

ILION CENTRAL SCHOOL DISTRICT

Ilion Jr/Sr High School
1 Golden Bomber Drive
Ilion, New York 13357

Barringer Road Elementary School
326 Barringer Road
Ilion, New York 13357

Remington Elementary School
77 East North Street
Ilion, New York 13357

ENTRANCE FORM

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FOR OFFICE USE ONLY

Name _____ Student # _____

New _____ Re-enter _____ Grade _____ Enter Date ____/____/____

School _____ Teacher _____ E: _____

Child's Full Legal Name: _____ Circle One: M F

Last First Middle

Mailing Address: _____ Telephone No. _____

Residential Address (if different from above) _____

Date of Birth: ____/____/____ Place of Birth: _____

*Proof of Birth: (ex.: birth/baptismal certificate) _____ Social Security No. _____

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

Mother's Maiden Name _____

Address _____ Address _____

Phone #: Home _____ Work _____ Phone #: Home _____ Work _____

Employment: _____ Employment: _____

Education: Highest Grade Completed: _____ Education: Highest Grade Completed: _____

*Proof of Residency Provided: (Item must indicate the parent's/guardian's name & address. Ex: rent receipt, mortgage bill/receipt, utility bill/receipt, cable TV bill/receipt, telephone bill/receipt, mailing address with street not P.O. Box): _____

With whom does the child live if not with the parents? _____ Relationship to child: _____

*Which parent(s)/guardian has legal custody? _____ In situations which involve legal separation or divorce, provide proof of custody. Examples of proof may be: legal court papers, a notarized statement signed by both parents. Proof of custody was provided on ____/____/____. (Keep a copy in the student's file.)

Please complete the next section if the child is in foster care:

Foster parent(s) name: _____

Address: _____ Phone: _____

Employer: _____

Child's School District of Origin: _____

Date child was placed in foster home: _____

Agency placing the child: _____ Phone: _____

Name of agency caseworker assigned to the child: _____

If we cannot reach you by phone, where may we call? (a local person or relative who will assume responsibility for your child)

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Additional comments on above information:

Brothers/Sisters living a home (use other side if necessary)

First Name	Last Name	Date of Birth	Sex: M/F	Full or Half or Step
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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Others living in the home

<u>Full Name</u>	<u>Date of Birth</u>	<u>Relationship to Student</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Schools the student has attended (Use other side if necessary)

<u>School Name</u>	<u>Address</u>	<u>Entry Date/Grade</u>	<u>Date Left/Grade</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child even been in a special program? Yes ___ No ___ In a special education program? Yes ___ No ___
If Yes, for what program? _____ Date _____

	<u>Yes</u>	<u>No</u>	<u>Dates in Program</u>
Specific Learning Disability	_____	_____	_____
Educable Mentally Disabled	_____	_____	_____
Emotionally Disabled	_____	_____	_____
Visually Impaired	_____	_____	_____
Physically Disabled	_____	_____	_____
Speech, Hearing, and Language Impaired	_____	_____	_____
Occupational/Physical Therapy	_____	_____	_____
Gifted and Talented	_____	_____	_____
Remedial Reading	_____	_____	_____
Remedial Math	_____	_____	_____

If your child was in a special program, indicated name and address of school where records may be obtained:

School Name _____
School Address _____
City/State/Zip _____

Has your child ever been retained? Yes ___ No ___ Grade retained _____ Year _____

If you answered Yes for your child being in a special education program, **all** of the following information and documentation must be received by our Committee on Special Education Office prior to your child being enrolled and placed in a program.

- _____ Current IEP Date Received ___/___/___
- _____ Current Psychological Date Received ___/___/___
- _____ Current Social History Date Received ___/___/___
- _____ Current Medical Records Date Received ___/___/___

Current Doctor's Prescription for any of the following therapies being received in school:

- _____ Speech Therapy Date Received ___/___/___
- _____ Occupational Therapy Date Received ___/___/___
- _____ Physical Therapy Date Received ___/___/___



**ILION CENTRAL SCHOOL DISTRICT
STUDENT RACIAL AND ETHNIC IDENTIFICATION**

**FORM
SREI**

Ilion Jr/Sr High School
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To the Parent/Guardian:

The Ilion Central School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Ilion Central School District in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and Federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check (✓) in the box for the category or categories which best describe your child. The Ilion Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: This form will be filed in the student's permanent record as confidential information

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

Please complete the form on the reverse side of this page



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All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Name of School: _____ Grade Level: _____

Student Name: _____ Date of Birth: _____

DIRECTIONS TO PARENT/GUARDIAN:

PLEASE ANSWER QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND.

