Click Here to Print Reset Form

# 2018-2019 Pre-School Student Information Form

Date: _____

Student First Name: _____ Last Name: _____

D.O.B: _____ Student's Social Security Number: _____

Language: _____ Sex: _____ Ethnicity: Hispanic ☐ Non-Hispanic ☐

Race: _____ Where was the student born? (Please Check one)

United States ☐ Mexico ☐ Other: _____

Father's First Name: _____ Father's Last Name: _____

Father's D.O.B: _____ Father's Cell Phone: _____

Mother's First Name: _____ Mother's Last Name: _____

Mother's D.O.B: _____ Mother's Cell Phone: _____

Married ☐ Single ☐ (Please Check one)

Street Address: _____ Mailing Address: _____

City: _____ Zip: _____ Telephone: _____

Father has high school diploma/GED: Yes ☐ No ☐

Mother has high school diploma/GED: Yes ☐ No ☐

Father's Employment: _____ Phone: _____

Mother's Employment: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Physician: _____ Phone: _____

Medication: _____

Student's first language: _____ Home Communication: _____

Language spoken at home: _____

Will your child ride the bus to school? Yes ☐ No ☐

Bus Number: _____

# Student Health Information Form

**Last Name** **First Name** **Grade**

**Date of Birth** **Emergency Contact Numbers**

**Please check any medical conditions your student has:**

- ☐ ADHD/ADD
- ☐ Asthma
- ☐ Birth Defects
- ☐ Hearing Difficulties
- ☐ Skin Problems
- ☐ Ear Infections
- ☐ Depression
- ☐ Diabetes
- ☐ Headaches
- ☐ Bone/Joint problems
- ☐ Anxiety
- ☐ Vision Difficulties
- ☐ Heart Defects
- ☐ Urinating Problems
- ☐ Serious Injury
- ☐ Seizures
- ☐ Stomach Problems
- ☐ High Blood Pressure
- ☐ Surgical History
- ☐ Anemia
- ☐ Constipation
- ☐ Other

Please explain checked medical conditions or anything more about your student's health that you think is important for us to know:

**Allergies (Drug & Food) & Reaction:**

1. 
2. 
3. 

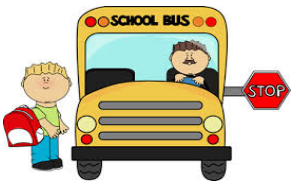
**Home Medications / Vitamins:**

1. 
2. 
3. 

**Assistive Devices:** (glasses, contacts, braces, hearing aids etc)

1. 
2. 
3. 


# Sublette School District
# Transportation 2018-2019




PLEASE PRINT CLEARLY

**Family's Last Name:** _____

| | | | |
|---|---|---|---|
| 1st Child's Name | Grade | 2nd Child's Name | Grade |
| 3rd Child's Name | Grade | 4th Child's Name | Grade |
| 5th Child's Name | Grade | 6th Child's Name | Grade |

Do you live in town or in the country? Town: ☐ Country: ☐

Will your child(ren) ride the bus? Yes: ☐ No: ☐

**If you live in the country what is your physical address:**

_____

**Directions to your home from Sublette:**

_____

_____

_____

## Phone Numbers

| | Home Phone | Cell Phone | Work Phone |
|---|---|---|---|
| **Mother's Name:** | | | |
| **Father's Name:** | | | |
| **Nearest Neighbors:** | **Home Phone** | **Cell Phone** | **Work Phone** |
| | | | |
| | | | |
| | | | |

If no one is at home when we arrive to drop off your child(ren) after school, what do you want the driver to do?

☐ Drop your child(ren) off anyway.

☐ Take my child(ren) back to the school.

**Mud Routes**

Some parents elect to have their child(ren) walk home from their mud route stop. Do you want us to allow your child to:

☐ Walk home from the mud stop.

☐ Take my child(ren) back to the school.

_____ _____

Parent Signature Date

# KAN Be Healthy (EPSDT) Screening Form

I.D. Number:_____

**Please note the Mandatory Blood Lead Questionnaire is a separate document. It is required at each screen 6 to 72 months**

| Name | Date of Birth | Age | Date of Screen |
|---|---|---|---|
| | | | |

## PHYSICAL GROWTH

T _____ P _____ R _____ BP _____

**Weight** _____ (lbs/kg) _____ th%

**Length** (Birth to 24 months) _____cm/in

**BMI** _____

BMI ≥ 85%: recommend appropriate nutrition input and physical activity.

Update Growth Chart (required at each screen)

**Weight/Length** _____ %

**Standing Height** (2 - 20 years) _____ cm/in

_____ th%

**Male** ☐ **Female** ☐

**Head Circ** (≤ 24 months) _____ cm/in

_____ th%

## BENEFICIARY & FAMILY HISTORY

☐ Refer to completed history form in chart.

