PLEASE COMPLETE FORMS AND RETURN THE FOLLOWING WITH YOUR FORMS IN THE ENVELOPE YOU RECEIVED WITH THE FORMS.

**KINDERGARTEN**:

1. Two different forms of proof of residency (i.e, tax bill, mail, driver's license, etc.)
2. Birth Certificate
3. Copy of immunizations

**PRE-K**:

1. Two different forms of proof of residency (i.e., tax bill, mail, driver's license, etc.)
2. Birth Certificate
3. Copy of immunizations
4. Proof of income (2020 federal tax return, 2020 W-2s or 3 current consecutive paystubs)

Should you have any questions, please feel free to contact the elementary office at 570-547-1608, ext. 1127 or by email at jkulka@montasd.org.

# MONTGOMERY AREA SCHOOL DISTRICT
# PRE-K REGISTRATION

CHILD'S NAME _____ SEX: F or M SS#: _____
Last First Middle (circle one)

GUARDIAN'S ADDRESS _____
Street Address Town State Zip Boro/Township

DOB_____ STATE OF BIRTH _____ **If other than PA, date entered PA** _____

CITY OF BIRTH _____ COUNTRY OF BIRTH _____ **If other than US, date entered US** _____

FATHER'S NAME _____ HOME # _____ CELL # _____

EMAIL ADDRESS _____ EMPLOYER AND # OF EMPLOYER _____

MOTHER'S NAME _____ HOME # _____ CELL # _____

EMAIL ADDRESS _____ EMPLOYER AND # OF EMPLOYER _____

STUDENT LIVES WITH (CIRCLE) - MOTHER - FATHER - STEPFATHER - STEPMOTHER OTHER _____

IS THERE A CUSTODAY AGREEMENT? YES NO NOT APPLICABLE
(PLEASE CIRCLE ONE)

If so, a copy must be on file in the office. If you do not have a copy with you today, please submit one to the elementary office ASAP.

NON-CUSTODIAL PARENT'S ADDRESS (If applicable) _____

LIST PRIORITY PHONE NUMBERS FOR FATHER AND MOTHER THAT WILL BE USED IN THE DISTRICT'S AUTOMATED CALLING SYSTEM

FATHER 1) _____ 2) _____ 3) _____

MOTHER 1) _____ 2) _____ 3) _____

**WHO SHOULD BE SET AS THE PRIORITY CONTACT FOR THE AUTOMATICE SYSTEM?** (CIRCLE ONE) MOTHER FATHER

***IF YOU SHOULD NEED TO CHANGE ANY OF THESE PHONE NUMBERS OR YOUR ADDRESS, YOU WILL NEED TO CONTACT THE OFFICE DIRECTLY. UPDATES OF ADDRESSES AND PHONE NUMBERS WILL ***NOT*** BE TAKEN OFF OF THE EMERGENCY CARD AT THE BEGINNING OF EACH YEAR. ***ALL CHANGES*** MUST BE DONE BY DIRECT CONTACT WITH THE OFFICE.***

NAMES OF OTHER ADULTS RESIDING IN THE CHILD'S HOUSEHOLD, ALONG WITH RELATIONSHIP AND PHONE NUMBER IF NOT LISTED ABOVE

_____

_____

NAMES AND AGES OF OTHER CHILDREN IN HOUSEHOLD _____

MEDICAL OR EDUCATIONAL NEEDS WHICH WE SHOULD BE AWARE? ____ YES ____ NO If so, please explain _____

_____

DOES YOUR CHILD HAVE AN IEP (Individualized Education Plan)? ____ YES ____ NO If so, please explain _____

_____

ETHNIC IDENTITY: (check 1) _____ Hispanic or Latino _____ Not Hispanic or Latino
(optional)

RACE: (you may check 1-2 that apply) _____ White _____ Black/African American _____ Asian _____ American Indian or Alaska Native
(optional) _____ Native Hawaiian or Other Pacific Islander

What is the primary household language _____

BY SIGNING BELOW I SWEAR THAT I AM A RESIDENT OF MONTGOMERY AREA SCHOOL DISTRICT AND ALL INFORMATION IS TRUE AND CORRECT.

