



**2022 - 2023**

**PIKEVILLE JUNIOR HIGH/HIGH SCHOOL ENROLLMENT PACKET**

***(IMPORTANT!! PLEASE SAVE THIS DOCUMENT TO YOUR COMPUTER BEFORE TYPING.)***

Full Student Name: \_\_\_\_\_

Please enter today's date (MM/DD/YYYY): \_\_\_\_\_

Dear Parent/Guardian:

In an effort to streamline registration we are providing an electronic enrollment packet to be completed at your convenience. The electronic packet is designed so certain pieces of information (the most common ones) only need to be entered once. Please be sure to click SAVE frequently so information will not be lost. After completing the document please print and sign where appropriate. Signature areas are highlighted in yellow. Please bring the completed enrollment packet to registration to lessen wait time.

We apologize for the length of the enrollment packet but we must update information every school year. An enrollment packet must be completed for each child wishing to attend Pikeville Junior High/High School. Thank you for choosing Pikeville Junior High/High School!

**FOR OFFICE USE ONLY**

Date Received:	
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<b>Student Information</b>	School Year:		Tuition Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a new address? <input type="checkbox"/> Yes <input type="checkbox"/> No
Full Name:			Grade:	Gender: .
Social Security #:			Birthdate:	Race:
Cell #:			Email:	
Mailing Address:				
Physical Address:				

<b>Parent/Guardian #1</b>			<b>Relationship:</b>	
Student lives with this person? <input type="checkbox"/> Yes <input type="checkbox"/> No			If not the parent, do you have legal/court documents on file with us? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Full Name:			Birthdate:	
Work Phone #:		Home Phone #:	Cell #:	
Mailing Address:				
Physical Address:				
Place of Employment:		Email:		

<b>Parent/Guardian #2</b>			<b>Relationship:</b>	
Student lives with this person? <input type="checkbox"/> Yes <input type="checkbox"/> No			If not the parent, do you have legal/court documents on file with us? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Full Name:			Birthdate:	
Work Phone #:		Home Phone #:	Cell #:	
Mailing Address:				
Physical Address:				
Place of Employment:		Email:		

<b>Other Household Members:</b> Please list ALL Other individuals (adults and students) living in your home at this time.					
Full Name	Relationship To Student	Gender	Birthdate	Grade	School Attending

<b>Emergency Contacts:</b> To ensure your child's safety, please list those individuals who may be contacted in an emergency situation and who are authorized to sign your child out from school <i>besides parents/guardians</i> . **Must be updated annually**				
Full Name	Relationship To Student	Work #	Cell #	Home #

<b>Transportation:</b> Student transportation will not be changed without written notification from parent/guardian.							
	Rides Bus	Is Transported By Parent		Drives Self			
To School	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
From School	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
<b>If your child is transferring from another school:</b>		<b>If transferring to PHS, has your child been previously identified or received services in any of the following.</b>					
School Attended:		<input type="checkbox"/>	Special Education	<input type="checkbox"/>	ESL	<input type="checkbox"/>	Speech
School Address:		<input type="checkbox"/>	Gifted & Talented	<input type="checkbox"/>	504 Plan	<input type="checkbox"/>	Vision
		School Phone #:					
<b>Parent/Guardian Printed Name:</b>							
<b>Parent/Guardian Signature:</b>					Date		

Student Information			
Full Name:			Grade:

Media Release Form	
<input type="checkbox"/>	I <b>DO</b> give permission to the school/news media to photograph/videotape my child. It is my understanding that this photograph/videotape or portions thereof may be used for public viewing. I agree to allow my child to participate in these projects without financial remuneration, and I understand that this releases the school/district from any future claims, as well as from any liability arising from the use of the said photograph/videotape.
<input type="checkbox"/>	I <b>DO NOT</b> grant permission for the school/news media to photograph/videotape/interview my child or to post information on the Web about my child.

