

CLINTON CENTRAL SCHOOL DISTRICT

75 Chenango Avenue
Clinton, New York 13323-1395
(315) 557-2255
Fax (315) 557-2331

Ellen Leuthauser
Elementary School Principal

February 12, 2016

Dear Families,

Welcome! The Clinton Elementary School faculty and staff are looking forward to the beginning of your child's formal public school education in September. We have several things planned over the next few months to make your child's initial experiences at our school as positive as possible.

Kindergarten registration is scheduled for the week of March 7-11. Please complete the enclosed forms and return them to school during that week. The office will be open from 8:00 a.m. - 4:00 p.m. **Please bring your child's original birth certificate and immunization records, and proof of residency (utility bill) with you.**

Parent-Student Kindergarten Orientation Days will be held on May 4 and May 11. The orientation program will include time for your child to "play" in a kindergarten classroom (without parents) while the parents meet with the kindergarten teachers and principal in a different area. The children will also learn about school bus safety. The parents and children will have an opportunity to ride on a school bus together. Parents who are unable to attend may send an adult relative or friend with their child. The Kindergarten Orientation Days are scheduled from 12:30 - 2:00 p.m. as follows:


May 4 - Last names A - K

May 11 - Last names L - Z

(Please check in at the Main Office)

Your child will return for kindergarten screening in June. We will be doing the vision, hearing, and basic skills screening at that time. You will have an opportunity to schedule an appointment for kindergarten screening at the Orientation Day in May.

Please contact our office should you have questions concerning information in this letter or about our kindergarten program in general. This will be an exciting new experience for everyone and we look forward to welcoming your family into our school family.

Sincerely,

Ellen Leuthauser, Principal

cc: S. Grimm
K Teachers
Transportation

CLINTON CENTRAL SCHOOL REGISTRATION

Date Registered _____ Entry Date _____ ID # _____ Busing ____ Yes ____ No

Student's Last Name _____ **First** _____ **M.I.** _____

Date of Birth _____ Birthplace _____

• Born a U.S. Citizen yes ____ no ____ Date Entered U.S. _____

Gender: Male ____ Female ____ Grade _____ HR _____

Mailing Address _____

Residential Address (if different) _____

Telephone _____ Listed Number: yes ____ no ____

DO NOT RELEASE TO:
Name
Relation to Student
Notes

Parent/Guardian Information

Parent/Guardian Name _____ **Relationship** _____

Address _____ **Home Phone Number** _____

Employer _____ **Work Phone** _____ **Cell** _____

E-Mail Address _____

Parent/Guardian Name _____ **Relationship** _____

Address _____ **Home Phone Number** _____

Employer _____ **Work Phone** _____ **Cell** _____

E-Mail Address _____

Other Children in Household (under age 21):

<u>Name</u>	<u>Date of Birth</u>	<u>School</u>	<u>Grade</u>	<u>M/F</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other Adults in Household:

Name _____ Relationship to Student _____

School/District Last Attended: _____

Address: _____

Telephone: _____

Contact Person/Position: _____

DO NOT RELEASE TO: _____ Relationship to child: _____

Emergency Contact Information

The individuals below have authorization to pick up my child and can be reached during school hours at the number listed.

Name 1 _____	Relationship to Child _____	Phone _____
Name 2 _____	Relationship to Child _____	Phone _____
Name 3 _____	Relationship to Child _____	Phone _____

Emergency & Health Information

Physician's Name: _____ Phone: _____
Dentist's Name: _____ Phone: _____
Preferred Hospital: _____
Emergency Comments/Special Circumstances: _____

Physical Update:

Has your child had any corrective treatment (glasses, dental care, immunizations, scoliosis checkup, etc.) surgery or illness requiring a physician's care this summer? Please specify: _____

Is there anything concerning the health of your child which the school should know to adjust or modify the school program? _____

Health Information Release: I give permission for the school nurse to share health information with his/her teachers and coaches. _____ Yes _____ No

1. **Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

YES, Hispanic NO, not Hispanic

2. Select one or more races from the following five racial groups [For question (2) Check (ü) all groups that apply to your child; check (ü) at least ONE box.]:

AMERICAN INDIAN OR ALASKA NATIVE: A person having origins in any of the original peoples of North and South America (Including Central America), and who maintains tribal affiliation or community attachment.

