

The mission of the Three Village Central School District, in concert with its families and community, is to provide an educational environment which will enable each student to achieve a high level of academic proficiency and to become a well-rounded individual who is an involved, responsible citizen.

**THREE VILLAGE
CENTRAL SCHOOL DISTRICT**

**Kenneth Bossert, Ed.D.
Assistant Superintendent
for Curriculum & Instruction**

Spring, 2011

Dear Parents,

Welcome to the Three Village Central School District. If you are preparing to register your first child to attend kindergarten, you are embarking on an important milestone in the life of your son/daughter. As you will soon learn, the Three Village School District is an outstanding educational institution.

We ask that you kindly complete the attached kindergarten registration packet (along with emergency contact information) and bring it with you to your child's kindergarten screening appointment. Your child's home school will be notified after you have met with the registrar in order to schedule an appointment for screening. Kindergarten screening takes place at each elementary school according to the schedule indicated on the district calendar (and our website). The screening process is designed to be a welcoming and friendly first experience for your child. You are notified of the results of the assessment via U.S. mail a few weeks after the screening has taken place. The results of the screening help us to balance our class sections and prepare effectively for your child.

Thank you for taking the time to complete the necessary paperwork. Should you have any questions, please do not hesitate to contact your child's building principal or my office at 730-4585. We look forward to working with you for years to come!

Regards,

Ken Bossert, Ed.D.

**Ken Bossert, Ed. D.
Assistant Superintendent
for Curriculum and Instruction**

North County Administrative Center ■ 100 Suffolk Avenue ■ Stony Brook, New York 11790-1821
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Neil Lederer, **Interim Superintendent of Schools**
Asst. Superintendents: Cheryl Pedisich, PPS/Educational Services ■ Jeffrey Carlson, Business Services ■ Dr. Kenneth Bossert, Curriculum & Instruction
Edward Sallie, **Interim Human Resources**

THREE VILLAGE CENTRAL SCHOOL DISTRICT
Stony Brook, New York 11790

Dear Parents:

In order to help ensure a successful initial school experience for your child, it is important to know something of your child's development, pre-school experiences and any special concerns or considerations you may feel are important to share. Please complete the following and return it at your child's kindergarten registration.

Kindergarten Social Development History

Child's name: _____ Birth date: _____ Age: _____

Home address: _____ Home phone: _____

Parent Name: _____ Age: _____ Education: _____

Employment: _____ Phone: _____

Parent Name: _____ Age: _____ Education: _____

Employment: _____ Phone: _____

Child lives with: mother, father, stepfather, stepmother (circle all that apply)

Stepparent's Name: _____ Age: _____ Education: _____

Employment: _____ Phone: _____

Stepparent's name: _____ Age: _____ Education: _____

Employment: _____ Phone: _____

If parents are divorced, please indicate who has custody of the child:

Custody Instructions: _____

Custodial Parent Name _____ Phone# _____

Court Documentation YES / NO

Children living inside the home:

Name, grade, age and school: _____

Name, grade, age and school: _____

Name, grade, age and school: _____

Name, grade, age and school: _____

Other children living outside the home:

Name and age: _____

Name and age: _____

Other persons living in the home: _____

Check if child is: Foster child _____ Adopted _____ Age when placed: _____

Birth and Infancy

A. Prenatal and Birth:

1. Mother's general health during pregnancy: _____ Complications _____
2. Labor and delivery: Normal _____
3. Specify any complications during pregnancy, labor and/or delivery: _____

4. Birth weight: _____
5. Infant's days in hospital: _____

B. Infancy:

1. Check one: **Early** **Average** **Later than peers**
Age of sitting _____ _____ _____
Age of crawling _____ _____ _____
Age of walking _____ _____ _____
Using single words _____ _____ _____
Using sentences _____ _____ _____
Toilet training _____ _____ _____

2. Please specify any concerns regarding your child's development:

Health History

1. Has your child had any serious illnesses, accidents, operations or hospitalizations?
Yes _____ No _____ If so, please describe: _____

2. Is your child taking medication on a regular basis? Yes _____ No _____
If so, please describe: _____
3. Please check any particular health problems your child has:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Asthma
<input type="checkbox"/> Faulty elimination	<input type="checkbox"/> Headaches
<input type="checkbox"/> Repeated colds	<input type="checkbox"/> Sinus trouble
<input type="checkbox"/> Other, please describe _____	<input type="checkbox"/> Earaches
	<input type="checkbox"/> Nosebleeds
	<input type="checkbox"/> Stomachaches

Speech and Language History

1. Can you understand your child's speech?
All/most of the time _____ Some of the time _____ Little of the time _____
2. Can others understand your child's speech?
All/most of the time _____ Some of the time _____ Little of the time _____
3. What is the primary language spoken in your home? _____
4. Are any other languages spoken in your home? Yes _____ No _____
If so, please list: _____

5. Uses language effectively to communicate with peers, adults? Yes _____ No _____
6. Maintains eye contact during conversation? Yes _____ No _____

Hearing and Vision History

1. Has your child's hearing ever been checked? Yes _____ No _____
- If so, where? _____ Date of last exam: _____
- Results: _____
2. Do you have any concerns regarding your child's hearing? Yes _____ No _____
- If so, please describe _____
3. Has your child had a lot of ear infections? Yes _____ No _____ At what ages? _____
4. Has your child's vision ever been checked? Yes _____ No _____
- If so, where? _____ Date of last exam: _____
- Results: _____
5. Do you have any concerns regarding your child's vision? Yes _____ No _____
- If so, please describe: _____
6. Does your child have listening or attention problems (e.g., easily distracted, short attention, span, darts from one activity to another)? Yes _____ No _____
- If so, please describe: _____

General Information

1. How many different places has your child lived? _____
2. Has your child attended preschool? Yes _____ No _____
- If so, where and when _____
- How did your child respond to this experience?

3. Are there any illnesses or special circumstances in the home which affect your child?
- Yes _____ No _____ If so, please describe _____
4. Have there been any changes in your child's life that may have been stressful or upsetting?
- Yes _____ No _____ If so, please describe _____
5. Does your child have any nervous habits or special fears? Yes _____ No _____
- If so, please describe _____
6. Do you feel your child is shy? Yes _____ No _____
7. Has your child received any educational support services (e.g., special education/OT/PT/speech/language)? Yes _____ No _____
- If so, please describe _____

8. What are your child's favorite activities and interests? _____

9. What does your child do that causes him/her to be disciplined most often? _____

10. What is the most effective discipline for your child? _____

11. Compared with other children his/her age, how well does your child:

	<u>Not As Well</u>	<u>About the Same</u>	<u>Better</u>
Get along with siblings?	_____	_____	_____
Get along with friends?	_____	_____	_____
Behave with parents?	_____	_____	_____
Play alone?	_____	_____	_____
Play with others?	_____	_____	_____

12. What is your child's attitude toward starting school?

13. Please check any areas of concern you have about your child:

_____ Eating	_____ Getting along with adults	_____ Bed-wetting
_____ Fears	_____ Uses baby talk	_____ Nightmares
_____ Sulking	_____ Nervous habits	_____ Whining
_____ Speech	_____ Wants to be babied	_____ Nail biting
_____ Coordination	_____ Doesn't sleep alone	_____ Destructive
_____ Daydreaming	_____ Temper tantrums	_____ Cries easily
_____ Fighting	_____ Restless sleeping	_____ Overly neat
_____ Teasing	_____ Complains of being sick	_____ Separation difficulty
_____ Jealousy	_____ Getting along with other children	_____ Shy in new situations
_____ Disobedience	_____ Lack of concern for other children	_____ Reaction to birth of siblings

14. Please note anything else you think may be helpful in making your child's school experience successful: _____

Name of person completing form: _____ Date: _____

Relationship to child:

If questionnaire was completed by an interviewer, please sign below:

Interviewer: _____ Date: _____

***** FOR INCOMING KINDERGARTEN STUDENTS *****

The following information is paperwork that needs to be completed by the Parent/Guardian, as well as your child's physician. Any questions can be addressed to the nurse's office where your child will be attending school.

HEALTH HISTORY – Must be completed, signed and returned at screening.

EMERGENCY CONTACT CARD – This temporary sheet must be completed, signed and returned at screening. It must include your home phone number, business, and cell phone numbers. The school must be provided with at least two local neighbors or relatives who will accept responsibility for your child in the event you cannot be reached. It is your responsibility to notify the health office of any change or addition of information to the card. A hard copy of the emergency contact card will be sent home at the start of the school year for you to complete.

Please list any additional family and friends who have your authorization to pick your child up during the school day, as well as at dismissal time. Please send in a note to your child's teacher if you are planning to pick him/her up early and also submit authorization that someone else will be signing out your child.

PLEASE HAVE YOUR CHILD'S DOCTOR COMPLETE THE FOLLOWING FORMS:

IMMUNIZATION CERTIFICATE – Please review the enclosed memo from the New York State Department of Health regarding the immunizations that are required by the State for entrance into school. Proof of the completed immunizations must be presented to the health office prior to the first day of school. State law requires the district to exclude students who have incomplete immunizations.

ELEMENTARY HEALTH APPRAISAL – New York State Education Law requires a physical examination for all new entrants to the school district. The Elementary Health Appraisal must be signed, stamped and dated by the physician, physician's assistant or nurse practitioner.

ADMINISTRATION OF MEDICATION - Submit **ONLY** if your child requires medication during the school day. The "Administration of Medication" form needs to be filled out by you and your child's physician for each medication and returned to the health office. This applies to both prescription and over the counter medications. The medication, in its original container, must be brought to the health office by a parent or guardian. Medication is not to be carried by your child. According to State law, medication cannot be administered if these requirements are not met.

DENTAL FORM – To be filled out by your child's dentist.

In order to achieve a better understanding of the health services, the following is a partial explanation of what we do and, what you, as parents or guardians, can do to make our efforts more effective.

FIRST AID:

In case of an injury, the nurse will administer first aid. If the injury is severe and a parent cannot be reached, the school will call 911.

SUDDEN ILLNESS:

If a child becomes sick in school, a parent will be called to come to school and take the child home. In the event a parent cannot be reached, the emergency contacts will be called and asked to come to school for your child.

SCREENING:

Vision and hearing screening, as well as height and weight, will be done during the school year. You will be notified of any problems. Any findings and recommendations by your child's physician should be reported back to the school's health office.

OUTDOOR DRESS:

Children should be dressed appropriately for the weather and expected to be outdoors at recess when the temperature is above twenty degrees and there is no precipitation.

CALLING IN ABSENCES:

Please notify the health/attendance office at your school when your child is going to be absent from school. For your convenience, our voice mail is on at all times. If you do not call in, you will receive a message requesting that you call us back regarding your child's absence. An absence note to your child's teacher is also required upon their return to school.

IMMUNIZATION REQUIREMENT FOR SCHOOL ENTRANCE AND ATTENDANCE

New York State Department of Health
Bureau of Communicable Disease Control Immunization Program

The following vaccines are required for a child to attend school:

- * 3 doses of diphtheria – containing toxoid (usually administered DPT, DT or TD).
- * 3 doses of oral polio vaccine (OPV) or enhanced inactivated poliovirus vaccine IPV.
- * 1 dose of mumps vaccine administered on or after 12 months of age.
- * 1 dose of rubella vaccine administered on or after 12 months of age.
- * 2 doses of measles vaccine, first dose administered on or after 12 months of age and the second dose recommended to be administered at 4 to 6 years of age and required for Kindergarten entry.
- * 3 doses of hepatitis B vaccine.
- * 1 dose of varicella vaccine, administered on or after 12 months of age or documentation by the physician stating that your child had the disease.

Religious or medical exemptions to these requirements must be submitted in writing to Mrs. Erin Blaney, Executive Director of Health, PE, Recreation and Athletics.

THREE VILLAGE CENTRAL SCHOOL DISTRICT IMMUNIZATION CERTIFICATE

Name of Student _____

Date of Birth _____

School _____

Grade _____

For vaccines given in combination, please list each component

DTap	1	2	3	4	5	
						Tdap <input style="width: 100%; height: 20px;" type="text"/>

DT or dT	1	2	3	4	5	

IPV	1	2	3	4	5	

HIB	1	2	3	4	

VARICELLA	1	2							
			<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">Hx of Disease</td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Year</td> </tr> </table>			Hx of Disease		Month	Year
Hx of Disease									
Month	Year								

MMR	1	2	

MEASLES			MUMPS			RUBELLA	

HEPATITIS B	1	2	3		HEPATITIS A	1	2

GARDASIL	1	2	3	
				MENACTRA <input style="width: 100%; height: 20px;" type="text"/>

SIGNATURE OF PHYSICIAN OR CERTIFYING AUTHORITY

DATE

STAMP

THREE VILLAGE CENTRAL SCHOOL DISTRICT
 Department of Health, Physical Education, Recreation and Athletics

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

THREE VILLAGE CENTRAL SCHOOL DISTRICT

HEALTH HISTORY

Name of Child _____ Grade _____ Teacher _____
Last _____ First _____ MI _____

Sex _____ Place of Birth: City _____ State _____ DOB _____

Birth Weight _____ lbs. _____ ozs. Full Term? _____ If premature, # of months _____

Difficulties with birth, please specify: _____

Home Address _____ Phone Number _____

Father's Name _____ Place of Birth: City _____ State _____

Mother's Name _____ Place of Birth: City _____ State _____
=====

Has your child had any of the following illnesses? Please circle the appropriate answer.

- Chicken Pox yes no
- Diphtheria yes no
- German Measles yes no
- Pneumonia yes no
- Scarlet Fever yes no
- Whooping cough yes no
- Hepatitis A yes no
- Hepatitis B yes no

Please complete the following: Does your child have:

1. Allergies to the following:

- Food yes no
- Medication yes no
- Environment yes no
- Insect stings yes no
- Other yes no

If so, what are the symptoms and treatment?

2. A vision problem? yes no
- | | | | | | |
|----------------|-----|----|-------------------|-----|----|
| Wears glasses | yes | no | If yes, full time | yes | no |
| Wears contacts | yes | no | If yes, full time | yes | no |
| Reading | yes | no | | | |
| Board work | yes | no | | | |
| Gym/recess | yes | no | | | |

Name of eye care specialist _____

3. A hearing problem yes no
Hearing aide yes no
Had an audiogram yes no

4. Speech difficulty yes no
Speech therapy yes no

Name of provider _____

5. Understands English? yes no
Speaks English? yes no

If not, primary language _____

6. Has your child:
Been Hospitalized yes no
Had Surgery yes no
Specify date(s) and reason(s):

HEALTH HISTORY

Does your child have any of the following chronic health problems?

DIAGNOSIS	YES	NO	MEDICAL TREATMENT/MEDICATION DURING OR OUTSIDE THE SCHOOL DAY
DIABETES			
TUBERCULOSIS			
SEIZURES (ACTIVE/INACTIVE)			
CYSTIC FIBROSIS			
CEREBRAL PALSY			
ASTHMA			
RESPIRATORY DISORDER			
HEMOPHILLIA			
HEART CONDITION			
HEART MURMUR			
CANCER			
SKIN DISORDER			
HEPATITIS A			
HEPATITIS B			
OTHER			

Does your child:

1. Experience frequent absences due to illness? _____
2. Experience frequent hospitalizations? _____
3. Require special transportation, equipment, precautions in lifting or moving? _____
4. Other _____

Date _____ Signature of Parent/Guardian _____

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 English. Your assistance in answering these questions is greatly appreciated.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL

DISTRICT <i>Please print or type clearly</i>	GRADE
SCHOOL	
STUDENT NAME	
DATE OF BIRTH	
STUDENT IDENTIFICATION NUMBER	
COUNTRY OF BIRTH / ANCESTRY	
NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.	
NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION	
DETERMINATION:	<input type="checkbox"/> Possible LEP <input type="checkbox"/> English Proficient

(✓ boxes that apply)

1. What language(s) is spoken in the student's English Other _____
home or residence? *specify*
2. What language(s) are spoken most of the time English Other _____
to the student, in the home or residence? *specify*
3. What language(s) does the student understand? English Other _____
specify
4. What language(s) does the student speak? English Other _____
specify
5. What language(s) does the student read? English Other _____
 Does Not Read *specify*
6. What language(s) does the student write? English Other _____
 Does Not Write *specify*
7. In your opinion, how well does the student understand, speak, read and write English?

<i>Very well</i>	<i>Only a little</i>	<i>Not at all</i>
<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"/>

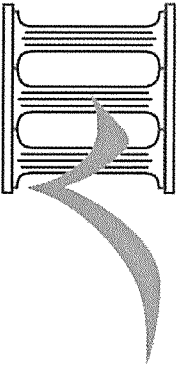
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Signature of Parent/Guardian/Other

Date : Month:

Day:

Year:



Dear Parent or Guardian:

Frequently, the school nurse is asked to administer medication to a student during school hours. The Three Village School District will allow this under specific conditions. These conditions are:

1. A written request from a parent giving permission for administration of medication.
2. A written request must be submitted by the prescribing physician including the purpose of the medication, the dosage, the time at which or special circumstances under which medication shall be administered, the period for which medication is prescribed and the possible side effects of the medication.
3. The medication must be in the original container identified for your child. The label must include name of doctor, name of the student, name of the medication, amount to be administered and when it is to be administered.
4. Only an adult may transport the medication to the Health Office, and only an adult may pick up any remaining medication at the end of the school year, or the end of the period of administration, whichever is earlier. All medication not picked up within five days of the period of administration will be discarded.