[For question (1) check (✓) the box that best describes your child.] Check (✓) only ONE box.

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 (✓) all groups that apply to your child; check (✓) 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 or 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.

Signature of Parent/Guardian/Other

Date

Relationship to Student (please check one box below):

[] Mother

[] Father

[] Guardian

[] Other (specify): _____

See reverse for important message to Parents/Guardians and Confidentiality Procedures and Regulations.

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ENGLISH AS A SECOND LANGUAGE SURVEY

Instructions: This form should be completed at the time a student enrolls in an Ilion school if English is not the language used in the home.

Student Name _____ Date _____

School Building Name _____ Grade _____

Name of person completing this survey _____
(please print)

CHECK THE CORRECT RESPONSE and COMPLETE:

1. Is a language other than English used in the home? _____ Yes _____ No

If yes, what is the language? _____

2. Did the student have a first language other than English? _____ Yes _____ No

If yes, what is the language? _____

3. Does the student most frequently speak a language other than English? _____ Yes _____ No

If yes, what is the language? _____

4. In what country was the child born? _____

5. In what country was the parent(s) born? _____

6. Please note the date of entry into the United States: _____

7. If child is from Puerto Rico, please note entry date to New York state: _____

8. Has the child even been enrolled in an ESL program? _____ Yes _____ No

If yes, what school district? _____

For how many years? _____

If known, the name of the ESL teacher: _____

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FOSTER CARE (Send completed form to PPS Secretary at Ilion Jr/Sr High School)

Student Name _____ Address _____
Number _____
Enrollment Date _____

School Entering (check one):
 Ilion Jr/Sr High
 Barringer Road
 Remington

School / Address last attended: _____

Agency / Case Worker: _____

Guardian Name: _____
Is this a relative of student? Yes No

Parent(s): Name: _____ Address: _____
Phone Number: _____

<p>FOR OFFICE USE ONLY:</p> <p><input type="checkbox"/> Inside Component Herkimer BOCES = No Billing</p> <p><input type="checkbox"/> Outside = Bill District _____</p> <p>Date: _____</p>	<p><u>FOSTER CARE</u></p> <p>Initial: (PPS) _____</p> <p>Services (check all that apply):</p> <p>CSE _____</p> <p>Counseling _____</p> <p>BOCES: Voc-Ed _____</p> <p>Pre-Voc _____</p> <p>Other: _____</p> <p>Other: _____</p> <p>Other: _____</p>
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ILION CENTRAL SCHOOL DISTRICT

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Medical Information Form

PLEASE COMPLETE BOTH PAGES – PARENT/GUARDIAN: The following information is a necessity to insure that our health records pertaining to your child are current and accurate.

Student Name: _____ Address: _____
Last First Middle Home Phone No.: _____
Sex: ___M___F Date of Birth: _____ Place of Birth: _____
Father's Name: _____ Mother's Name: _____
Mother's Maiden Name: _____
Guardian's/Step-parent's Name: _____
Physician to be called in an emergency: _____ Phone No.: _____
Emergency Contact Person: _____ Phone No.: _____

IMMUNIZATIONS: Give dates by month/day/year:
Oral Polio Vaccine: #1 _____ #2 _____ #3 _____ #4 _____ #5 _____
D.P.T. (Diphtheria/Pertussis/Tetanus) / D.T. or DPAT/DT:
#1 _____ #2 _____ #3 _____ #4 _____ #5 _____
Hep. B: #1 _____ #2 _____ #3 _____
Measles #1 _____ #2 _____ Mumps #1 _____ #2 _____ Rubella (three-day Measles) #1 _____ #2 _____
Tuberculin Test _____
Chicken Pox vaccine _____
Hib/B-Capsa #1 _____ #2 _____ #3 _____ #4 _____
If child is exempt, please specify vaccine and reason: _____

HEALTH HISTORY: Please complete as accurately as possible.

	<u>CHECK EACH</u>	
1. Allergies to food, drugs, or environmental (type of allergy: _____)	YES _____	NO _____
2. Hay fever, Asthma, Wheezing	YES _____	NO _____
3. Eczema or Frequent Skin Rashes	YES _____	NO _____
4. Bee Sting Allergy	YES _____	NO _____
5. Convulsions or Seizures	YES _____	NO _____
6. Heart Trouble or Murmurs	YES _____	NO _____
7. Diabetes	YES _____	NO _____
8. Tuberculosis	YES _____	NO _____
9. Tuberculosis in the Family	YES _____	NO _____
10. Kidney Disease	YES _____	NO _____
11. Pneumonia (Date _____)	YES _____	NO _____
12. Frequent (more than 3 per year) Colds, Sore Throat, or Ear Aches	YES _____	NO _____
13. Rheumatic Fever (Date _____)	YES _____	NO _____
14. Mononucleosis (Date _____)	YES _____	NO _____
15. Chicken Pox (Date _____)	YES _____	NO _____
16. Speech Problems	YES _____	NO _____
17. Bowel or Urinary Problems	YES _____	NO _____
18. Nutrition or Weight Problems	YES _____	NO _____
19. Behavior, Developmental, or Maturity Problems	YES _____	NO _____
20. Social Adjustment Problems (Family, Friends, School)	YES _____	NO _____

EXPLAIN ALL YES ANSWERS AND GIVE DATES OF ILLNESS/DIAGNOSIS:

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Medical Information Form
CONTINUED:

21. Is your child taking any medication? No _____ Yes _____
Name of medication _____
Reason _____
22. Severe accidents or injuries? No _____ Yes _____
Date _____ Explain _____
23. Hospitalizations? No _____ Yes _____
Date _____ Explain _____
24. Surgery? No _____ Yes _____
Date _____ Explain _____
25. Known vision problems? No _____ Yes _____
Date _____ Explain _____
26. Known hearing problems? No _____ Yes _____
Date _____ Explain _____
27. Other physical problems not mentioned? No _____ Yes _____
Explain _____
28. Did your child attend a preschool? No _____ Yes _____
Which preschool? _____

PRENATAL HISTORY:

1. Child's birth weight _____
2. Duration of pregnancy _____
3. Prenatal difficulties _____
4. Did child have any difficulties at birth? No _____ Yes _____
Explain _____

PHYSICAL ACTIVITY:

Does your child have any physical difficulty that would prevent him/her from participating in the normal physical education class or other activities? No _____ Yes _____

Explain _____

(If your child is unable to participate in physical education class, then a physician's certificate is required.)

NOTE: A student who has been absent more than 5 consecutive days and under the care of a physician should have a doctor's note before re-admittance. A child absent more than 5 consecutive days and not seen by a doctor is required to be examined by the school nurse before readmitted.

The New York State Education Law requires a physical examination before entrance to school and routinely at grades Pre-K, K, 2, 4, 7, and 10. Our school physician examines grades 2, 4, 7, and 10; all athletes and those with physical disabilities are examined yearly.

Pupil to be examined: _____ in school or _____ by the family physician.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

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Student Name: _____

D.O.B. _____

Grade Level: _____

Entry Date: _____

Previous School/Address: _____

By signing below:

I give permission for Ilion Central School to request all transfer records and pertinent information from my child's former school.

I certify that the student has had polio, diphtheria (DPT), MMR, and varicella, vaccines.

I certify that the information contained in this Entrance Form is true and correct to the best of my knowledge.

Date

Signature of Parent/Guardian

**

Additional Parental Consent for students entering a special education program:

I, as parent or guardian, agree with the Committee on Special Education's initial educational placement recommendation for:

Student's Name: _____

Classification (from current IEP): _____

Program Placement (based on current IEP): _____

I understand that this placement is based on current records that have been obtained from my child's previous school.

I understand that this placement may have been adjusted as determined by the Ilion School District staff.

I understand that this placement is temporary, and that the Ilion Committee on Special Education will convene in the near future to review the records from my child's previous school, and will make formal recommendations for program and services.

Date

Signature of Parent/Guardian

ILION CENTRAL SCHOOL DISTRICT

ENTRANCE FORM

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Ilion Jr/Sr High School
1 Golden Bomber
Ilion, New York 13357
Principal
Renee Rudd
(315) 895-7471

Barringer Road Elementary School
326 Barringer Road
Ilion, New York 13357
Principal
Frances LaPaglia
(315) 894-8420

Remington Elementary School
77 East North Street
Ilion, New York 13357
Principal
Jeremy Rich
(315) 895-7720

Assistant Superintendent
of Curriculum, Planning,
& Technology
Dr. Marsha Mays-Smith
(315) 894-3210

Counselors
Shannon Darrow
Michelle DelConte
Leon Frost
(315) 895-7120

DATE: _____

TO THE PARENTS OF _____
CHILD'S NAME

Dear Parents:

According to Chapter 53, Education Law of 1980, all new entrants to public schools in New York State must be screened for possibly handicapping conditions (such as learning disabilities, sensory deficits, physical impairments, etc.) or for giftedness (students who are capable of high academic aptitude, leadership, or special talent in one or more of the arts). Your child will be screened soon in areas of physical development, speech, and language, motor abilities and cognitive development. You will be notified of the results.

Sincerely,

Dr. Marsha Mays-Smith
Assistant Superintendent for Curriculum, Planning and Technology

PARENT SIGNATURE

**AN EQUAL OPPORTUNITY EMPLOYER
ILION CENTRAL SCHOOL DISTRICT**

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NOTE: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN'S PHYSICAL EXAMINATION FORM FOR SCHOOL ENTRANCE:
(PLEASE COMPLETE THIS FORM, AND RETURN IT TO THE HEALTH OFFICE OF THE SCHOOL ABOVE.)

Page 1 of 2

New York State Regulations require that before entering school, a child must have a physical examination and be on a regular schedule for completing required immunizations. The physician is requested to complete pertinent information on this form and check vaccination schedule on the attached pages to make recommendations for completing the required immunizations.

Student's Name: _____	Date _____
Birth Date: _____	Grade Level Entering: _____
	School: _____
Height (inches) _____	Teeth _____
Weight _____	Nose _____
BMI _____ BMI % _____	Heart _____
Blood Pressure _____	Abdomen _____
Urinalysis: Albumen/Sugar _____	Lungs _____
Blood Count/HCT _____	Skin _____
Nervous System (Neurological) _____	Eyes _____
Ears (Otosopic) or Auditory _____	Nutrition _____
Hernia _____	Genito-Urinary _____
Speech/Language _____	Tine Test – Tuberculin _____
Lymph Nodes (Lymphatic) _____	Tonsils _____
Psycho-Motor Development _____	
Lead Screening/Results _____	
Structural: 1. Scoliosis check _____	
2. Posture _____	
3. Feet _____	

1. Specific recommendations or remarks: _____

2. Is there a condition that may require a classroom emergency? NO _____ YES _____
Specify: _____

3. Is there a condition that may require a limitation or compensation in the school environment, program, or physical education? NO _____ YES _____
Specify: _____

4. Is this child on regular medication or under regular medical observation? NO _____ YES _____
Specify: _____

5. Should this child be seen by you again? NO _____ YES _____ When? _____

Physician's Name (printed) _____
Physician's Signature _____
Address _____
Telephone Number _____

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PHYSICIAN'S PHYSICAL EXAMINATION FORM FOR SCHOOL ENTRANCE:

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IMMUNIZATIONS: Give dates by month/day/year:

Oral Polio Vaccine: #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

D.P.T. (Diphtheria/Pertussis/Tetanus) / D.T. or DPAT/DT:

#1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Hep. B: #1 _____ #2 _____ #3 _____

Measles #1 _____ #2 _____ Mumps #1 _____ #2 _____ Rubella (three-day Measles) #1 _____ #2 _____

Tuberculin Test _____

Chicken Pox vaccine _____

Hib/B-Capsa #1 _____ #2 _____ #3 _____ #4 _____

Pevnar/Pneumonia #1 _____ #2 _____ #3 _____ #4 _____

Influenza #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

If child is exempt, please specify vaccine and reason: _____

Additional Comments:

Physician's Signature _____

Date _____

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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:

Birth Date: / /
 Month Day Year

Sex: Male
 Female

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

School:

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.