_____ _____
PARENT/GUARDIAN'S SIGNATURE DATE

MONTGOMERY AREA SCHOOL DISTRICT
120 PENN STREET
MONTGOMERY, PA 17752

**PROGRAMS FOR LIMITED ENGLISH PROFICIENCY STUDENTS**

*(Student Home Language Survey)*

Student's Name _____
First Name Middle Name Last Name

School: Montgomery Elementary Montgomery Jr./Sr. High School
(Circle One)

Person Completing Survey (for the student named above):
_____ Mother _____ Father _____ Guardian
_____ Other (specify): _____

Circle the best answer to each question and provide additional information (for the student named above):

| | | | |
|---|---|---|---|
| 1. | Was the first language you learned English? | No | Yes |
| 2. | Can you speak a language other than English? | No | Yes |
| 3. | Is any language other than English used at home? | No | Yes |
| 4. | Which language do you use most often with friends? | English | Other: _____ |
| 5. | Which language do you use most often at home? | English | Other: _____ |
| 6. | Which language do you use most often with other relatives? | English | Other: _____ |
| 7. | Have you attended school in a country other than the United States? | No | Yes (How long and what grades) |
| | _____ | | |
| 8. | Have you attended another school in the United States | No | Yes (Where and how long) |
| | _____ | | |

9. Please provide any other related information that would help the school (for example, referral to gifted or special education programs in prior schools, etc.): _____
_____
_____
_____

PLEASE COMPLETE THE FOLLOWING PAGES IF YOUR INCOME FALLS WITHIN THE CIRCLED AMOUNTS FOR YOUR FAMILY SIZE. AND RETURN WITH COPIES OF YOUR INCOME. IF YOU ARE UNSURE, PLEASE FILL OUT THE PAGES AND SUBMIT YOUR INCOME. I WILL CALL YOU TO LET YOU KNOW WHERE YOUR APPLICATION STANDS ONCE I HAVE TIME TO REVIEW THE INFORMATION.

**2021 Federal Poverty Level Guidelines**

| Family Size | 100% (Head Start Eligible) | 300% (Pre-K Counts Eligible) |
|---|---|---|
| 1 | $12,880 | $38,640 |
| 2 | $17,420 | $52,260 |
| 3 | $21,960 | $65,880 |
| 4 | $26,500 | $79,500 |
| 5 | $31,040 | $93,120 |
| 6 | $35,580 | $106,740 |
| 7 | $40,120 | $120,360 |
| 8 | $44,660 | $133,980 |
| Each Additional | +$4,540 | +$13,620 |

# 2021 PA Pre-K Counts Enrollment Form

(This information is confidential to the PA Pre-K Counts program)

**Date Form Completed:** _____ / _____ / _____
**MM** **DD** **YY**

| Last Name (Child) | First Name (Child) | Middle Initial |
|---|---|---|
| | | |

| Street Address | | County | |
|---|---|---|---|
| City | | State<br>PA | Zip Code |
| School District of Residence | | | |
| Home Phone | Work Phone | Email Address | |

| Child's Date of Birth | Age | Gender |
|---|---|---|
| | ☐ 2 ☐ 3 ☐ 4 ☐ 5 | ☐ Male ☐ Female |

**Race *(optional)***

- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Not Applicable
- ☐ American Indian or Alaskan Native
- ☐ White
- ☐ Other

**Ethnicity *(optional)***

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Not Applicable

**Primary Language**

- ☐ English
- ☐ Spanish
- ☐ Other _____ (please specify)

| Name of Parent or Guardian completing this application | Gender |
|---|---|
| | ☐ Male ☐ Female |

**Relationship to Child**

- ☐ Father
- ☐ Mother
- ☐ Guardian
- ☐ Other _____ (please specify)

**(Select)**

- ☐ Biological
- ☐ Foster
- ☐ Adoptive
- ☐ Other _____ (please specify)

**Role**

☐ Primary Guardian ☐ Legal Guardian

☐ Secondary Guardian ☐ Other _____

(please specify)

**List Household Members below for determination of family size** *(required)*:

| | *Relationship to Child* | *Age* |
|---|---|---|
| **1** | ENROLLING CHILD | |
| **2** | | |
| **3** | | |
| **4** | | |
| **5** | | |
| **6** | | |
| **7** | | |
| **8** | | |

Per PKC Statute, Regulations, and Guidance, the following members of the household are included in family size:

- Parent of the child (biological or adoptive mother or father, stepmother or stepfather, caretaker or spouse)
- A biological, adoptive, unrelated or foster child or stepchild of the parent or caretaker who is under 18 years of age and not emancipated.
- A child who is 18 years of age or older but under 22 years of age who is enrolled in high school, a general educational development program, or a post-secondary program leading to a degree, diploma or certificate and who is wholly or partially dependent on the income of the parent or caretaker or spouse of the parent or caretaker.
- Others supported by the income of the parent(s) or guardian(s) of the child enrolling or participating in the program. ***If counted toward family size, any applicable income of these persons must also be counted for eligibility purposes.***

Note: A family size value of one (1) with an income of $0 is entered when a foster child is applying for Pennsylvania Pre-K Counts.

**DETERMINED FAMILY SIZE =**

| **Employment Status of parent/guardian** | **Employment Status of 2nd parent/guardian (if applicable)** |
|---|---|
| ☐ Employed Full-Time | ☐ Employed Full-Time |
| ☐ Employed Part-Time | ☐ Employed Part-Time |
| ☐ Unemployed | ☐ Unemployed |
| ☐ Other _____ | ☐ Other _____ |

**Household Income Sources** *(Must check all that apply)*:

| | | | | |
|---|---|---|---|---|
| ☐ Employment | ☐ Self-Employment | ☐ Unemployment Compensation | ☐ Worker's Compensation | ☐ TANF Cash payments |
| ☐ Social Security | ☐ SSI | ☐ Child Support | ☐ Alimony | ☐ Other |

**Other Child Eligibility Risk Factor Criterion** *(Must check all that apply):*

| | |
|---|---|
| ☐ | **Behavioral Supports:** A child who was referred to PA Pre-K Counts from an appropriately credentialed health or mental health practitioner who is not employed by the PA Pre-K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required. |
| ☐ | **Child Protective Services:** A child who is a foster child, a kinship care child or receiving Children and Youth services. |
| ☐ | **Education Level of Guardian:** Does not have high school diploma or GED or post-secondary degree. |
| ☐ | **English Language Learner:** A child whose first language is not English and who is in the process of learning English is considered an English Language Learner. |
| ☐ | **Individualized Education Plan (IEP):** A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider. |
| ☐ | **Incarcerated Parent:** A child for whom one of the child's parents is currently in prison. |
| ☐ | **Homeless:** A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following:<br>A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to lack of alternate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;<br>B. Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;<br>C. Children who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings. |
| ☐ | **Migrant (Non-Immigrant)/Seasonal Student:** A migrant child has moved from one school district to another in order to accompany or to join a migrant parent or guardian, who is a migratory worker or migratory fisher, within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work including agri-related businesses such as meat or vegetable processing, working in nurseries such as Christmas and evergreen trees farming. |
| ☐ | **Teen Mother:** A child whose mother was under the age of 18 when the child was born. |

To the best of my knowledge, the information provided in this application and the associated income documentation is accurate. I understand that I may be asked to verify or substantiate information provided.

**Parent/Guardian** (Signature) **Date**

**Parent/Guardian Name** (Print Name)

RETURN THIS PAGE

# Montgomery Area School District Health History

Students Name_____ Parents_____

Address_____ Phone Number_____

Grade_____ Is Student transferring from another school?_____ State transferring from_____

The information on this form will help the school nurse in determining the health status of your child and will assist him/her to receive the maximum benefits from his educational experience.

Has your child had any of the following? If so please describe.

Whooping Cough_____

German Measles_____

Mumps_____

Bee Sting Allergy_____

Other Allergy_____

Asthma_____

Heart Disease_____

Diabetes_____

Ear Disease_____

Vision Problems_____

Serious Accidents_____

Operations_____

Scarlet Fever_____

Measles_____

Polio_____

Bowel Disease_____

Stomach Problems_____

Skin Disease_____

Chicken Pox_____

Recurring Illness_____

Hearing Problems_____

Urinary Tract Disease_____

Emotional Problems_____

Other Issues_____

Please list any illness or health problem which you or your family doctor feels should be known by school personnel. _____

Family Doctor_____ Phone Number_____

Please feel free to contact the school nurse at 570-547-1608 ext 125 to discuss any confidential information you wish to share

RETURN THIS PAGE.
Please fill out in addition to attaching immunization record.

MONTGOMERY AREA SCHOOL DISTRICT

Child's Name _____ (Last) (First) (Middle)

Birth Date _____ Sex _____

Father's Name _____ (Last) (First) (Middle)

Mother's Name _____ (Last) (First) (Maiden)

Child Lives With _____

Address _____ Telephone _____

## PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

| VACCINE Circle appropriate item | Enter Month, Day, And Year Each Immunization Was Given DOSES | | | | |
|---|---|---|---|---|---|
| Diptheria and Tetanus (DTaP, DTP, Td or DT) | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / |
| Polio (OPV or IPV) | 1 / / | 2 / / | 3 / / | 4 / / | |
| Hepatitis B | 1 / / | 2 / / | 3 / / | | |
| Measles - Mumps - Rubella (MMR) | 1 / / | 2 / / | or Measles Serology: Date | | Titer |
| Varicella (Vaccine or Disease) | 1 / / | 2 / / | Rubella Serology: Date | | Titer |
| Other | 1 / / | 2 / / | Mumps disease diagnosed by a physician: Date | | |

Doses required by law for new school enterers (K or 1st Grade) are shaded in green.
Age appropriate dose(s) of varicella vaccine or history of disease and 3 doses Hepatitis B vaccine required for entry into 7th grade.
To the best of my knowledge, this child has received the minimum required immunizations. Source ☐ Written ☐ Verbal ☐ Both

Signed _____ DO NOT SIGN UNLESS MINIMUM REQUIRED DOSES ARE COMPLETE Date _____
(PHYSICIAN, PUBLIC HEALTH OFFICIAL, SCHOOL NURSE, OR THEIR DESIGNEE)

H502.320 Rev. 2/01

I certify that the information provided is correct _____
Parent or Guardian

## STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

### MEDICAL EXEMPTION

The physical condition of the above named child is such that immunization would endanger life or health.

Signed _____ Date _____
(PHYSICIAN)

### RELIGIOUS EXEMPTION

(Includes a strong moral or ethical conviction similar to a religious belief.)

Parent or guardian of the above named child adheres to a religious belief whose teachings are opposed to such immunizations.

State your reason for requesting a religious exemption _____

_____

_____

_____

Signed _____ Date _____
(PARENT OR GUARDIAN)

THIS FORM MUST ACCOMPANY YOUR CHILD TO THE FREE VISION SCREENING

RETURN

NORTH CENTRAL SIGHT SERVICES INC.

Member of Pennsylvania Association for the Blind

ROBERT B. GARRETT PRESIDENT/C.E.O.

W AA A H NA O UK

DATE: MAY 14 & 15, 2015

SITE: MONTGOMERY AREA PRESCHOOL REG.

SCR: _____ REFERRED: ☐

# FREE VISION SCREENING!

Our organization is scheduled to perform **FREE Vision Screenings** at your child's preschool. Young children don't always know they are having trouble seeing because they often don't know how they should see the world around them. Most eye problems do not go away as a child grows! Early detection and treatment yields the best results. Parents should also be alert for signs of vision problems that include: frequent rubbing of the eyes, holding books and papers close to the face, squinting, excessive blinking, or tilting of the head from one side to the other. Covering one eye to favor the other, frequent sties or redness, and even watery eyes can also be signs of a vision problem.

The screening will be conducted by our highly trained staff using the latest technology--the Welch Allyn SPOT Screener, a camera like device that scans the eye for **SIX** different vision problems in a matter of seconds. Please fill out the consent form below and return to your child's preschool as soon as possible. *Only children with signed consent forms will be able to participate.*

## VISION SCREENING CONSENT & REGISTRATION FORM | COMPLETE IN FULL (PLEASE PRINT)

**Please mark one:** ☐ I DO want my child screened. ☐ I DO NOT want my child screened.

Child's Name: _____ Age: ____ Date of Birth: _____ Gender: M F

Parent/Guardian Name: _____ Phone: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Email (optional): _____ County of Residence: _____ School Dist: _____

Known Vision Issues/Concerns: _____

Date of child's last eye exam: _____ (Circle One): Pediatrician or Optometrist/Opthalmologist

As the undersigning parent/guardian, I hereby grant permission to North Central Sight Services, Inc. to screen the vision of the above named child. If a professional eye exam is recommended, I give my consent to permit North Central Sight Services, Inc to obtain information from the examining eye specialist regarding my child's eye examination and recommended treatment and to furnish such information, as needed, to the appropriate school/agency. I also understand that follow-up is required and that I may be contacted by the agency for further information. In addition, I understand that this procedure is a limited vision screening, designed only to detect certain symptoms of potential vision problems in children. It is not an eye exam and is not intended to take the place of a professional eye exam performed by an optometrist or opthalmologist.

**Parent/Guardian Signature:** _____ DATE: _____

Occasionally, North Central Sight Services will use pictures taken during screenings and events for marketing purposes. If you wish for your child's picture not to be used in our non-profit marketing material, please initial here. _____

Office Use Only

| OD | | OS | |
|---|---|---|---|
| SE | _____ | SE | _____ |
| DS | _____ | OS | _____ |
| DC | _____ | DC | _____ |

North Central Sight Services, Inc.

2121 Reach Road PO Box 3292 Williamsport, PA 17701-0292

Phone (570) 323-9401 Toll Free 1-866-320-2580 Fax (570) 323-8194

Our Prevention of Blindness and Social Services Programs are funded in part through grants from the PA Dept. of Labor and Industry, Bureau of Blindness & Visual Services, Office of Vocational Rehabilitation, and the United Way.

FILL OUT AND RETURN

Attachment N

Dear Parents:

The School Health Law requires **medical examinations** for children in Grades Pre-K, K, 6, and 11 and **dental examinations** for those in Grades Pre-K, 1, 3 and 7. These grades were selected because they represent critical periods of growth and development in a child's life.

You are receiving this letter because your child will require this exam **next** school year. **(2021-2022).**

We are recommending that these examinations be done by your family physician or dentist. They can best evaluate your child's health and assist you in obtaining necessary treatment and corrections. An exam dated no earlier August 27, 2020 will be accepted for the 2021-2022 school year. Sports physicals done during the school year will also be accepted.
After this mandated exam, **please provide a copy to the school nurse** or your doctor can fax it directly. The nurse's office fax is 570-515-0093.

Sincerely,

Mrs. Walton, RN, MSN, CSN
School Nurse

---

Name of Child _____ Grade (next year) _____

_____ Yes, I want the exam done at school.

_____ No, I will have a private exam for my child.
_____ - Date exam is scheduled.

_____ _____
Parent Signature Date

YOU KEEP

# Attention Parents/Guardians

## DON'T WAIT — VACCINATE NOW

FOR ATTENDANCE IN ALL GRADES children need the following:

- 4 doses of tetanus*
  (1 dose on or after the 4th birthday)
- 4 doses of diphtheria*
  (1 dose on or after the 4th birthday)
- 3 doses of polio
- 2 doses of measles**
- 2 doses of mumps**
- 1 dose of rubella (German measles)**
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) vaccine or history of disease

*Usually given as DTP or DTaP or DT or Td
**Usually given as MMR

Children ATTENDING 7th grade need the following:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) (if 5 years has elapsed since last tetanus immunization)
- 1 dose of meningococcal conjugate vaccine (MCV)

These requirements allow for the following exemptions:
Medical reason
Religious belief
Philosophical/strong moral or ethical conviction
If your child is exempt from immunizations,
he/she may be removed from school during an outbreak.

Pennsylvania's school immunization requirements can be found in 28 PA.CODE CH.23 (School Immunization)
Contact your health care provider or call 1-877 PA HEALTH for more information

pennsylvania
DEPARTMENT OF HEALTH

Dear Parents/Guardian: CONFIRM WITH DOCTOR THAT YOUR CHILD HAS ALL.