Student Usage of Computers, Network, Internet and Telephones
<p>I, the student, understand and will abide by the Pikeville Independent School District's Acceptable Use Procedures for the Network, Internet and Telephone Usage. I further understand that any violation of the regulations stated in these procedures is unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked, school disciplinary action may be taken, and/or appropriate legal action may be pursued. This document shall be valid until revisions are made to the District Acceptable Use Policy or until the student, parent, or guardian makes a written request to change the access.</p>
<p>I, the parent/guardian have read and discussed the District Acceptable Use Procedures for the Network, Internet and Telephone Usage with my child. I understand that access to the Network and Internet is designed for educational purposes. The District has taken precautions to eliminate controversial materials; however, I recognize it is impossible to restrict access to all controversial materials. I will not hold the District/school responsible for materials my child acquires on the Network or Internet. Further, I accept full responsibility for supervision when my child's use is not in a school setting. I hereby give permission to issue an account for my child and certify that the information contained on this form is correct.</p>

Technology Information									
Do you have a computer at home?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Is the computer less than 5 years old?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
What type of device(s) do you own? (Check all the apply):	Desktop	<input type="checkbox"/>	Laptop	<input type="checkbox"/>	Tablet	<input type="checkbox"/>	Chromebook	<input type="checkbox"/>	
Do you have Internet Access at home?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
If yes, what type?	Cable	<input type="checkbox"/>	DSL	<input type="checkbox"/>	Satellite	<input type="checkbox"/>	Dial-Up	<input type="checkbox"/>	
If no, do you use cellular service (i.e. 3G, 4G, LTE, etc.) to access the web, email, or social media?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
If you have Internet capability, would you prefer communication via email?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					

<p><b>Parent/Guardian Printed Name:</b> _____</p> <p><b>Parent/Guardian Signature:</b> _____ <b>Date:</b> _____</p>
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Student Information	
Full Name:	Grade:

School-Related Student Trip Permission Slip and Medical Release Form	
Mode of Transportation: <i>SCHOOL BUS</i>	Cost to Student, if applicable: \$ <i>VARIES PER TRIP TAKEN</i>
<input type="checkbox"/>	I <b>DO</b> give permission for my child to participate in the above mentioned school-related student trip(s).
<input type="checkbox"/>	I <b>DO NOT</b> give permission for my child to participate in the above mentioned school-related student trip(s).
In addition, in the event of accident or sudden illness while on the school-related student trip, I authorize school personnel to contact the physician(s) listed on my child's school enrollment data forms and authorize those physician(s) to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event physician(s), parent(s), or other persons designated by the parent cannot be contacted, school personnel are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of said child.	

FERPA														
<p>The Family Educational Rights and Privacy Act (FERPA), a federal law, requires that the Pikeville Independent School District, with certain exceptions, obtain your written consent to the disclosure of personally identifiable information from your child's education records. However, Pikeville Independent Schools may disclose appropriately designated "directory information" without written consent, unless you have advised the District to the contrary in accordance with District procedures. The primary purpose of directory information is to allow the Pikeville Independent Schools to include this type of information from your child's education records in certain school publications. Examples include:</p> <p><i>A playbill, showing your student's role in a drama production; The annual yearbook; Honor roll or other recognition lists; Graduation programs; and Sports activity sheets, such as for wrestling, showing weight and height of team members.</i></p> <p>Directory information, which is information that is generally not considered harmful or invasion of privacy if released, can be disclosed to outside organizations without a parent's prior written consent. Outside organizations include, but are not limited to, companies that manufacture class rings or publish yearbooks. <u>In addition, two federal laws require local educational agencies (LEAs) receiving assistance under the Elementary and Secondary Education Act of 1965 (ESEA) to provide military recruiters, upon request with three directory information categories-names, addresses and telephone listings-unless parents have advised the LEA that they do not want their student's information disclosed without their prior written consent.</u></p> <p>If you do not want Pikeville Independent Schools to disclose directory information from your child's education records without your prior written consent, you must notify the District <b>in writing</b> by September 1st. Pikeville Independent School has designated the following information as directory information:</p> <table border="0"> <tr> <td>Student Name</td> <td>Participation in official activities and sports</td> </tr> <tr> <td>Address</td> <td>Telephone listing</td> </tr> <tr> <td>Weight and height of members of athletic teams</td> <td>Electronic mail address</td> </tr> <tr> <td>Photograph</td> <td>Degrees, honors and awards received</td> </tr> <tr> <td>Date and place of birth</td> <td>Major field of study</td> </tr> <tr> <td>Dates of attendance</td> <td>Grade level</td> </tr> <tr> <td>The most recent educational agency or institution attended</td> <td></td> </tr> </table>	Student Name	Participation in official activities and sports	Address	Telephone listing	Weight and height of members of athletic teams	Electronic mail address	Photograph	Degrees, honors and awards received	Date and place of birth	Major field of study	Dates of attendance	Grade level	The most recent educational agency or institution attended	
Student Name	Participation in official activities and sports													
Address	Telephone listing													
Weight and height of members of athletic teams	Electronic mail address													
Photograph	Degrees, honors and awards received													
Date and place of birth	Major field of study													
Dates of attendance	Grade level													
The most recent educational agency or institution attended														

