

FILLMORE CENTRAL SCHOOL

April 22, 2025

Dear Families;

Fillmore Central School will provide a Three-Year-Old Preschool Program for eligible students during the 2025-26 school year. Children born between December 2, 2021 and December 1, 2022, are eligible to participate in the 3PK program.

The Three-Year-Old Preschool Program is a **voluntary** program for parents who desire a Pre-Kindergarten experience for their children. The program

- **is a full day session (8:05 - 3:13),**
- **follows the Fillmore Central School calendar,**
- **is located in the Fillmore Central School building,**
- **is no cost to parents,**
- **has a certified teacher and support staff,**
- **provides a developmentally appropriate play-based curriculum focusing on cognitive, social, emotional, and physical skill development.**

Unfortunately, until your student turns four years of age, Fillmore will not be able to provide transportation for students in the 3-year-old preschool. Once your student turns four and you want them transported please call our greeter at 585-567-2252 to set this up.

If you are interested in your child being a member of the 2025-26 Three-Year-Old Preschool Program, please complete and return all of the enclosed Pre-Kindergarten entrance forms. In addition, please submit a copy of your child's ***immunization records and birth certificate***. All paperwork must be submitted before your child may enter the program.

Applications must be received by July 31, 2025. The 3-Year-Old preschool program is only permitted to service eighteen students in each class. If more than thirty-six student applications are submitted, Fillmore Central will institute a lottery system to fill the preschool openings. In-District students receive priority fulfillment. Also, In-District students enrolled in the 3-year-old program will have first rights to the District's UPK program for 4-year-old students the following year. Out-of-District students must complete and return an Out-of-District application and await District approval.

If you have any questions, please contact me at 567-4432. Thank you for your interest in our 3-year-old preschool program. We look forward to receiving your child's registration information and working with you and your child.

Sincerely,
Sarah Petre
PreK-12 Assistant Principal

**Fillmore Central School
3-Year Old Pre-Kindergarten
Entrance Checklist**

Child's Name: _____

Date of Birth: _____

- _____ Entrance Form
- _____ Parent Contact form/ emergency contacts (list of persons who may pick students up)
- _____ Emergency Form
- _____ Developmental and Social History Form
- _____ Health Form
- _____ Physical (completed by a physician)
- _____ Home Language Questionnaire/ Identification of Homeless Students Form.
- _____ Immunization Records
- _____ Dental Health Certificate
- _____ Birth Certificate

Please return all forms and the checklist to:

Sarah Petre
PK-12 Assistant Principal
104 W Main Street
Fillmore, NY 14735

Office use:

Date Information Received: _____

Preschool applications and additional forms must be returned before July 31, 2025

Fillmore Central School Entrance Form

Student Number: _____ Grade: _____ Teacher: _____ Bus Number: _____
Date Registered: _____ First Date Attended: _____ SSN: _____

Student Information

DOB: _____ Sex: M F
Last Name First Name MI ___ school-age ___ preschool age child

Place of Birth _____ Circle: New Student Former Student Year(s) Attended: _____

Ethnicity (Check): Is your child Hispanic/Latino or of "Spanish origin" ___ Yes ___ No
Please select one: ___ American Indian or Alaskan American ___ Asian ___ White/ Other
___ Black or African American ___ Native Hawaiian or Other Pacific Islander

☐ District Resident ☐ Non-Resident ☐ Placed by DSS/ Agency Agency Name: _____

Address: _____ Telephone: _____
_____ Emergency Number: _____

How many schools has this child attended? _____ Previous School: _____
My child receives or is eligible for ___ free lunches ___ reduced price lunches. (if known)
My child participates in a half day vocational program. ___ yes (program: _____) ___ no

Custodial Parent/ Guardian Information

Name: _____ Active Duty _____ Relationship: _____

Name: _____ Active Duty _____ Relationship: _____

Mailing Address _____

(If different from above): _____

The child's parents are: ___ Married ___ Single Parent ___ Divorced (Custody Papers: ___ received ___ needed)
The child is in foster care: ___

Non-Custodial Parent/ Guardian Information (The following people should receive information about the child.)

Name: _____ Active Duty _____ Relationship: _____

Name: _____ Active Duty _____ Relationship: _____

Mailing Address: _____ Telephone: _____

Census Information: Other Children in the Family

Pre-School Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

In School Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Special Placement Approval

I agree to the temporary continuation of the classification and programs in which my child, _____, was placed in his/her previous school prior to transferring to Fillmore Central School. My child's program included:

___ CSE (Resource Room/ Consultant Teacher/ Special Class) ___ Remedial Reading ___ Remedial Math
___ Academic Intervention Service (Area: _____) ___ Gifted and Talented Program ___ Speech

Route to: ___ CSE ___ Psychologist ___ 5-12 Office ___ District Office ___ Guidance Office
___ Mrs. Barber ___ Cafeteria ___ Attendance ___ Bus ___ Remedial ___ Speech

Identification of Homeless Students

This questionnaire is intended to address the McKinney-Vento Act. Your answers will help the administrator determine residency documents necessary for enrollment of this student.

