterling Health Care, Inc. Center. Consent is hereby given for such visits to the school nursing office for the purposes of examination, treatment, and procedures rendered by a qualified Nurse Practitioner. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment. I authorize payment of medical benefits to the supplier for services provided by Sterling Health Care, Inc. Center. I understand that I may be billed separately for services provided by clinic providers for treatment related services. I hereby authorize payment directly to the professional providing these services which would otherwise be payable to me. *Services performed by the school nurse are not billed.

Authorize for Release of Medical Information

I hereby authorize the release of medical information as necessary for settlement of this claim. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records, as well as release of records to my child's primary care provider. Further, I release Sterling Health Care, Inc. Center and any related corporations or affiliates from any liability resulting from the release of these medical records and agree to identify and hold them harmless from any such liability. This constitutes permission to release medical information regarding sexually transmitted disease, if applicable, to Third Party Payor pursuant to KRS 214.420.

I have read the above and understand that items above as it applies to me. I verify I have received a Notice of Privacy Practices (45 CFR 164.520 (2) (ii) and Bill of Rights.

Date _____ Signature of the Parent/Legal Guardian (REQUIRED) _____

Best **phone number** to reach you _____ **Email** to link you to Patient Portal for child's health record _____

Date _____ Signature of Witness _____

If parent/legal guardian signs with (X) or authorized person gives verbal consent, two signatures with names, addresses, and telephone numbers must be entered below.

Date _____ Phone Number _____ Witness Name _____ Address _____

Date _____ Phone Number _____ Witness Name _____ Address _____