

# Pre-School Application



STUDENT			
Last Name		First Name	Middle Name
Birth Date	<input type="checkbox"/> Female      Male		Student's SSN
Language	Is the student Hispanic/Latino? <input type="checkbox"/> YES <input type="checkbox"/> 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) <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Hospital Record <input type="checkbox"/> Transcript <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST NAME	FIRST NAME	D.O.B.
RELATIONSHIP TO STUDENT	Mailing Address (if different from Student)	CITY, STATE	ZIP CODE
<b>CHECK ALL THAT APPLY:</b>			
CONTACT ALLOWED? <input type="checkbox"/> YES <input type="checkbox"/> NO      HAS CUSTODY ? <input type="checkbox"/> YES <input type="checkbox"/> NO      If NO to Custody, Are MAILINGS ALLOWED? <input type="checkbox"/> YES <input type="checkbox"/> NO      RELEASE TO ? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PRIMARY LANGUAGE	SPEAKS ENGLISH? <input type="checkbox"/> YES <input type="checkbox"/> NO	PARENT/GUARDIAN EMAIL	PLACE OF EMPLOYMENT
PRIMARY PHONE Number :		ALTERNATE PHONE Number :	
<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TO CONTACT <input type="checkbox"/> UNLISTED		<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TO CONTACT <input type="checkbox"/> UNLISTED	

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

STUDENT NAME

Marital Status	Single	Married	Separated	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 :
<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TO CONTACT		<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TOCONTACT
2	RELATIONSHIP	NAME
PRIMARY PHONE :		ALTERNATE PHONE :
<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TO CONTACT		<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ADHD/ADD             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Serious Injury      |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Birth Defects        | <input type="checkbox"/> Bone/Joint problems | <input type="checkbox"/> Stomach Problems    |
| <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> Anxiety             | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Skin Problems        | <input type="checkbox"/> Vision Difficulties | <input type="checkbox"/> Surgical History    |
| <input type="checkbox"/> Ear Infections       | <input type="checkbox"/> Heart Defects       | <input type="checkbox"/> Anemia              |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Urinating Problems  | <input type="checkbox"/> Constipation        |
|   |  | <input type="checkbox"/> Other               |

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

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

1. 

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2. 

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3. 

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**Home Medications / Vitamins:**

1. 

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2. 

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3. 

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

1. 

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2. 

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3. 

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### 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 \_\_\_\_\_

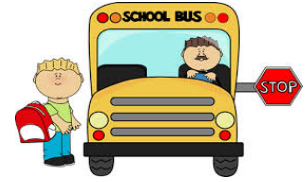
Address of Physician or Nurse \_\_\_\_\_

City \_\_\_\_\_

Zip Code \_\_\_\_\_



# Sublette School District Transportation 2024-2025



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
<b>Mother's Name:</b>			
<b>Father's Name:</b>			
<b>Nearest Neighbors:</b>	<b>Home Phone</b>	<b>Cell Phone</b>	<b>Work Phone</b>

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:

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 \_\_\_\_\_

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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

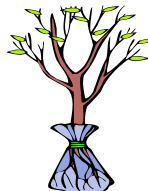
Preparation of soil



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**

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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 \_\_\_\_\_