Tri-Valley Central School District

54 Moore Hill Road ~ Grahamsville, New York 12740

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*

Child Resides With:
Both Parents: _____
Mother: ___ Father: _____
Other: _____

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*

CC: Transportation, Attendance, Nurse, PPS

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*
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

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)

CC: Attendance, Nurse, PPS

Tri-Valley Central School District

84 Moore Hill Road • Grahamsville, New York 12740

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).

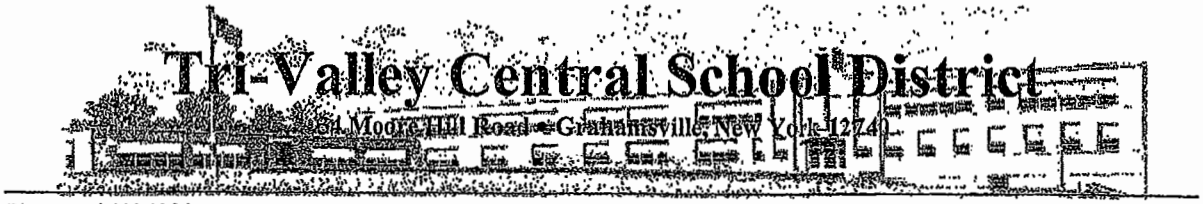
I agree to the release of the above information to the Academic Support for Kids Program (ASK). I understand as a result of this referral a representative from ASK will be contacting me.

_____

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

_____ _____
Date *McKinney-Vento Act Liaison Signature*

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 hearby 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)

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colon-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.

First	*Middle*	*Last*

Month	*Day*	*Year*	❑ Male ❑ Female

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?	❑ English	❑ Other	*specify*	
2. What was the first language your child learned?	❑ English	❑ Other	*specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother *specify*	❑ Father *specify*	❑ Guardian(s) *specify*	
4. What language(s) does your child understand?	❑ English	❑ Other	*specify*	
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak	
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read	
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ Does not write	

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***
❑ ❑ ❑ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ 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: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____
MO DAY YR.

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ 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: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, 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

CC: Nurse
TVCS Registration Packet

Tri-Valley Central School District

154 Moore Hill Road • Grahamsville, New York 12740

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 ADMINSTRATION

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: _____

CC: Nurse

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_____

CC: Guidance

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

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:	_____
Elevated Lead:	☐ Yes	☐ No	☐ Not done	DATE:	_____
Dental Referral:	☐ Yes	☐ No	☐ Not done	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: _____

				Referral
Body Mass Index: _____ _____ . _____	Vision – without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision – with glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th through 49th ☐ 50 through 84th	Vision – Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Hearing ☐ Pass 20 db sc both ears or:			

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

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

CC: Nurse

Dental Health Certificate- Optional

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

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 ½ 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.