

Pre-School Application



STUDENT			
Last Name		First Name	Middle Name
Birth Date	☐ Female Male		Student's SSN
Language	Is the student Hispanic/Latino? ☐ YES ☐ NO		Race
Where was the Student born?		United States	Mexico Other:
Student's First Language	Home Communication		Language spoken at home
Proof of Age Provided (CHECK ONE) ☐ Birth Certificate ☐ Hospital Record ☐ Transcript ☐ Other:			
Student Physical Address		Student Mailing Address (IF DIFFERENT FROM PHYSICAL ADDRESS)	
	APT #		APT #
CITY, STATE	ZIP CODE	CITY, STATE	ZIP CODE

FATHER			
LIVES WITH STUDENT ☐ YES ☐ NO	LAST NAME	FIRST NAME	D.O.B.
RELATIONSHIP TO STUDENT	Mailing Address (if different from Student)	CITY, STATE	ZIP CODE
CHECK ALL THAT APPLY:			
CONTACT ALLOWED? ☐ YES ☐ NO HAS CUSTODY ? ☐ YES ☐ NO If NO to Custody, Are MAILINGS ALLOWED? ☐ YES ☐ NO RELEASE TO ? ☐ YES ☐ NO			
PRIMARY LANGUAGE	SPEAKS ENGLISH? ☐ YES ☐ NO	PARENT/GUARDIAN EMAIL	PLACE OF EMPLOYMENT
PRIMARY PHONE Number :		ALTERNATE PHONE Number :	
☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT ☐ UNLISTED		☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT ☐ UNLISTED	

MOTHER			
LIVES WITH STUDENT ☐ YES ☐ NO	LAST NAME	FIRST NAME	D.O.B.
RELATIONSHIP TO STUDENT	Mailing Address (if different from Student)	CITY, STATE	ZIP CODE
CHECK ALL THAT APPLY:			
CONTACT ALLOWED? ☐ YES ☐ NO HAS CUSTODY ? ☐ YES ☐ NO If NO to Custody, Are MAILINGS ALLOWED? ☐ YES ☐ NO RELEASE TO ? ☐ YES ☐ NO			
PRIMARY LANGUAGE	SPEAKS ENGLISH? ☐ YES ☐ NO	PARENT/GUARDIAN EMAIL	PLACE OF EMPLOYMENT
PRIMARY PHONE Number:		ALTERNATE PHONE Number:	
☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT ☐ UNLISTED		☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT ☐ UNLISTED	

STUDENT NAME

Marital Status	Single	Married	Seperated	Divorced	Widowed
Father has high school diploma/GED:	Yes	No			
Mother has high school diploma/GED:	Yes	No			
Will your child ride the bus to school?	Yes	No	Bus Number: _____		

EMERGENCY CONTACTS

1	RELATIONSHIP	NAME
PRIMARY PHONE :		ALTERNATE PHONE :
☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT		☐ CELL ☐ HOME ☐ WORK ☐ OK TOCONTACT
2	RELATIONSHIP	NAME
PRIMARY PHONE :		ALTERNATE PHONE :
☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT		☐ CELL ☐ HOME ☐ WORK ☐ OK TOCONTACT

MEDICAL INFORMATION — THE SCHOOL CANNOT BE FINANCIALLY RESPONSIBLE FOR MEDICAL, DENTAL, AMBULANCE, OR HOSPITAL SERVICE.

PHYSICIAN’S NAME & Number	PREFERRED HOSPITAL	MEDICAID # (IF APPLICABLE)
Insurance Name / Group # / ID #		
ALLERGIES / HEALTH FACTORS / COMMENTS		
LIFE THREATENING? ☐ YES ☐ NO		

Please read and select Yes or No for each of the following.

- ☐ YES **NO** In the event of serious injury, it may be necessary to contact local emergency medical personnel immediately. Attempts will then be made to contact the parents/guardians or designated persons to inform them of the situation. The child will be treated by medical personnel as needed.
- ☐ YES **NO** In case of an illness or injury to the above named student, the school is authorized to proceed in its emergency medical plan including any necessary transportation to receive such treatment. I understand that the school is not financially responsible for individual medical, dental, ambulance, or hospital services. I realize that it will be necessary for me to inform the school of any address or phone number changes that may occur during the school year. I understand that the coaches/sponsors of my child will be prepared to take the appropriate emergency steps by keeping a copy of this form with them at all contests and activities.
- ☐ YES **NO** I give permission for the exchange of information between the school nurse or other school representative to copy and send this student’s immunization records to schools, physician’s offices, and health departments as needed.
- ☐ YES **NO** I give permission to USD #374 or its designated representative to permit my child’s picture to be taken or likeness reproduced and disseminated to various media/communications, such as local newspapers and the district’s website. I hereby release the above party from liabilities arising out of what I might deem misrepresentations by virtue of distortion, optical illusions or faulty mechanical reproductions. The publicity of that minor child received by virtue of the first such use that may be made thereof shall be full and adequate compensation for this consent. I agree all such uses of his/her name, voice, likeness, portraits, pictures, photographs, films videotapes, audiotapes, or writings and reproductions thereof, including but limited to tapes, plates, and negatives connected therewith are and shall remain property of USD #374.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

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

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Child Health Assessment is optional for children in Registered Family Day Care Homes. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. Any Health Assessment Form should be attached to the KDHE Medical Record Form.

Child's Name _____ Date of Birth _____

Past Health History (Developmental – Illness – Hospitalization) _____

Allergies _____

Current Medications _____

Nutritional Status _____

Physical Examination

Height _____

Weight _____

Head _____

Abdomen _____

EENT _____

GU _____

Teeth _____

GYN _____

Heart _____

Skeletal _____

Lungs _____

Neurological _____

Screening Tests (Dates Done and Results)

Vision _____

TBC. Test _____

Hearing _____

Sickle Cell _____

Speech _____

HGB. _____

DDST _____

U.A. _____

Lead _____

Other _____

Diagnosis:

Recommendation:

Do you see this child for regular health supervision: Yes _____ No _____

Signature of Licensed Physician or Nurse Approved for Child Health Assessments _____

Date (MM/DD/YYYY) _____

Print the Name of the Individual Signing Above _____

Phone number _____

Address of Physician or Nurse _____

City _____

Zip Code _____



Sublette School District Transportation 2021-2022



PLEASE PRINT CLEARLY

Family's Last Name: _____

1st Child's Name	Grade
3rd Child's Name	Grade
5th Child's Name	Grade

2nd Child's Name	Grade
4th 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

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:

- What language did your child first learn to speak/use?
English Spanish Other (please specify) _____
- What language does your child most often speak/use at home?
English Spanish Other (please specify) _____
- What language do you most often speak/use with your child?
English Spanish Other (please specify) _____
- 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

Preparation of soil



Harvest (fruit
and vegetables)



Milling,
Cotton



Trees
Planting,
Cutting



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: _____

X

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 igual 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 agrícola? _____ Si _____ No

3. ¿Está trabajando en trabajo relacionado con agricultura? _____ Si _____ No

4. ¿Ha estado empleado en algún trabajo en Kansas relacionado con agricultura mencionado abajo durante los últimos 3 años? _____ Si _____ No



**Ganado,
Procesando,
Empacando**



Lucería



Huevo



**Cultivando, Preparación
de Tierra**



Pescado



**Cosechando
(frutas y verduras)**



Mollinos



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



**Invernadero, 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

Domicilio: _____ Telefono: _____

Firma de Padre/Guardián _____ Fecha _____