Student Printed Name: _____
Student Signature: _____ Date: _____
Parent/Guardian Printed Name: _____
Parent/Guardian Signature: _____ Date: _____

**\*\* PIKEVILLE HIGH SCHOOL ONLY \*\***

**Student Information**

Full Name:

Grade:

**Pikeville Independent Schools – Random Drug & Alcohol Testing Program – Consent To Test Form (Grades 9-12)**

The student and his/her parent(s) or guardian(s) acknowledge that the Pikeville Independent School District ("District") has the right to perform random drug and alcohol testing on students who wish to exercise the privilege of participating in high school athletics, extracurricular activities or who wish to exercise the privilege of driving and/or parking on school property.

The student and his/her parent(s) or guardian(s) understand that as a condition of the student being allowed to participate on any Pikeville High School athletic team, extracurricular activity and/or as a condition of the student being allowed to drive and/or park on school property, the student may be required to undergo and successfully pass a random screening for alcohol, illegal drugs or other banned substances, as set forth in the District's Use of Alcohol, Drugs, and Controlled Substances Policy and Student Random Drug Testing Procedures (09.423 and 09.423 AP.1) which can be found and printed from the following website: <http://policy.ksba.org/p07/>. The student and his/her parent(s) or guardian(s) acknowledge that they have read and understand this policy and procedure and that they agree to all the terms and conditions contained in the policy and procedure.

The student and his/her parent(s) or guardian(s) hereby consent to participate in the random drug and alcohol testing program and to the disclosure of testing results to designated District personnel and parent(s) or guardian(s). The student and his/her parent(s) or guardian(s) further understand that the student's refusal to submit to a drug screening will be treated in the same manner as if the student had tested positive for banned substances.

No student shall be penalized academically for testing positive for banned substances during random drug testing.

The privilege of being allowed to participate on any Pikeville High School athletic team, extracurricular activity, and/or being allowed to drive to and/or park on school property is contingent on the signing of this consent form.

This consent form shall remain in effect for a period of twelve (12) months from the date it is executed. Any revocation of this consent form shall disqualify the student from participating in extracurricular activities or driving to and from school for a period of twelve (12) months.

I plan to participate in the following (please mark all that may apply):

<i>Athletic Program (any PHS team)</i>	<input type="checkbox"/>	<i>Extracurricular Activities (clubs or organizations)</i>	<input type="checkbox"/>	<i>Student Driver</i>	<input type="checkbox"/>
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**Student Printed Name:** \_\_\_\_\_

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Printed Name:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Kentucky Migrant Education Program

Parent Employment Survey



## Versión en español en el otro lado de la hoja

The Migrant Education Program (MEP) is authorized by Title 1, Part C of the Elementary and Secondary Education Act (ESEA). The **KEDC Regional Migrant Education Program** (606-547-1414) provides a variety of educational services to families who work in agriculture, **regardless of their nationality** or legal status. This program is **free of charge** to all eligible families and **may** include tutoring, free lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

A program employee may contact you for further information if needed.

Child's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

1. In the past three years, has your family lived in another Kentucky school district, another state, and/or another country?

Yes ☐ (continue to #2)

No ☐ (stop here)

2. In the past three years, has anyone in your household had a job working with any of these products (**not including your own property**) on a farm, in a field, in a greenhouse, in a nursery, or in a factory?  
Please circle all that apply.



