Barbourville Independent School
2021-2022 Returning
Student Enrollment

Student Information

Enrollment Date: ______________ Social Security No.: ___________________ Grade: __________________

Student Name: ____ DOB: __________________

Last *First* *M.I.*

Physical Address: ____

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Mailing Address (if different): ____

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Phone: ______________________________ Email ____

Last School Attended: ____

Race/Ethnicity: White/ Not Hispanic ☐ Hispanic ☐ Black/ Not Hispanic ☐ American Indian ☐ Asian ☐

Gender: __________

Household Information

Mother's Name: ________________________ Address: ____

Cell Phone Number: __________ Email Address: ____

Father's Name: ________________________ Address: ____

Cell Phone Number: __________ Email Address: ____

Child lives with: Mother & Father ☐ Mother ☐ Father ☐ Grandparents ☐ Aunt ☐ Uncle ☐

Anyone other than natural parents who has legal guardianship:

____

Name *Relationship*

____

Name *Relationship*

Emergency Contact Information

Name: ____

Relationship: ____

Phone Number: ____

Other siblings enrolled at Barbourville Independent:

Name: ____ Grade: _________

Name: ____ Grade: _________

Name: ____ Grade: _________

Name: ____ Grade: _________

Name: ____ Grade: _________

Name: ____ Grade: _________

Barbourville Independent School
2021-2022 Student Handbook Information

Student Information

Directions to Parents and Guardians:

Please initial beside each section and sign at the end. The student will also need to sign indicating understanding.

_____ I have received, read, and understand to the best of my ability the Barbourville Independent Schools Discipline Code Handbook. I have discussed the Student Code of Conduct and Student Handbook with my/our child. I further understand:

(1) The standards of conduct that prohibit the possession, sale, or use of illicit drugs or alcohol and controlled substances (Drug-Free Schools and Committees Act, CFR 34 86.200). Disciplinary sanctions are consistent with local, state, and federals laws up to and including expulsion, and referral for prosecution will be imposed on students who violate these mandatory standards of conduct.
(2) Unlawful possession of a weapon, firearm, or other deadly weapon, destructive device, or booby trap on school property in Kentucky is a felony punishable by a maximum of five (5) years in prison and a ten thousand dollars ($10,000) fine (KRS 527.070).

_____ The Barbourville Independent School takes pride in the accomplishment of each of our students. Sometimes we get the opportunity to share our student's achievements through photographs, newspaper articles, radio spots, or videos that may be used at a presentation, display, on television, or website. We would like to include your child in these positive experiences.

- ☐ I give permission for my child's name and/or picture to be used in the media during the school year.
- ☐ I **do not wish** my child's name and/or picture to be used in the media at any time during the school year.

_____ I have read the Parent Involvement Policy and Student Compact as written in the handbook (pages 6-8).

_____ The Outlook Live e-mail solutions is provided to your child by the district as part of the Live@Edu service from Microsoft. By signing this form, you hereby accept and agree that your child's rights to use the Outlook Live e-mail service, and other Live@Edu services as the Kentucky Department of Education my provide over time, are subject to the terms and conditions set forth in district policy/procedure as provided and that the data stores in such Live@Edu services, including the Outlook Live e-mail service, are managed by the district pursuant to the policy 08.2323 and accompanying procedures. You also understand that the Windows Live ID provided to your child also can be used to access other electronic services that provide features such as online storage and instant messaging. Use of those Microsoft services is subject to Microsoft's standard consumer terms of use (the Windows Live Service Agreement), and data stored in those systems are managed pursuant to the Windows Live Service Agreement and the Microsoft Online Privacy Statement. Before your child can use those Microsoft services, he/she must accept the Windows Live Service Agreement and, in certain cases, obtain your consent.

_____ I understand the Barbourville Independent School district does not carry insurance on students, and I have been given the information and opportunity to purchase student insurance at my own expense.

Parent or Guardian Signature:	Date:
Student Signature:	Date:

Barbourville Independent School
2021-2022 Permission to Release Student & Emergency Contact Form

Student Information

Please list the name, driver's license number, relationship, and phone numbers of any adult that has your permission to sign your child out of school in case of an emergency. Be sure to include other approved parents, step-parents, etc.

Student Name: ____ SSN: ______________
Last *First* *M.I.*

Parent Name: ____ SSN: ______________
Last *First* *M.I.*

Name	Driver's License Number	Relationship	Phone Number

Barbourville Independent School
2021-2022 Transportation Information

Student Information

The Barbourville Board of Education must keep records for student transportation. Please complete this form for each student. If not completed by student or parents, then a school official (teacher, clerk, etc.) may interview the student and complete the form. Information must be verified and entered into the KSIS for each student.

Student Name: ____ DOB: ______________

Last *First* *M.I.*

Physical Address: ____

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Mailing Address (if different): ____

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Phone: ______________________ Cell Number: ______________________

Bus Rider Information

In general as a matter of routine:

Rider Information:	**Yes:**	**No:**
I do not ride the bus		
I ride the bus twice daily over one mile		
I ride the bus twice daily under one mile		
I ride the bus once daily over one mile		
I ride the bus once daily under one mile		

Bus Number that picks you up at home:

Bus Number that drops you off at home:

Please give directions to your child’s pick up and/or drop off place if different than your home address.

2021-2022 CONSENT FOR SCHOOL HEALTH SERVICES

SCHOOL: ______________________ **TEACHER:** ______________________

STUDENT'S FULL NAME:

____

STUDENT'S SOCIAL SECURITY # ______________________ **BIRTHDATE:** ______________

MALE _______ **FEMALE** _______ **RACE** _______

ADDRESS: ______________________ **CITY:** ______________ **ST:** KY **ZIPCODE:** __________

ANY KNOWN DRUG ALLERGIES: NO____ **YES**____ **IF YES, PLEASE LIST** ______________________

MEDICAL INSURANCE: ______________________ **POLICY #** ______________

PRIMARY CARE PROVIDER: ______________________ **PHONE #:** ______________

PHARMACY: ______________________ **PHONE #:** ______________

MOTHER'S NAME: ______________________ **PHONE #** ______________

FATHER'S NAME: ______________________ **PHONE #** ______________

EMERGENCY CONTACT: ______________________ **PHONE #** ______________

PLEASE LIST ANY OPERATIONS, HOSPITALIZATIONS OR SERIOUS INJURIES OR ILLNESSES: ______________________

____

PLEASE LIST ANY OF THE STUDENT'S FAMILY MEMBERS HEALTH PROBLEMS:

MOTHER: ______________ **FATHER:** ______________ **GRANDPARENTS:** ______________

I authorize payment to be made to Family Health Care Associates (FHCA) on my behalf for services received. I also release this information to Medicaid/ K-Chip for billing purposes for visits to the school health clinic. I understand that no guarantees are being made as to the effects of any exam or treatment on my child. I further understand that I will not be billed for any services that my child receives at the school clinic during the school session except for vaccines that are not required. I acknowledge receipt of the Notice of Privacy Practices (NPP) and Bill of Rights. I request that payment of authorized medical insurance benefits be made to FHCA on my behalf for services rendered to my child. I have read this statement and understand that my signature indicates that I do consent and assign benefits as stated above. I also authorize FHCA staff providing services at the school clinic to provide health information from my child's medical record to and from the designee of the school and my child's physician only as needed under the guidelines of HIPAA and FERPA consistent with Federal Laws for the purpose of providing safe and appropriate school health services and programs. I consent to care which may include screening, assessments, lab tests, treatment, first-aid, over the counter and/or prescription medication, telemedicine and any other health service given to my child by staff or agents of FHCA. I authorize the school health clinic staff to release medical information about my child that impacts learning environment to his/her/primary care provider, school principal/guidance counselor or designee. Incase you are going to have clinical visits using videoconferencing technology; you will be able to see and hear the provider and they will be able to see and hear you, just as if I were in the same room. Since 1994, the technology has connected tens of thousands of patients and providers in Kentucky. The information may be used for diagnosis, therapy, and follow-up and/or education. Expected Benefits: Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites; Patient remain closer to home where local healthcare providers can maintain continuity of care; Reduced need to travel for the patient or other provider. The Process: I will be introduced to the provider and anyone else who is in the room with the provider. I may ask questions of the provider or any telemedicine staff in the room with me, if I am unsure of what is happening. If I am not comfortable with seeing a provider on videoconference technology, I may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to insure videoconference is secure, and no part of the encounter will be recorded without your written consent. Possible Risks: There are potential risks associated with the use of telemedicine which include, but may not be limited to; A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision; Technology problems may delay medical evaluation and treatment for an encounter; in very rare instances, security protocols could fail, causing breach of privacy of personal medical information. By Signing this Form, I understand the following:1.) I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent, except as noted above. 2.) I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. 3.) I also understand that if the provider believes I would be better serviced by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit. 4.) I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. 5.) I release the School District/Board of Education and Family Health Care Associates from any liability related to the administration of medication or treatment so long as Reasonable and Customary Care is provided. Patient Consent to the Use of Telemedicine: I have read and understand the information provided above regarding telemedicine, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care. I hereby authorize FHCA to provide any services listed above in the course of my diagnosis and treatment.

Parent/Legal Guardian Signature: ______________________ **Date** __________