☐ No changes in medical Hx unless indicated.

☐ Previous Hx reviewed from_____ visit.

☐ Patient currently in Foster care, no previous hx available.

Present Concern: _____

Medications: _____

Serious Illness/Accidents: ☐ No ☐ Yes (date & type)

(including Hospital or ER visits)

Allergies (food & drug) _____

Birth History (Length, weight, complications, etc. - if known)

Operations: ☐ No ☐ Yes (date & type)

(Circle and indicate the relationship with disease / problem. **P**-Parent, **G**-Grandparent, **B**-Brother, **S**-Sister, **Self**)

| | | | | | |
|---|---|---|---|---|---|
| Allergies (food & drug) | | Drug or ETOH Abuse | | Mental Illness | |
| Asthma | | Earaches | | Obesity | |
| Birth defects | | Epilepsy/Seizures | | Scoliosis/Arthritis | |
| Blood Disorder/ Sickle Cell | | Headache | | Speech, Visual, Hearing | |
| Cancer | | High Blood Pressure | | Ulcers/Colitis | |
| Colds/sore throat | | Kidney/Liver Disease | | Urinary/Bowel | |
| Diabetes | | Lung Disease | | Heart Disease/Stroke | |

## BODY SYSTEMS

| SYSTEMS | WNL | ABN | Comments (Describe any Abnormal Findings) |
|---|---|---|---|
| General Appearance | ☐ | ☐ | |
| Integumentary | ☐ | ☐ | |
| Head-Neck | ☐ | ☐ | |
| Eyes/Ears/Nose & Throat | ☐ | ☐ | |
| Oral/Dental | ☐ | ☐ | |
| Pulmonary | ☐ | ☐ | Lung sounds? |
| Cardiovascular | ☐ | ☐ | Murmur? |
| Abdomen/Gastrointestinal | ☐ | ☐ | |
| Genitourinary | ☐ | ☐ | Tanner Score (as appropriate): Evaluate for excessive menstrual bleeding Enuresis |
| Trunk / Spine | ☐ | ☐ | |
| Musculoskeletal | ☐ | ☐ | |
| Neurological | ☐ | ☐ | |

## Vision Screen

**Ages 0 to 3 yr -** Corneal Light Reflex Present: Yes ☐ No ☐
**Ages 3 yr thru 20 -** Bruckner Exam: Pass ☐ Refer ☐
**All ages -** Outer Inspection: Normal ☐ Abnormal ☐
Eye Tracking: Pass ☐ Refer ☐ PERRLA: Pass ☐ Refer ☐
Ocular Motility(strabismus/cross cover test): Pass ☐ Refer ☐

**Ages 3 thru 20**:
**.Distance Acuity -** Tool used:_____ Score: L R Both
**Near Acuity -** Tool used: _____ Score: L R Both
Last exam:_____ Further comments (see below)

## NUTRITION

☐ WIC participant
☐ Referred to WIC
☐ Breast Feeding ☐ Formula
Amount & how often: _____
Number of Servings per day

| | | | |
|---|---|---|---|
| Bread/Cereal | _____ | Dairy | _____ |
| Fat/Sweet/Sugar | _____ | Fruit | _____ |
| Meat/Bean/Egg | _____ | Vegetable | _____ |
| Fluid Intake: water | _____ oz. | Soda | _____ |
| Milk | _____ oz. | Juice | _____ |

## PHYSICAL ACTIVITY

☐ Biking ☐ Basketball ☐ play outside
☐ Skating ☐ Walking ☐ other sports

How many hours screen time/Day? (i.e. TV, Games, PC)
☐ 0-1 hr ☐ 1-2hr ☐ 3-5hrs ☐ 5+hrs

**KBH participant currently pregnant?** ☐ Yes ☐ No
If "yes", then complete following :
1. Prenatal Record initiated? ☐ Yes ☐ No
2. On prenatal vitamins? ☐ Yes ☐ No
3. Referred for OB/GYN cares? ☐ Yes ☐ No
Referred to:

## LABORATORY

Obtain CBC with automated differential in infants between 9-12 months. Obtain CBC with automated differential in males at age 15 and in females at menarche. Annual CBC's with diff are required depending on lifestyle/ health needs, please see Provider Manual. Was CBC obtained? Yes ☐ No ☐ Indicate further follow-up in Plan of Care.

## DEVELOPMENTAL / EMOTIONAL

*Please refer to KMAP Provider Manual for AAP recommended Developmental Tools.*
**Children < 6 yrs**. A completed developmental screening tool **to include the screener's interpretation and report** regarding meeting developmental milestones. If further testing/intervention is required, please include in Plan of Care.