ASIAN: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

BLACK OR AFRICAN AMERICAN: A person having origins in any of the Black racial groups of Africa.

WHITE: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Photographs: Throughout the school year there are times when the media may be publicizing our students and the school. A photo of your child may be taken at school or while on a field trip. Please note if we have permission to include your child in a photo or news clip if that opportunity arises.

_____ Yes, you may include my child.

_____ No, do **not** include my child in a photo opportunity.

I hereby declare under penalty of perjury that the information provided on this enrollment form is accurate and truthful to the best of my knowledge. I understand that the provision of false information may result in the exclusion of my child(ren) from attendance at the Clinton Central School District, the demand by the District for the payment of tuition, and/or the institution of any other appropriate legal action available to the District.

Parent/Guardian Signature _____ Date _____

CLINTON ELEMENTARY CONFIDENTIAL

Questionnaire completed by: _____ Relation _____

Child's Name: _____ Date of Birth: _____

Child's Nickname: _____

Father/Guardian's Name: _____ Year of Birth: _____

Mother/Guardian's Name: _____ Year of Birth: _____

Occupation: _____
Father Mother

Step Parent: _____ Occupation: _____

.....

I. Developmental History:

1. Were there any problems during the pregnancy with this child? (e.g. German measles, toxemia, bleeding, RH incompatibility) _____

2. What was the child's condition at birth? (normal weight, breathing difficulties, etc.)

3. In your opinion, was this child low, average, or fast in: Walking _____
 Talking _____
 Toilet Training _____

4. Does this child have any difficulty with speech, hearing, or sight? _____

5. Is this child or has this child been in speech therapy? _____

II. Description of Child:

1. Please use a few words to describe this child's personality. _____

2. What are his/her strengths? What does he/she do best? What does he/she like to do?

3. What are the most difficult subjects or areas for this child? _____

4. Do you feel this child has any special needs in school? _____

5. Did this child attend a preschool program? Yes _____ No _____
Where? _____ How many years: _____
6. Has this child ever been in any special education program such as a resource room, individual tutoring, work with a teacher of the hearing or vision impaired, psychiatric day care, infant stimulation program, etc.? Please explain: _____

7. How does this child get along with others? _____
Family: _____
Other Children: _____

III. Family History

1. Have there been any events in the life of your family which have affected this child?
Examples: Family move, death, divorce, birth of a sibling. Explain: _____

2. Have you taken this child for any professional consultations, therapy, clinic visits, etc., which relate to his/her performance in school? _____

ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: Mary Hosey-Pardi

Name of School: Clinton Elementary

Name of Student: _____
Last First Middle

Gender: Male Date of Birth: ____/____/____ Grade: ____ ID#: _____
 Female Month Day Year (preschool-12) (optional)

Address: _____ Phone: _____

- Proof of Residency:** Utility Bill
 Current Paycheck
 Real Estate Agreement

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (Please check one box.)

- In a shelter
 With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
 In a hotel/motel
 In a car, park, bus, train, or campsite
 Other temporary living situation (Please describe): _____
 In permanent housing

Print name of Parent, Guardian, or
Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or
Student (for unaccompanied homeless youth)

Date



Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled *Language Background and Educational History*. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.		
STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	_____
			<i>specify</i>
	<input type="checkbox"/> Guardian(s)		_____
			<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write
			<i>specify</i>

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

District Name (Number) & School

Address

Home Language Questionnaire (HLQ)—Page Two

Educational History	
8. Indicate the total number of years that your child has been enrolled in school _____	
9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them. Yes* No Not sure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *If yes, please explain: _____	
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below	
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____	
Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)	
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.) _____ _____	
12. In what language(s) would you like to receive information from the school? _____	

Month: Day: Year:

Signature of Parent or of Person in Parental Relation Date

Relationship to student: Mother Father Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ	
NAME: _____	POSITION: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:	
NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW	
NAME: _____	POSITION: _____
ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ Mo. DAY YR.	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ Mo. DAY YR.	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____	

TRANSPORTATION REQUEST

PLEASE give the exact address of the pick up and drop off location and/or any information that would be helpful in identifying your home or the home of your childcare provider.