Students **will not** be permitted to take any medication if the established procedures are not followed. This includes over the counter drugs such as Tylenol, aspirin, throat spray, etc.

It is the responsibility of the student to report to the Health Office at the prescribed time for the purpose of receiving the medication.

This procedure must be repeated at the beginning of each school year whenever there is a case of continued need for medication.

If you have any questions concerning our district policy, please feel free to call the school nurse at any time.

Sincerely,
Erin Blaney
Executive Director of Health & Physical Education

THREE VILLAGE CENTRAL SCHOOL DISTRICT
PARENT AND PHYSICIAN'S AUTHORIZATION
FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Authorization for Administration of Medication

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in a properly labeled, original container from the pharmacy. I understand that the school nurse or other designated person, in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian): _____

Address: _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by the physician:

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

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency & Route of Administration: _____

Time to be taken during the school hours: _____

Duration of Treatment: _____

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

Other Recommendations: _____
=====

Name of Physician (please print): _____

(If authorization is signed by a Physician's Assistant or Nurse Practitioner, the name of the supervising physician must be indicated).

Signature: _____ Date: _____

Address: _____ Phone: _____

THREE VILLAGE CENTRAL SCHOOL DISTRICT
Stony Brook, NY 11790

Child's Name _____

REGISTRATION FORM

Family Name _____ Address _____

Mailing Address _____ Home Phone _____

Previous Residence _____ Date Moved to Three Village School District _____

Father's Name _____ Father's Birthplace _____

Father's Occupation _____ Father's Employer _____

Employer's Address _____ Employer's Phone _____

Mother's Name _____ Mother's Birthplace _____
(first name) (maiden name)

Mother's Occupation _____ Mother's Employer _____

Employer's Address _____ Employer's Phone _____

Are the parent's listed above residing with child? Yes No If you answered NO to the above, please list the names of persons residing at the above address and relationship to the child. Also include their place of employment, address and telephone number.

Languages of home _____

Children's Name(s)	Date of Birth	Birthplace (State)	Sex	Grade	*Proof of Birth Date	Previous School & Address	Present School
(last) (first)	_____	_____	_____	_____	_____	_____	_____
(last) (first)	_____	_____	_____	_____	_____	_____	_____
(last) (first)	_____	_____	_____	_____	_____	_____	_____
(last) (first)	_____	_____	_____	_____	_____	_____	_____

Birth Certificate _____
Parent's Signature _____

**THREE VILLAGE CENTRAL SCHOOL DISTRICT
ELEMENTARY PHYSICAL / HEALTH APPRAISAL**

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

PHYSICAL EXAM

DATE OF EXAM: _____ ALLERGIES: _____

Height: _____ Weight: _____ Blood Pressure: _____ Resting Pulse: _____

REQUIRED: **REQUIRED:**
 Body Mass Index : Weight Status Category (BMI Percentile):
 less than 5th 5th through 49th 50th through 84th 85th through 94th 95th through 98th 99th and higher

REQUIRED:
 SPECIFY CURRENT DISEASES:

AUDIOMETRY MUST INCLUDE VALUES: **AUDIOMETRY MUST INCLUDE VALUES:**
 AS 500 1000 2000 4000 Hz AD 500 1000 2000 4000 Hz

Vision - Uncorrected: R L Vision - Corrected: R L

EXAM ENTIRELY NORMAL URINALYSIS:
 Specify any abnormality: _____
 SPEC. GRAV PRO. GLUC. MICRO

MEDICAL	NORMAL	ABNORMAL FINDINGS	MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
NEUROLOGICAL			CONCUSSION	DATE:	
EYES / EARS			SCOLIOSIS / SPINE		
NOSE / THROAT			SHOULDER		
HEART / MURMUR			ARM		
LUNGS			HAND		
ABDOMEN			HIP		
GENITALIA			LEG		
SKIN					
HERNIA					
TEETH / MOUTH					

PHYSICAL EDUCATION / PLAYGROUND / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, playground, & school activities OR only as checked:

Specify medical accommodations needed for school: _____

Restrictions: _____

Provider's Signature: _____ Phone: _____ Fax: _____

Provider's Name/Address: _____ Stamp: _____

Parent Signature: _____ Parent Phone Number: _____ Date: _____

Rev. 2/20