**Children 6-21 yrs.** A completed developmental screening tool **to include the screener's interpretation and report** or document all developmental/emotional observations found below. Include further testing/intervention needs in Plan of Care.

**Developmental Tool used:**_____

| | | | |
|---|---|---|---|
| Sleep Habits | _____ | Tired / overactive? | _____ |
| Discipline: | _____ | Vocational concerns? | _____ |
| Peer Interaction: | _____ | Exercise | _____ |
| Grade Level | _____ | Average Marks | _____ |
| Special Education: | _____ | Special Needs: | _____ |

Any emotional or behavioral problems? _____
Emotional Observations:_____

## IMMUNIZATIONS

Copy of record in chart
Current ☐
Behind ☐
Unknown ☐
Requested from Parent ☐
Referred to VFC provider ☐

Needs (circle): Rota
HepB DTaP Flu
Hib IPV MMR
MCV4 MPSV4 PCV
Varicella HepA HPV
Other:

## DENTAL

Sees Dentist? Yes ☐ No ☐
Last dental exam date: ____/_____/_____
# times brushes/day: _____
Dental Referral (annually at a minimum 1-20yr)
Yes ☐ No ☐ ~ Fluoride Varnish? Yes ☐ No ☐

## HEARING SCREEN

Maintain in record completed paper hearing screens & report or qualifying hearing screen procedure & report.

Age birth to 4, perform Risk Indicators for Hearing Loss **and** Hearing Developmental Scales Pass ☐ Refer ☐
Hearing Health History >4: Pass ☐ Refer ☐
Or Screen Procedure:_____

## HEALTH EDUCATION AND ANTICIPATORY GUIDANCE

**Circle Those Reviewed/ Handouts Given**

| | | | |
|---|---|---|---|
| 1. Behavior/Discipline | 5. Family Planning | 9. Parenting | 13. Self Breast Exam |
| 2. Oral /Dental | 6. Immunizations | 10. Safety/Poisons | 14. Sexuality |
| 3. Development | 7. Lifestyle | 11. Substance Abuse | 15. Exercise |
| 4. Physical Activity | 8. Nutrition | 12. Self Testicular Exam | 16. Weapon Safety |

17. Other:_____

## RESULTS/PLAN OF CARE

**Screening Results:** _____

**Plan/Referrals (dental, vision, hearing, dietary, etc):**_____

**Recommended Return Date:**

**Parent/Caregiver and/or Patient informed of KBH Screen findings and verbalizes understanding of findings and recommendations. Yes ☐ No ☐**
**Parent/Caregiver and/or Patient Signature:**_____
**Date:** _____

**Screening Providers Signature:** _____

**(Licensed Physician, ARNP, PA, or Registered Nurse credentialed to perform KAN Be Healthy screens)**

form revised 12/6/07

# Mandatory Blood Lead Screening Questionnaire

## To be completed at each KBH Screen from 6 to 72 months

| **Does your child:** (circle response received) **DATE**: (MM/DD/YYYY) | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1) **Live in or visit a house or apartment built before 1960?** (This could include a day care center, preschool, the home of a baby-sitter or relative, etc.) | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** |
| 2) **Live in or regularly visit a house or apartment built before 1960 with previous, ongoing or planned renovation or remodeling?** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** |
| 3) **Have a family member with an elevated blood lead level?** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** |
| 4) **Interact with an adult whose job or hobby involves exposure to lead?** (Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and/or making pottery). | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** |
| 5) **Live near a lead smelter, battery plant or other lead industry?** (Ammunition/explosives, auto repair/auto body, cable/wiring striping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten (foundry work). | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** |
| 6) **Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** |
| **One positive response to the above questions <u>requires</u> a blood lead level test. Please, remember blood lead level tests are required at 12 and 24 months, regardless of the score. Was blood drawn for a blood lead level test?** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** | **Yes** **No** |
| **Interviewing Staff Initials** | | | | | | |

**Staff Signature:**

| | | |
|---|---|---|
| | | |
| | | |

Patient Name: _____ I.D. Number: _____;

Revised 12/2007

## HOME LANGUAGE SURVEY

Upon enrollment, every student or parent/guardian must be given a Home Language Survey. This survey will be used to determine which students should be assessed for English proficiency. If a language other than English is indicated in any of questions 1-4, the student will be assessed to determine eligibility for English to Speakers of Other Languages (ESOL) services. The assessments approved by Kansas State Department of Education include: The Language Assessment Scales (LAS)/LAS LINKS/Pre-LAS, the IDEA Proficiency Test (IPT)/Pre-IPT, the Language Proficiency Test Series (LPTS), and the Kansas English Language Proficiency Assessment (KELPA)/KELPA-P. If a student scores below proficient/fluent in any of the language domains: listening, speaking, reading, or writing, s/he is eligible for ESOL services. Please complete one form for each child.

**Student Information:**

| Name | Grade |
|---|---|
| Address | Date of Birth |
| Date first enrolled in a school in the U.S. | Phone Number |

**Student Language Information:**

1. What language did your child first learn to speak/use?
   English ☐ Spanish ☐ Other (please specify) _____
2. What language does your child most often speak/use at home?
   English ☐ Spanish ☐ Other (please specify) _____
3. What language do you most often speak/use with your child?
   English ☐ Spanish ☐ Other (please specify) _____
4. What language do the adults at home most often speak/use?
   English ☐ Spanish ☐ Other (please specify) _____

**Parent/Guardian Information:**

Which language do you read/write? English ☐ Spanish ☐ Other (specify)_____

**Migrant Education Program Information:**

The Migrant Education Program (MEP) is authorized by Title I Part C of the Elementary and Secondary Education Act of 1965 (ESEA). The MEP provides formula grants to local education agencies to establish or improve education programs for children who may qualify for the Migrant Program. Please help us determine your child's eligibility for the Migrant Program by responding to the following questions.

Has your family moved in the last 36 months to seek or obtain agriculture or fishing related work?
Yes _____No _____

If yes, was the move from one school district to another? Yes _____ No _____

Signature of Parent or Guardian Date

# SUBLETTE USD 374
## Identification & Recruitment Parent Survey

Please complete the following information to help us determine if your child/children qualify for the migrant program. This program provides extra academic help for students who may need assistance as well as other benefits. Thank you for your help!

**1.** Has your family moved into this district within the past 3 years? ☐ Yes ☐ No
(**Note: If you answer "NO" to the above question, do not answer questions #2, #3 & #4.)**
**2.** Are you now looking for agricultural work? ☐ Yes ☐ No
**3.** Are you now working in agricultural work? ☐ Yes ☐ No
**4.** Were you employed in any agriculturally related jobs listed below in Kansas within the last 3 years?
☐ Yes ☐ No


Feed Cattle,


Dairy


Eggs

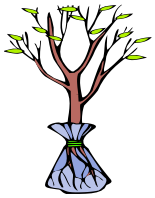

Cultivation,


Fishing

Processing, Packaging


Harvest (fruit and vegetables)


Milling, Cotton


Trees Planting, Cutting

Preparation of soil


Greenhouse, Nursery, Sod

| **Parent/Guardian Names** | **Present Job/Job Title** | **Last Employment** |
|---|---|---|
| Father:_____ | _____/_____ | _____ |
| Mother:_____ | _____/_____ | _____ |

**Please list all children**

| First | Last | Sex | School | Grade | Date of Birth | Age |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Address: _____Telephone:_____

✕_____ _____
**Signature of Parent or Guardian** **Date**

# SUBLETTE USD #374
## Encuesta Para Los Padres

Por favor complete la siguiente información para que nos ayude a determinar si sus hijos/a (s) califica para el programa migrante. Este programa provee ayuda académica extra para estudiantes que necesitan asistencia al ígual que otros beneficios. ¡ Gracias por su ayuda!

1. ¿Se ha cambiado a este distrito los últimos 3 años? _____Si _____No

**Nota: Si contesto "no" a la pregunta de arriba, no responda a las preguntas #2, #3, & #4.**

2. ¿Está buscando trabajo de agrícultural?_____Si _____No

3. ¿Está trabajando en trabajo relacionado con agrícultura?____ Si ___No

4. ¿Ha estado empleado en algún trabajo en Kansas relacionado con agrcultura mencionado abajo durante los últimos 3 años?_____Si _____No

**Ganado, Procesando, Empacando**

**Lucería**

**Huevo**

**Cultivando, Preparción de Tierra**

**Pescado**

**Cosechando (frutas y verduras)**

**Mollinos**

**Árboles Podar, Plantar, Derribar o Cortar**

**Inverndero, vivero, Cultivar Pasto**

---

Padres/Guardianes Nombres Trabajo presente/posición de Trabajo Ultimo Trabajo

Padre: _____ _____ / _____ _____

Madre: _____ _____ / _____ _____

Por favor escribir todos los nombres de los niños que viven en la casa.

| Apellido, Nombre | Sexo | Escuela | Grado | Fecha de Nacimiento | Edad |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Domicilo:_____ Telefono: _____

Firma de Padre/Guardián _____ Fecha _____