

Phone (845) 985-2296

Thomas W. Palmer, Superintendent

REGISTRATION CHECK LIST

Student's Name(s) _____

Registration Appointment Date: _____ Time: _____

ITEMS REQUIRED AT TIME OF REGISTRATION

- Original Birth Certificate (or certified copy)
- Custody Papers (if applicable)
- Parent/Guardian's Photo ID
- Two Proofs of Residency (deed, lease, utility bill, driver's license, voter registration, income tax return, current paycheck with address on it)
- Any other information regarding your child, such as a recent report card, IEP, testing results, etc.
- Recent Physician's Physical (form included in General Registration Packet)
- Recent Dental Health Certificate (form included in General Registration Packet)
- Immunization Record signed by physician

FORMS TO BE COMPLETED PRIOR TO REGISTRATION APPOINTMENT

- General Registration Packet (11 pages)
- Early Dismissal Form (Grades K-6 only)
- Other: _____
- Other: _____

Tri-Valley Central School

34 Moore Hill Rd.

Grahamsville, NY 12740 **PLEASE PRINT IN INK**

For Office Use Only:

Grade _____ Homeroom _____ Bus # _____ ID# _____

Date of Entry _____ Proof of Residency Supplied

Proof of Birth: Birth Cert. Baptism Cert Physician's Cert Hospital Cert.

STUDENT'S NAME: _____

First

Middle

Last

Mailing Address: _____

Street

City

State

Zip

911 Address (if different from above): _____

Street

City

County

State

Zip

Home Telephone: _____

County of Residence: _____

Gender: _____ (M/F) **Birth Date:** _____

Place of Birth: _____

City

State/Province

Country

TRANSPORTATION INFORMATION (Transportation can only be provided within the Tri-Valley district)

Please Circle: My child will be transported to school from: HOME or BABYSITTER
At dismissal my child will be transported to: HOME or BABYSITTER

Babysitter's Name: _____ **Phone Number:** _____

Babysitter's 911 Address: _____

Street(not P.O. Box)

City

If **LEGAL CUSTODY** has been established, then fill in this portion.

Custody Type: Sole Joint 50/50 Temp Foster Visitation

(person(s) with legal custody or guardianship)

(when established)

(person(s) with right to make educational decisions)

Special considerations/visitations/restrictions: _____

Mother/Guardian: (should receive mailings)

Full Name: _____

Salutation: _____

Relationship to Student: _____

Employer: _____

Work Phone: _____ **Cell:** _____

E-mail: _____

Address*: _____

(*If different from student) Emergency Contact Pick-up Rights

Father/Guardian: (should receive mailings)

Full Name: _____

Salutation: _____

Relationship to Student: _____

Employer: _____

Work Phone: _____ **Cell:** _____

E-mail: _____

Address*: _____

(*If different from student) Emergency Contact Pick-up Rights

Others living in the child's household:

Name

Age (if child)

Grade (if child)

Gender

Relationship to Child

<i>Name</i>	<i>Age (if child)</i>	<i>Grade (if child)</i>	<i>Gender</i>	<i>Relationship to Child</i>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Tri-Valley Central School

34 Moore Hill Rd.
Grahamsville, NY 12740

Previous School: _____ Telephone for Previous School: _____

Dates Attended: _____ Grades Attended: _____ Fax for Previous School: _____

Language Spoken in Home? _____

Is your child Hispanic, Latino, or of Spanish origin? YES, Hispanic ____ NO, not Hispanic ____

Child's Ethnicity: American Indian ____ Asian ____ Black ____ Native Hawaiian/Pacific Islander ____
White ____

Health Comments: Glasses ____ Hearing ____ Seizures ____ Asthma ____ Allergies _____

DEVELOPMENTAL HISTORY: Do you have concerns about your child's development in any of the following areas?