Livestock (cattle, pigs, sheep, dairy, etc.) ☐



Eggs ☐



Chickens ☐



Crops (wheat, corn, soybeans, etc.) ☐



Vegetables ☐



Processing (meat, fruit, vegetables, trees, etc.) ☐



Tobacco ☐



Fruits ☐



Hay ☐



Nursery, Sod, Greenhouse ☐



Trees, Timber, Plants, Flowers ☐



Soil Preparation ☐

If you circled one or more, continue to #3.

None of these ☐ (stop here)

3. Parents' Names: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Please list all children in the household less than 22 years of age:

Name	Date of Birth	Grade	School

## Home Language Survey

Dear Parent/Guardian:

The purpose of the home language survey (HLS) is to determine the primary or home language of the student. This information is essential in order for schools to provide meaningful instruction for all students. The HLS is part of the statewide identification process required under Section 3113(b)(2) of the Every Student Succeeds Act (ESSA) and 703 KAR 5:070 and the related [Inclusion of Special Populations Guidance](#).

The HLS must be given to all students in grades K-12 upon their initial enrollment in the district as a first screening process to identify potential English learner students. The HLS is administered one time, upon initial enrollment in grades K-12 and remains in the student's cumulative file.

Please note that the answers to the survey below are student-specific. **If a language other than English is recorded for ANY of the required survey questions below, the district is legally obligated to do further assessment of your child to determine if they are eligible for language support.**

Answers will not be used for determining legal status or for immigration purposes. If your child is identified for English language services, you may decline some or all of the services offered to your child.

If you have any questions on how to complete the HLS, please contact your child's school.

### Student Information (required):

Name: \_\_\_\_\_

Grade: \_\_\_\_\_

### Student Language Background (required):

1. What is the language most frequently spoken at home? \_\_\_\_\_
2. Which language did your child learn when they first began to talk? \_\_\_\_\_
3. What language does your child most frequently speak at home? \_\_\_\_\_
4. What language do you most frequently speak to your child? \_\_\_\_\_

### Language for School Communication (not required):

5. In which language would you prefer to receive all school information: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

By signing here, you certify that responses to the four required questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for language support services, to help them become fluent in English. Students qualifying for language support services are entitled to services as an English learner and will be tested annually to determine their English language proficiency as required by ESSA 1111(b)(2)(G).

### For School Use Only

School personnel who administered and explained the HLS and potential placement of a student into an English language development program if a language other than English was indicated:

Name: \_\_\_\_\_

Date: \_\_\_\_\_



SCHOOL/HOMEROOM: \_\_\_\_\_

GRADE: \_\_\_\_\_

## CONSENT FOR SCHOOL HEALTH SERVICES/MEDICATION ADMINISTRATION

## PIKE COUNTY HEALTH DEPARTMENT/PIKEVILLE INDEPENDENT SCHOOLS

CHILD'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ GENDER \_\_\_\_\_ RACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CHILD'S SOCIAL SECURITY #: \_\_\_\_\_

PARENT/LEGAL GUARDIAN: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

DO YOU PREFER TO RECEIVE THE SUMMARY OF YOUR CHILD'S VISIT BY: ☐ MAIL ☐ E-MAIL

PARENT/GUARDIAN E-MAIL ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE \_\_\_\_\_  
(Other than Parent)

MEDICAL INSURANCE CARRIER: \_\_\_\_\_ CARD HOLDER'S NAME: \_\_\_\_\_

POLICY ID#: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_ NUMBER IN HOUSEHOLD: \_\_\_\_\_

STUDENT'S DOCTOR: \_\_\_\_\_ DOCTOR'S PHONE: \_\_\_\_\_

STUDENT'S DENTIST: \_\_\_\_\_ DENTIST'S PHONE: \_\_\_\_\_

PHARMACY OF CHOICE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

SEIZURES \_\_\_\_\_ ALLERGIES/ASTHMA (food, insects, medication, latex, fluoride, other) \_\_\_\_\_

DOES YOUR CHILD REQUIRE AN EPI-PEN PRESCRIPTION FOR ANY ALLERGIES? YES ☐ NO ☐

## CURRENT MEDICATIONS

## CHRONIC MEDICAL ILLNESSES

## SIGNIFICANT MEDICAL / SOCIAL HISTORY (Including Injuries)

SIGNIFICANT FAMILY MEDICAL HISTORY ☐ Hypertension ☐ High Cholesterol ☐ Diabetes ☐ Other \_\_\_\_\_

Please check any of the following, which you will allow your child to be given, and state dosage if necessary. All doses not specified will be given according to the child's age and weight using manufacturer's guidelines.

<input type="checkbox"/>	Advil/Motrin (Ibuprofen)	<input type="checkbox"/>	Benadryl	<input type="checkbox"/>	Orajel (toothache) Chloraseptic (sore throat)
<input type="checkbox"/>	Aloe Vera (for burns)	<input type="checkbox"/>	Cold Remedies (cough syrup, decongestant)	<input type="checkbox"/>	Sun Screen (SPF 15 or above)
<input type="checkbox"/>	Antacids (Maalox, Tums, etc.)	<input type="checkbox"/>	Diarrhea Medication	<input type="checkbox"/>	Topical Antiseptics
<input type="checkbox"/>	Antibiotic Ointment (Neosporin)	<input type="checkbox"/>	Eye Drops (Visine, Murine, etc)	<input type="checkbox"/>	Tylenol (acetaminophen)
<input type="checkbox"/>	Anti Nausea/Anti Vomiting	<input type="checkbox"/>	Hall Mentho-lyptus cough drops	<input type="checkbox"/>	
<input type="checkbox"/>	Anti-itch Spray or Lotion (insect bites, etc.)	<input type="checkbox"/>	Hydrocortisone Cream (for itching)	<input type="checkbox"/>	

## Additional instructions of consideration: \_\_\_\_\_

The following information will aid the School Nurse in making an accurate assessment of your child in case of illness or emergency. Please check the appropriate space if your child has ever had any of the following:

<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Persistent Cough	<input type="checkbox"/>	Exposed to Tuberculosis
<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Sleep Problems	<input type="checkbox"/>	Head, Eyes, Ears, Throat Problems
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Unexplained Weight Loss/Gain	<input type="checkbox"/>	Stomach or Bowel Problems	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Unexplained tiredness	<input type="checkbox"/>	Joint or Muscle Pain or Stiffness	<input type="checkbox"/>	Anaphylactic Episodes

***IF THIS INFORMATION SHOULD CHANGE, PLEASE NOTIFY THE SCHOOL NURSE, IMMEDIATELY!!!***

I consent to care at the school provided by the Pike County Health Department which may include screenings such as Scoliosis screening, vision and hearing exams, assessments, lab tests, treatment, first-aid, over the counter medicine, and any other health service given to me/my child by staff or agents of the Pike County Health Department. I understand that no guarantees are being made as to the effect of any exam or treatment on me/my child. I like-wise release the staff from any liability related to the administering of the above medications to my child so long as the treatment is provided according to the above instructions. I authorize the school health clinic to release medical information about my child, as permitted by the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), to his/her primary care provider and to share pertinent medical information (history of allergies or significant medical history) with school staff who may need to provide care to my child in an emergency. I understand that the sharing of this information is on a need to know basis only. I also understand that the information obtained for the school physical, including immunization information, will be released to my child's school. If my child has Medicaid or KCHIP, I also authorize the school clinic to release this information to those agencies so that the Medicaid or KCHIP can be billed for visits to the school clinic. This permission can be revoked at any time. No services will be provided unless the signed form is returned. I agree to provide the agency nurse an order from my child's physician for any prescription medications before they can be given. I also understand by signing this consent, I acknowledge that I may request a copy of the Pike County Health Department's Privacy Notice by calling the Pike County Health Department's main office at 437-5500 or have access to a copy of the Pike County Health Department's Privacy Notice located at [www.pikecountyhealth.com/v3/uploads/documents/pchd\\_hipaa\\_pp.pdf](http://www.pikecountyhealth.com/v3/uploads/documents/pchd_hipaa_pp.pdf).

Signed: X \_\_\_\_\_ Printed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian) (Parent or Guardian)



**CONSENT FORM FOR SCHOOL SERVICES WITH THE  
PIKE COUNTY HEALTH DEPARTMENT**

**Registration (COMPLETE FRONT AND BACK OF THIS FORM)**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cellular) \_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male Female Ethnicity: Hispanic/Latino Not Hispanic/Latino  
Circle Race: 1. White 2. Black 4. American Indian 5. Oriental 6. Hispanic (white) 7. Hispanic (black)  
Allergies to Food or Medicine: \_\_\_\_\_  
Do you have Medicaid? \_\_\_\_ Yes \_\_\_\_ No Medicaid # \_\_\_\_\_  
Coventry / Wellcare / Aetna / Passport / Anthem MCO# \_\_\_\_\_  
Private Insurance: \_\_\_\_\_  
Subscriber: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

**BRIGHT SMILES DENTAL SERVICES**

Does your child have a dentist? Yes No If so, who? \_\_\_\_\_  
Does your child need premedication before a cleaning? Yes No Date of last cleaning: \_\_\_\_\_  
List any current medications that your child takes (include over the counter and herbal): \_\_\_\_\_  
Does your child have any diseases such as ADHD, asthma, heart conditions, diabetes, and contagious conditions? Yes No  
If so, please list: \_\_\_\_\_

**This service will be provided at no cost to the participant. KY Medicaid will be billed.**

**PUBLIC HEALTH EDUCATION SERVICES**

The Pike County Health Department presents to Pike County Schools to provide education in a classroom setting for various health areas. These areas include, *but not limited to*, diabetes, physical activity, alcohol/drug education, self-confidence, bullying, risky behaviors, etc. All programs are curriculums approved through agencies such as, *but not limited to*, the US Dept. of Health and Human Resources (Office of Population Affairs), KY Department of Public Health, KY Department of Education, etc. The Public Health Education Services Program serves as a supplement to health and physical education classes across the county. **This service will be provided at no cost to the participant. KY Medicaid will be billed.**

**PREVENTIVE WELL CHILD / SPORTS PHYSICALS**

The Pike County Health Department will provide Well Child / Sports Physicals throughout various times of the year. No invasive medical procedures will be provided in the physicals. All physicals will be performed by a Nurse Practitioner certified under the Ky Board of Nursing. Parents will be asked to complete the following forms prior to physical assessment being completed.

1. PCHD Pediatric History and Physical Form AND / OR 2. KHSAA Athletic Participation / Physical Examination Form.

**This service will be provided at no cost to the participant. Medicaid, Private Insurance, and Third Parties will be billed.**

**CONSENT FOR SERVICES**

**Consent for Pike County Health Department Services:** Of my own free will I consent to care for my child which may include screenings, exams, lab tests, vision/hearing screenings, age appropriate education, scoliosis screening, and any other health service given to my child by staff or agents of this health department. I understand that no guarantees are being made as to the effect of any exam or treatment on my child. I also understand my child may be tested for HIV infection, Hepatitis B, or any other disease carried by blood or body fluids if such a test(s) is needed for a diagnosis, to assist in medical treatment, or if a health care worker is exposed to your child's blood, body fluids or tissues. The Bright Smiles Program does not take the place of regular check-ups at a dental office. The preventive dental services are done by a Public Health Registered

Dental Hygienist without the onsite presence of a dentist according to KRS 313.040. The Dentist Board member for your county is Dr. James Justice of Elkhorn Dental, who is supportive of the standards of practice of the Public Health Hygienists and work with the Board of Health to develop and adopt protocols for these services. I understand that my child may be screened to check the retention of the sealants by the Public Health Dental Hygienist during the school year. Other services include age appropriate dental assessment, dental cleaning, fluoride varnish, dental sealants, oral hygiene, and a personal dental report card. The Preventive / Sports Physicals do not take the place of routine visits at a primary care facility. All services will be provided to the child, based on this consent, unless the appropriate signature is placed in the appropriate declined areas of this form. This consent expires 1 year from the date signed.

**Authorization for payment:** If my child has Medicaid or KCHIP or Humana, Anthem or other health Insurance, I also authorize the release of this information to those agencies so the Medicaid/KCHIP/Humana/Anthem and other private insurances can be billed for visits in the school setting. I request that payment of medical benefits be made to the Pike County Health Department on my behalf, for services my child receives. I also authorize the local health department to release medical information about my child to Medicaid, Other Third Party Payors (private insurance, etc.) and their agents to determine payment for services. No child will be excluded from these services for inability of payment from a third party payor source. There is no "out of pocket" fees from the parent/guardian associated for any services provided by the Pike County Health Department.

Check Individual Box for Consent for Services

☐ **BRIGHT SMILES DENTAL SERVICES**

☐ **PUBLIC HEALTH EDUCATION SERVICES**

☐ **PREVENTIVE WELL CHILD / SPORTS PHYSICALS**

X \_\_\_\_\_  
Signature of Parent/Guardian Authorizing Consent

\_\_\_\_\_  
Date

**PIKE COUNTY HEALTH DEPARTMENT  
RECIEPT OF PRIVACY NOTICE ACKNOWLEDGMENT**

By signing this form, you acknowledge that you have access to a copy of the Pike County Health Department Privacy Notice located at [www.pikecountyhealth.com](http://www.pikecountyhealth.com) or I may request a copy by calling the Pike County Health Department's main office at (606) 437-5500. The Privacy Notice explains how your health information will be handled in various situations. By signing, you are aware that the information contains Protected Health Information and the information is to be protected according to the Health Insurance Portability and Accountability Act (HIPPA). We must try to have you sign this form on your first date of service with us after April 14, 2003.

[ ] I am aware of the Pike County Health Department Privacy Notice and how to obtain a copy.

X \_\_\_\_\_  
Signature of Parent/Guardian Authorizing Consent

\_\_\_\_\_  
Date

**Additional Information for 2021-2022 School Year**

School: \_\_\_\_\_

Grade: \_\_\_\_\_

Age of Child: \_\_\_\_\_

List ALL Household Members who are infants, children, and students up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper)

MI Child's Last Name

[illegible]

Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

Write a case number here then go to STEP 4 (Do not complete STEP 3)

**Case Number:**

Write only one case number in this space.

**Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)**

How often?

Child income

	Weekly	Bi-Weekly	2x Month	Monthly
\$				

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work				How often?				Public Assistance/ Child Support/Alimony				How often?				Pensions/Retirement/ All Other Income				How often?			
					Weekly	Bi-Weekly	2x Month	Monthly					Weekly	Bi-Weekly	2x Month	Monthly					Weekly	Bi-Weekly	2x Month	Monthly
	\$								\$												\$			
	\$								\$												\$			
	\$								\$												\$			
	\$								\$												\$			
	\$								\$												\$			

**Last Four Digits of Social Security Number (SSN) of  
Primary Wage Earner or Other Adult Household Member**

X	X		
X	X	X	X

Check if no SSN

**STEP 4** Contact information and adult signature. Mail Completed Form To: 2514 Leitchfield Road, Elizabethtown, KY 42701

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

<div> <div>Street Address (if available)</div> <div>Apt #</div> </div>		<div>City</div>	<div>State</div>	<div>Zip</div>	<div>Daytime Phone and Email (optional)</div>
<div>Printed name of adult signing the form</div>		<div>Signature of adult</div>			<div>Today's date</div>



## INSTRUCTIONS Sources of Income

Sources of Income for Children	
Sources of Child Income	Example(s)
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability Payments - Survivor's Benefits	- A child is blind or disabled and receives Social Security benefits - A Parent is disabled, retired, or deceased, and their child receives Social Security benefits
- Income from person outside the household	- A friend or extended family member regularly gives a child spending money
- Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults		
Earnings from Work	Public Assistance / Alimony / Child Support	Pensions / Retirement / All Other Income
- Salary, wages, cash bonuses - Net income from self-employment (farm or business)  If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private pensions or disability benefits - Regular income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household

## OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino  
Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights 1400  
Independence Avenue, SW  
Washington, D.C. 20250-9410

fax: (202) 690-7442; or

email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

Eligibility:

Free	Reduced	Denied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24 Monthly x 12

Total Income

Household Size

Weekly	Bi-Weekly	2x Month	Monthly
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Categorical Eligibility ☐

Determining Official's Signature

Date

Confirming Official's Signature

Date

Verifying Official's Signature

Date