Child's Name _____ Grade _____

Address _____ HR _____

Parent/Guardian _____ Relationship to child _____

Home # _____ Work # _____

Parent/Guardian _____ Relationship to child _____

Home # _____ Work # _____

The above address is where my child will be picked up and dropped off. Y N

My child does **not** require bus transportation. _____

If busing is at a location other than home address above then complete below:

AM Bus pick child up at:

Resident's Name _____ Phone # _____

Address _____

PM Bus drop child off at:

Resident's Name _____ Phone # _____

Address _____

.....
In the case of an **emergency closing** while school is in session my child is to take the bus to:

_____ Bus # _____
Name of Resident

_____ Home Other
Address

DATE _____ PARENT SIGNATURE _____

CLINTON CENTRAL SCHOOL DISTRICT

75 Chenango Avenue
Clinton, New York 13323-1395
(315) 557-2255
Fax (315) 557-2331

Ellen Leuthauser
Elementary School Principal

Dear Parent(s),

Education Law and Regulations of the Commissioner of Education

Require physical examinations of children when they:

- Enter the school district for the first time
- Are in grades K, 2, 4, 7, and 10
- Participate in interscholastic sports

We are required by New York State Law to give school physicals to all kindergarten, second graders, fourth graders, and new school entrants if a private physical is not provided.

If your child has had or is scheduled to have a private physical for the 2016-2017 school year, please have your physician complete our health form (see attached). You may also submit a physical exam form from your own private physician. Please complete the attached form so that no duplicate or unwanted school physicals are performed on your child. An acceptable physical can date as far back as 12 months from the date of entry. If no records are received your child will be scheduled to receive a school physical.

Please discuss with your child the fact that an exam will be given and that the doctor will listen to his/her heart, lungs, etc. The boys will be given an exam to detect undescended testicles. A few minutes of discussion with your child will make him/her much more at ease.

In addition to the physical exam requirement for school, we are requesting that a dental health certificate be provided. Each dental health certificate must be signed by a duly licensed dentist and shall describe the dental health condition of the student when the exam was conducted. A dental health certificate form is attached and a list of dental providers that offer free or reduced fee screening will be provided upon request.

If you should need any help with these requirements or have any questions, please contact Elizabeth Hobaica, R.N., Clinton Elementary School Nurse at 557-2258.

Sincerely,

Elizabeth Hobaica RN
Elizabeth Hobaica, R.N.
Elementary School Nurse

Clinton Elementary School
75 Chenango Ave.
Clinton, NY 13323

STUDENT MEDICATION POLICY

The following procedures will be followed when medication is to be administered/or taken by a student during the school day. This applies to prescription, non-prescription ("over the counter"), short-term, long-term, and as needed (prn's) medication.

The New York State Education Department mandates the following guidelines:

1. The parent or legal guardian must submit a written request to the school for the administration of any medications. (Forms are available in the Health Office.)
2. A written prescription from the student's physician indicating name of medication, dosage, frequency, method of administration and reason for medication must be sent to the school. This may be FAXED to 557-2331, attention Elizabeth Hobaica, R. N.
3. All medication must be in a properly labeled container. (Prescription medications must be in the original pharmacy container.) An adult must bring K-5 medication directly to the school nurse.
4. At the conclusion of the school year, an adult must pick up all medications. Unclaimed medication will be disposed of on the last day of school.

Thank you for your help with this. Please call me at 557-2258 if you should have any questions or concerns.

Elizabeth Hobaica RN

Elizabeth Hobaica, R.N.

NEW STUDENT HEALTH HISTORY

Clinton Central Schools
75 Chenango Avenue
Clinton, NY 13323
Phone: (315)557-2255 ♦ Fax: (315)557-2331