Speech or Language? Yes No Physical Development? Yes No
Ability to Learn? Yes No Social or Emotional? Yes No

If you answered yes to any of the questions above, please explain: _____

Any Previous Special Education Programs? _____ In which grades? K-7 8-12

Any Previous Remedial Programs? _____ Any Previous Retention? _____

OTHERS TO BE CONTACTED IN CASE OF EMERGENCY (other than parent)

Name	Salutation	Home Phone	Cell Phone	Work Phone	Relationship to Child	Emergency Contact	Authorized Pick-up
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Physician to be called in an emergency: _____ Tel.# _____

Hospital to be called in an emergency: _____ Tel.# _____

AUTHORIZED RELEASE FROM SCHOOL: I authorize the Tri-Valley School District to release my child during school hours to the individuals selected for "authorized pick-up" above.

(Signature of Parent)

(Date)

Tri-Valley Central School District

84 Modra Hill Road • Granthamville, New York 12741

Phone (845) 985-2296

Thomas W. Palmer, Superintendent

Student Residency Questionnaire

Name of School _____

Name of Student: _____ Sex: Male
Last First Middle Female

Birth Date / / Age:
Month / Day / Year

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? Yes No
2. Is this temporary living arrangement due to loss of housing or economic hardship? Yes No

Signature of Parent/Legal Guardian _____ Date _____

If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.

Parent Signature **Date**

Where is the student presently living? (Check one box.)

- In a motel/hotel due to lack of housing
- In a shelter
- With relatives or others due to lack of housing
- In an abandoned apartment/building
- In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite
- Temporarily housed in a shelter awaiting foster care placement

Name of Parent(s)/Legal Guardian(s) _____

Address _____ Zip _____ Phone _____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

*I agree to the release of the above information to the Academic Support for Kids Program (ASK).
I understand as a result of this referral a representative from ASK will be contacting me.*

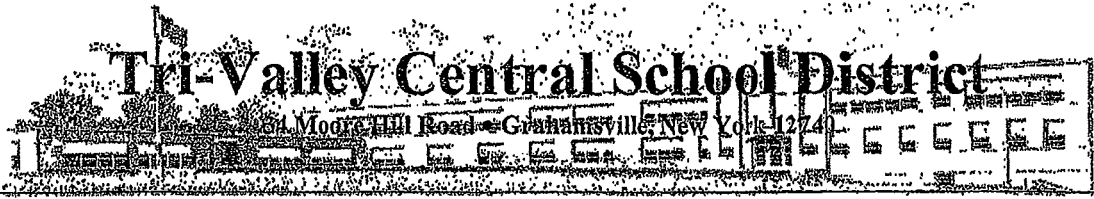
I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Date
Updated September 2010

Page 3 of 11

McKinney-Vento Act Liaison Signature
TVCS Registration Packet

CC: PPS



Phone (845) 985-2296

Thomas W. Palmer, Superintendent

Request For Records

Student's Name _____

(Grade _____ DOB _____) has enrolled in the Tri-Valley Central School District. Please forward copies of the information listed to the address(es) circled below:

- ✓ academic records
- ✓ birth certificate
- ✓ immunization records
- ✓ attendance records
- ✓ standardized testing
- ✓ health and dental records

Tri-Valley Central School
 Registration and Attendance Office
 34 Moore Hill Road
 Grahamsville, NY 12740
 (845) 985-2296 x 5405
 Fax: (845) 985-2825

Date: _____

Requesting Records From:

School: _____

Street: _____

City: _____

State/Zip: _____

Phone: _____

Fax: _____

Physician: _____

Fax: _____

- ✓ Psychological evaluations and special education recommendations (if any), should be sent to the address below:

Tri-Valley Pupil Personnel Services
 34 Moore Hill Road
 Grahamsville, NY 12740
 (845) 985-2296 x 5308
 Fax: (845) 985-2481

PARENTAL RELEASE STATEMENT

I hereby authorize the release of the above mentioned records to the Tri-Valley Central School.