Your child may not be up to date with the Pa State Immunizations required for school for the 2021-2022 school year. It is possible that the school does not have the most up to date immunization record for your child. Please contact your doctor and either set up an appointment for the needed doses or get an updated copy and provide it to the school nurse. **They will be placed on provisional enrollment for 2021-2022 (this applies to all students, hybrid and remote) without these immunizations and a copy given to the nurse. They will not be allowed to attend after the fifth day of school next year without these.**

You may contact your doctor or local Department of Health at 570-327-3440 to obtain these vaccinations if you do not have health insurance.

**Please make sure the updated copy is then giving to the school nurse.**
**They can be faxed to me at 570-515-0093. Please call to confirm they have been received to prevent exclusion**

The immunizations needed are listed below:

_____ DTP #1 #2 #3 #4 (After 4th birthday)

_____ Hepatitis #1 #2 #3

_____ Polio #1 #2 #3 #4 (after 4th birthday)

_____ MMR #1 #2

_____ Varicella #1 #2

7th grade:

_____ Tdap

_____ MCV (Meningococcal)

12th grade:

_____ MCV (Meningococcal)

Thank you for your prompt attention to this matter

Sincerely,

Mrs. Walton RN, MSN, CSN

FOR YOUR DOCTOR TO FILL OUT AND RETURN

**Significant Medical Conditions (√)**
If Yes, Explain

| | Yes | No | |
|---|---|---|---|
| Allergies | ☐ | ☐ | |
| Asthma | ☐ | ☐ | |
| Cardiac | ☐ | ☐ | |
| Chemical Dependency | ☐ | ☐ | |
| Drugs | ☐ | ☐ | |
| Alcohol | ☐ | ☐ | |
| Diabetes Mellitus | ☐ | ☐ | |
| Gastrointestinal Disorder | ☐ | ☐ | |
| Hearing Disorder | ☐ | ☐ | |
| Hypertension | ☐ | ☐ | |
| Neuromuscular Disorder | ☐ | ☐ | |
| Orthopedic Condition | ☐ | ☐ | |
| Respiratory Illness | ☐ | ☐ | |
| Seizure Disorder | ☐ | ☐ | |
| Skin Disorder | ☐ | ☐ | |
| Vision Disorder | ☐ | ☐ | |
| Other (Specify) | ☐ | ☐ | |

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

**Report of Physical Examination (√)**

| | Normal | Abnormal | Not Examined | Comments |
|---|---|---|---|---|
| • Height (inches) | | | | |
| • Weight (pounds) BMI | | | | |
| • Pulse ( ) | | | | |
| • Blood Pressure | | | | |
| • Hair/Scalp | | | | |
| • Skin | | | | |
| • Eyes/Vision | | | | |
| • Ears/Hearing | | | | |
| • Nose and Throat | | | | |
| • Teeth and Gingiva | | | | |
| • Lymph Glands | | | | |
| • Heart – Murmur, etc | | | | |
| • Lung – Adventitious Finding | | | | |
| • Abdomen | | | | |
| • Genitourinary | | | | |
| • Neuromuscular System | | | | |
| • Extremities | | | | |
| • Spine (Presence of Scoliosis) | | | | |

_____
Date of Examination

_____
Signature of Examiner

_____
PRINT Name of Examiner

_____
Address

_____
Telephone Number

FOR PRE-K DENTIST - RETURN AFTER COMPLETED

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

# PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ___

| NAME OF CHILD | AGE | SEX | GRADE | SECTION/ROOM |
|---|---|---|---|---|
| Last First Middle | | ☐ M ☐ F | | |

ADDRESS

No. and Street | City or Post Office | Borough or Township | County | State | Zip

## REPORT OF EXAMINATION

| | | TOOTH CHART | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RIGHT | | | | | | | | LEFT | | | | | | | | |
| UPPER | | 1 | 2 | 3 | 4 A | 5 B | 6 C | 7 D | 8 E | 9 F | 10 G | 11 H | 12 I | 13 J | 14 | 15 | 16 | Upper |
| LOWER | | 32 | 31 | 30 | 29 T | 28 S | 27 R | 26 Q | 25 P | 24 O | 23 N | 22 M | 21 L | 20 K | 19 | 18 | 17 | Lower |
| | UPPER | | | | | | | | | | | | | | | | | Upper |
| | LOWER | | | | | | | | | | | | | | | | | Lower |

Is The Child Under Treatment ☐ Yes ☐ No

Treatment Completed ☐ Yes ☐ No

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address