NAME OF STUDENT: _____ DOB: _____ PLACE OF BIRTH: _____

SEX _____ Mother's Name: _____ Father's Name: _____

HOME ADDRESS: _____ TELEPHONE #: _____

NUMBER & AGES OF SIBLINGS: _____

1. Was your child born prematurely? Yes No
2. Did he/she have any growth or development problems as an infant or young child? Yes No
3. Does your child have any of these health problems? If so, please check and explain. (Please be specific):
 - Ear problems _____
 - Eye problems _____
 - Diabetes _____
 - Headaches _____
 - Hearing Loss _____
 - Heart condition _____
 - Nosebleeds _____
 - Seizure disorder _____
 - Other _____
4. Does your child have asthma or allergies? Please provide specific information regarding reactions and treatments:
 - Medications/Drugs _____
 - Foods/Plants _____
 - Bee/Insect Bites _____
 - Animals/Other _____
 - Treatment recommended by physician for allergic response _____

Is your child receiving allergy shots? Yes No

Has asthma been diagnosed by a physician? Yes No

What triggers your child's asthmatic episodes (exercise, respiratory infections, cold air, chemical fumes)? _____

5. Has your child had any of the following illnesses? If yes, please give dates and explanation.
 - Chicken Pox
 - German Measles
 - Measles
 - Mononucleosis
 - Mumps
 - Pneumonia
 - Scarlet Fever
 - Strep throat/multiple infections
 - Tuberculosis
 - Tuberculosis of a family member (indicate relationship to child)

6. Please list specific severe illnesses, injuries or surgeries:

_____	@ age _____	Hospitalized for _____	days
_____	@ age _____	Hospitalized for _____	days
_____	@ age _____	Hospitalized for _____	days

* *If your child requires medication during the school day, please contact the school nurse regarding the school medication policy.*

7. Does your child have any disabilities or chronic illness? _____

8. Does your child take any medications on a regular basis? _____

9. Has your child ever been diagnosed or treated for an emotional disorder? Yes No

10. Does your child wear glasses or contact lenses? Yes No

11. Does your child have dental problems, or is he/she receiving orthodontic treatment? Yes No

12. What is the date of his/her most recent exam? _____

13. What school did your child last attend? _____

14. Was the most recently completed school year a healthy one for your child? Yes No

15. Approximately how many school days did he/she miss because of illness during the last school year?

16. Have you already provided the school with a record of your child's immunizations? Yes No

*(A signed record from a physician or clinic, or a copy of a school immunization record, must be presented before school attendance begins. If this information is not received, **New York State Public Health Law** requires that your child be excluded from school.)*

Signature of Parent _____ Date _____

PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE.

Please complete and return to the elementary health office.

Child's Name: _____

Teacher's Name: _____

_____ I will provide records of my child's physical exam for the 2016-2017 school year. (Please send in documentation of a completed physical exam form from your physician or the date of the scheduled appointment.)

_____ Date of upcoming physical exam.

_____ My child may have a school physical.

_____ I have already supplied the school nurse with the Physical Exam Record.

Parent/Guardian Signature

Date

CLINTON CENTRAL SCHOOL HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____
 Date of Exam: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached
 No immunizations given today
 Immunizations given since last Health Appraisal:
 Sickle Cell Screen: Positive Negative Not done Date: _____
 PPD: Positive Negative Not done Date: _____
 Elevated Lead: Yes No Not done Date: _____
 Dental Referral: Yes No Not done Date: _____

SPECIFY CURRENT DISEASES: Asthma Diabetes: Type 1 Type 2 Hypertension Hyperlipidemia
 Other: _____

Significant Medical/Surgical History: _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 NONE Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Exercise Pulse: _____

Body Mass Index	Vision - without glasses/contact lenses	R	L	<i>Referral</i>
Weight Status Category: (BMI Percentile)	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - Near Point	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

Recommendations/Referrals: _____

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form
 Name: _____ Dosage/Time: _____
 Name: _____ Dosage/Time: _____

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
 ___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball,
 ___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.
 Specify medical accommodations needed for school: _____ None
 Known or suspected disability: _____ Please monitor
 Restrictions: _____ Please monitor
 Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Clinton Central School

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / /
Month Day Year

Sex: Male Female

Will this be your child's first visit to a dentist? Yes No

School: Name _____ Grade _____

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? Yes No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date _____

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

- Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
- No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) _____ Dentist's Signature _____

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Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

- Yes No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes No **Untreated Caries** – Does this child have an open cavity? [At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
- Yes No **Dental Sealants Present**

Other problems (Specify): _____

III. Treatment Needs (check all that apply)

- No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
- May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
- Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems...