Public Schools of Edison Township

ENROLLMENT CENTER
312 PIERSON AVENUE * EDISON, NEW JERSEY 08837
TELEPHONE (732) 452-4570 FAX (732) 452-4576
Monday through Friday 9:00 am – 3:00 pm

Bernard F. Bragen, Jr., Ed.D.
Superintendent of Schools

Richard Benedict
Manager of Enrollment/ Data Systems/
District Homeless Liaison/Stability Liaison

ENROLLMENT REQUIREMENTS

* PARENT OR GUARDIAN MUST ENROLL A STUDENT (UNLESS STUDENT IS AN ADULT)
* STUDENT MUST LIVE IN EDISON
* STUDENT MUST BE PRESENT IN ORDER TO ENROLL OR RE-ENROLL

THE FOLLOWING DOCUMENTS SHOULD BE PRESENTED AT THE TIME OF ENROLLMENT:

PREFERRED PROOFS OF RESIDENCY:
FOUR (4) OF THE FOLLOWING PROOFS OF RESIDENCY MAY BE SUBMITTED:

Current property tax bill, deed, lease, lease renewal or signed letter from landlord, indicating residency
Current utility bill with name and address
Photo ID of parent/guardian with current address (Driver's License, Permanent Resident Card, etc.)
Paid rent receipts or cancelled rent checks
Current automobile registration or insurance card
Bank or credit card statement
Documents pertaining to military status and assignment
Court orders, State agency agreements and other evidence of court or agency placements or directives

(Note: Alternate documentation of residency will be considered.)

PROOF OF STUDENT'S DATE OF BIRTH
Birth Certificate / Passport / Other Official Document Indicating Age

UPDATED IMMUNIZATION RECORD
Document in English, with student's name, doctor or clinic name, and month, date & year of shots

SCHOOL RECORDS (if available) – Transfer Card / Withdrawal or Leaving Certificate / Report Card / Letter from previous school, confirming attendance and grade level / Test Scores / IEP

PROOF OF CUSTODY, if applicable, may be requested.

FOR MORE INFORMATION, VISIT US ON THE WEB AT: http://www.edison.k12.nj.us/enrollment

2/14
RB/kk

Nothing Less Than Excellence

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

REGISTRATION HEALTH HISTORY

Student's Name:_____ **Date of Birth:**_____

School:_____ **Grade:**_____

IMMUNIZATION RECORD

Immunization Document Received Date _____

Requested from parents/guardian Date _____

CHILDHOOD ILLNESSES, INJURIES, OPERATIONS, ORTHOPEDIC CONDITIONS:
Please give age of child when illness, injury, occurred explain:

Asthma _____
Chicken Pox _____
Diabetes _____
Heart Condition _____
Kidney/Bladder Condition _____
Strep Infection _____
Measles_____
Mononucleosis_____
Ear Infections_____
Pneumonia/Bronchitis_____
Rheumatic Fever_____
Seizure(s) _____

Other

Any known speech/hearing problem: _____
Any known Visual Problem: _____
Allergies or Eczema: _____
Behavioral Difficulties: _____
Gastrointestinal Problem: _____
Toileting Difficulties: _____
Neurological Disorders: _____
Muscle or Bone Problems: _____
Other Medical Conditions: _____
Previous Injuries/Accident: _____
Sleeping Problems: _____
Significant or Frequent Illness: _____
Surgery: _____
Breathing Difficulties: _____
Nutritional/Eating Problems: _____
Other difficulties: _____

Has the child ever had prolonged use of medication, or is any medication or therapy being given at this time? If so, please explain:_____

_____

(over)

Physical Limitations:

_____

_____

Has your child ever been confined to a hospital? If so, please explain:

_____

_____

Has your child ever been advised not to participate in a sport or to reduce activity? If so, please explain:

_____

_____

Has your child had a loss of, or serious impairment of a paired organ such as a kidney, eye, lung, etc. If so, please explain:

_____

_____

List additional health information.

_____

_____

I/we give permission for the nurse to share any health-related information with principal, guidance counselors & teachers on a "need to know" basis for as long as my child is a student in Edison Public Schools.

My child is covered by health insurance ___ yes ___ no

My child receives his/her health care at: _____
Name of health care provider or clinic

_____ _____
Signature of Parent/Guardian Date

Public Schools of Edison Township

ENROLLMENT CENTER

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PARENT/GUARDIAN CONSENT FOR RELEASE OF RECORDS

NAME OF PREVIOUS SCHOOL _____

ADDRESS _____

_____

NAME OF STUDENT _____

GRADE _____ DATE OF BIRTH _____

The above student has enrolled in the Edison Township Public School System. Please send a transcript of his/her past and current grades (report card), health records, standardized test scores, special services records and any other pertinent information concerning this student.

Thank you.

_____ _____
Signature of Parent/Guardian Date

Please send records to: (name and address of new Edison school)

_____

_____

_____

RB/ka

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Public Schools of Edison Township

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FRAUDULENT STATEMENTS

_____ Any false statements, answers, or declarations provided during the enrollment process may be subject to criminal prosecution for the crime of false swearing in violation N.J.S.A. 2C:28-2. If convicted of such crime, you may be punished by a fine of up to $10,000.00 and/or be imprisoned for up to eighteen (18) months.

_____ Pursuant to N.J.S.A. 18:A:38-1 if you fraudulently allow a student to use your residence and you are not the primary financial supporter of the student, you will have committed a disorderly persons offense. If you are convicted of such offense, you may be fined up to $1,000.00 and/or be imprisoned for up to six (6) months.

The Edison Township Board of Education will prosecute to the fullest extent of the law.

_____ _____

Signature of Parent/Guardian **Date**

RB/ml
12/9/19

OFFICE USE ONLY:
GE: ___ SE: ___

Public Schools of Edison Township

312 Pierson Avenue * Edison, New Jersey 08837
Telephone (732) 452-4948 Fax (732) 452-4992

ID#:

SPECIAL EDUCATION MEDICAID INITIATIVE (SEMI)
PARENTAL CONSENT FORM

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing

I understand that billing for these services by the district **does not** impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: _____ (please print)

Child's Date of Birth: _____/_____/_____

Parent/ Guardian: _____

Date: _____/_____/_____

I give consent to bill for SEMI: Yes ☐ No ☐

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.

Nothing Less Than Excellence

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO BOX 712
TRENTON, NJ 08625-0712

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

VALERIE HARR
Director

August 25, 2014

Dear Parent/Caregiver:

The purpose of this letter is to let you know about the **Special Education Medicaid Initiative (SEMI)** program. Your child may be receiving special education services in school such as speech therapy, occupational therapy or physical therapy under SEMI.

Here are three things you should know about SEMI:

1. Your school district may be eligible to receive federal money through the SEMI program which helps to pay for special education services.
2. A school district may receive SEMI money only if a consent form is signed by the parent.
3. Signing the consent form will have no effect on your child's Medicaid health coverage for services outside of school.

If you do not sign the consent form, it will not affect the services your child receives in school since the district is required to provide a free and appropriate public education, including all services listed in your child's Individualized Education Plan (IEP).

The SEMI program is an important source of funding for the school districts. We appreciate your assistance in this program and hope that you will consider the importance of signing the parent consent form and submitting it to your district.

Please feel free to contact your district's special education department if you have any questions.

Sincerely,

Valerie Harr
Director

Public Schools of Edison Township

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NEW STUDENT PHYSICAL EXAMINATION

School: _____ **Enrollment Date:** _____

Grade: _____

Dear Parent / Guardian of _____:

Your child has been enrolled as a new student in the Edison Public Schools. State regulations N.J.A.C. 6A:16-2.2 and district policy 5141.3 require you to submit documentation of a physical examination for your child. The physical examination documentation must be submitted to the school nurse by _____.

Your child will be excluded from school if this requirement is not met.

The physical exam must be signed by a U.S. licensed physician, Advanced Practice Nurse or Physician's Assistant, and must include the physician's address and telephone number. The physical exam must have been conducted within 365 days of your child's Edison school entry date.

If you do not have health insurance, you may call the Edison Health Department to make an appointment for a physical exam. Please call 732-248-7285 for location, directions, cost and further information. This service is available **ONLY** to families who do not have health insurance.

Please be sure to take the attached physical form to be completed by the health department staff or your child's physician, and return it to the nurse at your child's school by the date noted above.

Thank you for your prompt attention to this important matter. If you have questions about this physical examination requirement or the due date, please contact your child's school nurse.

RB/ka
3/11

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

Date of Exam: _____

EXAMINATION		
Height _____ Weight _____ ☐ Male ☐ Female		
BP ____/____ (____/____) Pulse _____ Vision R 20/_____ L 20/_____ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Date of Exam: _____

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

EDISON TOWNSHIP BOARD OF EDUCATION
EDISON, NEW JERSEY 08837

HS Form #14G

SEASON: ___Fall ___ Winter ___Spring
SPORT: _____

HEALTH HISTORY UPDATE FOR INTERSCHOLASTIC &/ or INTRAMURAL PARTICIPATION

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice MUST provide a health history update questionnaire (HS Form #14G) of medical issues experienced since last medical examination.
Must be completed and signed by the student's parent or guardian.

PRINT CLEARLY IN INK:

Student: _____ Grade/Section: _____ Student ID#: _____
(Last, First, Middle Initial)

Address: _____ Home Phone: (____) _____-_____

Cell Phone: (____) _____-_____ Date of last Physical Examination: ____/____/_____ Male: ___ Female:___

Since the last physical examination, has your child EXPERIENCED the following (please explain in detail any "YES" answers):

1. Been medically advised not to participate in a sport? Yes No
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes No
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes No
4. Fainted or "blacked out?" Yes No
5. Experienced chest pains, shortness of breath or "racing heart?" Yes No
6. Has there been a recent history of fatigue and unusual tiredness? Yes No
7. Been hospitalized or had to go to the emergency room? Yes No
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes No
9. Started or stopped taking any over-the-counter or prescribed medications? Yes No

_____ _____ _____
DATE SIGNATURE of Parent/Guardian PRINTED Name Parent/Guardian

ANY CHANGES IN STATUS MAY NEED CLEARANCE BY YOUR MEDICAL PROVIDER

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE BY THE FOLLOWING DUE DATES:
August 1st Fall Sports
November 1st Winter Sports
February 15th Spring Sports

IMPORTANT: Forms returned AFTER due date, MAY NOT be cleared to participate PRIOR TO 1ST practice session

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

DENTAL HEALTH FORM

Dear Parent/Guardian:

An important part of your child's total well-being is the care of the teeth and prevention of decay. In order to promote positive dental health maintenance at an early age, we are asking you to have your family dentist complete the dental form below and return it to the school. This dental form then becomes an essential part of your child's school and health records.

The condition of a child's teeth often affects not only attendance at school but also performance including speech development, in school. Statistics demonstrate that many children have not achieved as well as their capabilities indicate because of discomfort and pain due to cavities and discomfort, pain and illness from teeth that are abscessed.

All parents are interested in the scholastic achievement, health and welfare of their children. In order to improve the dental health of the children of our township, especially those who will be entering kindergarten in September, you are urged to arrange for dental examination of your child's teeth by your family dentist without appreciable delay. The preventive measure of determining tooth defects and decay and obtaining early corrective treatment will help protect permanent teeth and assist in their proper development.

Following the dental examination, please ask your dentist to complete the attached form and return it to school as soon as possible.

Respectfully,

_____ _____ _____
School Nurse School Phone

==========

TO BE COMPLETED BY FAMILY DENTIST

I have examined _____ D.O.B. _____

Please check one: _____ Patient under treatment.

_____ Dental treatment completed.

_____ No treatment necessary.

Remarks: _____

_____

_____
Signature of Dentist

_____
Date