Date

Signature of Parent/Guardian

(Parent permission is no longer required when records are requested by authorized school personnel. (Family Educational Rights and Privacy Act, Final Rule on Education Records, Federal Register, June 17, 1976, Vol. 41, NO> 118, page 24673)



Lisette 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 style="text-align: right; font-size: small;">specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i style="text-align: right; font-size: small;">specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother _____ <i style="text-align: right; font-size: small;">specify</i>	<input type="checkbox"/> Father _____ <i style="text-align: right; font-size: small;">specify</i>
	<input type="checkbox"/> Guardian(s) _____ <i style="text-align: right; font-size: small;">specify</i>	
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i style="text-align: right; font-size: small;">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 style="text-align: right; font-size: small;">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 style="text-align: right; font-size: small;">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 style="text-align: right; font-size: small;">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:
<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between; font-size: x-small;"> District Name (Number) & School Address </div>	<div style="border-bottom: 1px solid black; height: 20px;"></div>

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 referred 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 received 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? _____	

_____ <i>Signature of Parent or of Person in Parental Relation</i>	Month: _____ Day: _____ Year: _____ _____ <i>Date</i>
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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: _____ <small>MO. DAY YR.</small>	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: _____ <small>MO. DAY YR.</small>	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: _____ _____	

Parental Consent/Denial For School Physical Exams Offered At TVCS

I, _____, DO or DO NOT (Circle One)
Parent/Guardian Signature

authorize Bethel Medical Family Practice of the Tri-Valley Central School District Health Services Department to perform a cost-free physical exam on my child or ward:

Name of Student

at the Tri-Valley Central School during his/her enrollment. Educational Law and Regulations of the Commissioner of Education require physical exams of children when they:

- Enter the school district for the first time
- Are in Grades K, 2, 4, 7, and 10
- Are referred by/to the Committee on Special Education
- To participate in interscholastic sports

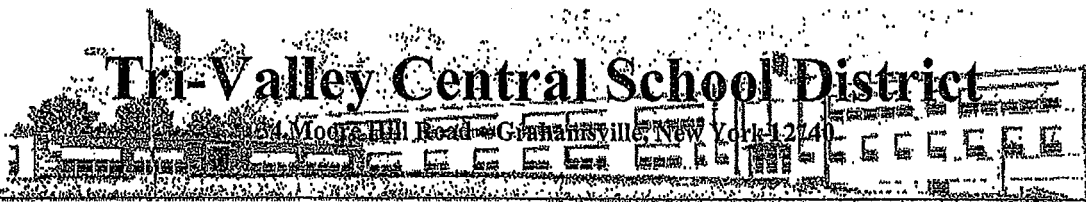
I understand that all reasonable precaution and care will be taken in giving health physicals to my child. The physical exams are done by the school district's Medical Director and with the assistance of a registered nurse. The School Nurse will report to the parents in writing all significant findings which may require professional attention. The medical evaluation consists of the history and physical examination. Scoliosis screening is done by the Medical Director and the School Nurse.

Signature of Parent/Guardian

Date

I UNDERSTAND THAT ALL REPORTS, TESTING, AND MEDICAL ISSUES WILL BE SHARED ONLY WITH NECESSARY PERSONNEL (IE: teachers, administrators, coaches).

Parent/Guardian Signature



Phone (845) 985-2296

Thomas W. Palmer, Superintendent

**Parent and Physician's Authorization for Administration of
Medication in School and School Activities**

A. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ DOB: _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any): _____

PLEASE CHECK ONE:

- Self-directed student:** means that the student can: Identify the correct medicine, identify the purpose of the medication, determine dosage being administered, describe what will happen if the medication is not taken, and able to refuse the medication if the student has any concerns about its appropriateness.
- Non self-directed student:** means that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

I assess this student to be self-directed Yes No
 Student may self-carry and self-administer medication Yes No

NOTE: The school nurse will also assess self-direction for the school setting. Parent should send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given at home.

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

- All medications for K-5 are held in the nurse's office, during the field trip, the teacher carries the medication.
- Medication must be in the original pharmacy labeled container with specific orders and the name of the medication.
- Medication and refills must be brought to school by parent, guardian or responsible adult.

B: To be completed by Parent/Guardian:

Your signature below indicates your approval for your child to be self-directing and able to follow the medication order(s) listed above while in school and/or on school trips.

Parent Signature: _____ Date: _____

School Nurse: _____ Date: _____



Phone (845) 985-2296

Thomas W. Palmer, Superintendent

This letter only applies to students in grades 9-12.

Dear Parent/Guardian,

In 2001, the "No Child Left Behind Act" was passed by Congress. The "No Child Left Behind Act", in part, deals with promoting military service. This act requires that schools release, to military recruiters, a directory of students with names, addresses and phone numbers. The law also provides the parent/guardian the right to request that their child's name, address and phone number **not** be released. The "No Child Left Behind Act" mandates schools to inform parents and students of this right.

This is the reason I am writing this letter. Unless the form attached below is returned to Tri-Valley Secondary School as soon as possible, your child's name, address and phone number **will** be released to any military recruiter requesting such a list.

If you have any questions concerning this matter, feel free to contact me.

Sincerely yours,

Sherelyn Carattini, Principal

I hereby inform Tri-Valley Secondary School that I do **not** want my child's name, address and phone number released to any military recruiters. To ensure your request this form **must** be returned as soon as possible.

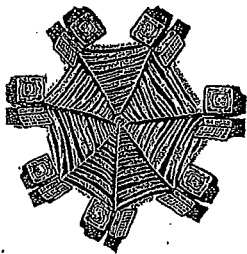
Student(s) Name _____

(please print)

Parent/Guardian Name _____

(please print)

Parent Signature _____ Date _____



Expected Graduation Year _____

**NETWORK USE AGREEMENT
(For Student Use)**

Student Name: _____ Grade: _____

School: _____ Date: _____

FOR GRADES 3-12:

I have read, understand, and agree to the terms of the District's Acceptable Use of District's Information Technology Network Policy (Board Policy #8360). I understand that I have no right to privacy when I use the District's Network and I understand that the District may monitor my communications while using the District's Network. I understand that, if I violate the rules, the District may not allow me to use the Network and I may face other disciplinary measures. I understand that my Network account may be terminated at any time for any reason.

Please write: I will promise to use the Network only as directed by my supervising staff member. _____

Student Signature: _____ Date: _____

For New Students ONLY

Grades 3-12 - Password Requested (6 - 8 letters or digits): _____ (do not fill in if you already have one)

FOR ALL GRADES:

I have read, understand, and agree to the terms of the District's Acceptable Use of District's Information Technology Network Policy (Board Policy #8360). I understand that my child has no right to privacy when he/she uses the District's Network and I understand that the District may monitor my child's communications while using the District's Network. I further understand that any violation of District policy may result in suspension or revocation of my child's Network access and privileges. I understand that my child's Network account may be terminated at any time for any reason.

I hereby release the District, its personnel, and any institutions with which it is affiliated, from any and all claims and damages of any nature arising from my child's use of, or inability to use, the District's Network including, but not limited to, claims that may arise from the unauthorized use of the system to purchase products or services.

Parent/Legal Guardian Name (Please print): _____ Relationship: _____

Parent/Legal Guardian Signature: _____ Date: _____

This space reserved for System Administrator – New Students Only

Assigned User Name _____ Date: _____

Assigned Password _____ Initials: _____

Grades 7-12 "Search Access" Orientation Date: _____ Librarian Signature: _____

- Added to Novell
- Added to ClassLink
- Added to Graduation Year Group and Student Group
- E-mail assigned (grades 9-12 only)

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM (TO BE FILLED OUT BY PHYSICIAN)

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

IMMUNIZATIONS / HEALTH HISTORY

Please attach updated Immunization record
 No immunization given today

Sickle Cell Screen: Positive Negative Not done DATE: _____
 PPD: Positive Negative Not done DATE: _____
 Dental Referral: Yes No Not done DATE: _____
 Lead Screening: Results: _____ DATE: _____

Significant Medical/Surgical History: See attached _____

Allergies: LIFE THREATENING Food _____ Insect _____
 Seasonal Medication _____ Other _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Date of Exam: _____

Body Mass Index: _____	Vision – without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision – with glasses/contact lenses	R	L	
<input type="checkbox"/> EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Vision – Near Point	R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:			

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

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____
 Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No
 Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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-county, 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: _____

OPTIONAL INFORMATION, if known

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)
 Provider's Name/Address: _____ Fax: _____
 Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. Rev.10/08

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: / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Month Day Year		

School: <small>Name</small>	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

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.