1. Presently, where is the student living? *Check one box:*

Section A	Section B
☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "double-up") ☐ In a shelter ☐ In a hotel/motel, car, park, bus, train or campsite (please specify) ☐ With friends or family members (other than parent/guardian) ☐ Other temporary living situation (Please Describe) ☐ Independently <i>CONTINUE:</i> If you checked a box in Section A , complete #2	☐ Choices in Section A do not apply ☐ In permanent housing ☐ Other (Please specify)

2. The student lives with:

- | | |
|--|---|
| ☐ 1 parent
☐ 2 parents
☐ 1 parent & another adult | ☐ a relative, friend(s) or other adult(s)
☐ alone with no adults
☐ an adult that is not the parent or the legal guardian |
|--|---|

Home Language Questionnaire (HLQ) CR 154 A-14

<i>Dear Parent or Guardian:</i> <i>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.</i> <i>Thank You</i>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">TO BE COMPLETED BY SCHOOL PERSONNEL</th> </tr> </thead> <tbody> <tr> <td colspan="2">District/ School: Fillmore Central School</td> </tr> <tr> <td style="text-align: center;">Student Name</td> <td style="text-align: center;">Grade</td> </tr> <tr> <td style="text-align: center;">Date of Birth</td> <td style="text-align: center;">Student Identification Number</td> </tr> <tr> <td colspan="2">Country of Birth/ Ancestry</td> </tr> <tr> <td colspan="2">Number of Years enrolled in school outside the US</td> </tr> <tr> <td colspan="2">Name/ Position of school personnel completing this section</td> </tr> <tr> <td colspan="2">Determination: ☐ Possible LEP ☐ English Proficient </td> </tr> </tbody> </table>	TO BE COMPLETED BY SCHOOL PERSONNEL		District/ School: Fillmore Central School		Student Name	Grade	Date of Birth	Student Identification Number	Country of Birth/ Ancestry		Number of Years enrolled in school outside the US		Name/ Position of school personnel completing this section		Determination: ☐ Possible LEP ☐ English Proficient	
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(✓ boxes that apply)

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

	Very Well	Only a little	Not at all
Understands English	☐	☐	☐
Speaks English	☐	☐	☐
Reads English	☐	☐	☐
Writes English	☐	☐	☐

Parent/ Guardian Signature: _____ Date: _____

FILLMORE CENTRAL SCHOOL

Parent Contact Information

Student Name: _____ Grade _____

Home Address: _____

Mailing Address: _____

Parent/Guardian 1: (resides with student)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Parent/Guardian 2: (resides with student)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Parent/Guardian 1: (DOES NOT reside with student)

Name: _____ Relationship: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Has Custody: _____ Receives Mailings: _____

Parent/Guardian 2: (DOES NOT reside with student)

Name: _____ Relationship: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Has Custody: _____ Receives Mailings: _____

In the case of a Custody Agreement - Please Circle the appropriate answers:

Do you have a custody agreement: Yes No

If there is a custody agreement, have you provided a copy of the paperwork/court order to the school: Yes No

Emergency Contact Information (these persons may also pick up your student)

Contact 1:

Name: _____ Relationship _____

Phone: _____

Contact 2:

Name: _____ Relationship _____

Phone: _____

Contact 3:

Name: _____ Relationship _____

Phone: _____

After School Program or Care Provider

Name: _____

Student: _____
Last First Grade Teacher

*****Physical Conditions Possibly Needing Special Consideration**

Allergies: _____

Other Conditions: _____

In case of an accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician below and to follow his/ her instructions. If it is impossible to contact this physician, the school may make whatever arrangements that seem necessary.

Signature Parent/ Guardian _____ Date _____

Physician Name: _____
Telephone Number: _____
Preferred Hospital: _____

*****Early Dismissal Destination** In the event school closes early, my child will go to the indicated destination.

Name _____ Telephone _____ Relationship _____

Address _____

*****Court Papers** Please indicate whether any type of court paper impacts this student (a copy of the court papers must be on file to be enforced by the school).

Are there any court papers impacting this child? _____ Yes _____ No
Please identify the type of court papers: _____

Standing Order for Over-The-Counter Medication Permission Form

I give permission for Fillmore Central School to administer the following OTC medication to my child to assist him/her to complete the school day. I understand this is for emergencies only and if my child needs the following medication on a regular basis I will fill out the OTC Medication Permission form and supply the OTC medication for my child.

- ☐ Tylenol/Acetaminophen
- ☐ Advil/Ibuprofen
- ☐ Hydrocortisone Cream
- ☐ Triple Antibiotic Cream
- ☐ Chloraseptic Throat Spray
- ☐ Tums
- ☐ Solarcaine
- ☐ Sun Screen

Parent/ Guardian Signature _____ Date _____

Consent to Publish Name/ Picture

Fillmore Central School is proud of and enjoys sharing the accomplishments of students of all ages. At the same time, it is important to respect the rights of parents and guardians to not have information shared or publicized about their child. For this reason, the district is collecting parent and guardian consent to publish students' names and/ or pictures across various media.

As the parent/ guardian of _____, I am providing consent to Fillmore Central School to publish my child's picture, name, audio clips, student teaching videos, video clips and other school work in various media sources, **including the school newsletter, yearbook, website, newspapers, etc. If you check no, your student will not appear in these sources.**

_____ Yes _____ No

Parent/ Guardian Signature _____ Date _____

3 Pre-K _____

UPK _____

Fillmore Central School
Pre Kindergarten
Developmental & Social History Form

CHILD NAME: _____ **DOB:** _____

Person completing the form: _____

Parents: The questions on this form are intended to provide school staff with information which will help us better understand your child's development, experiences and uniqueness. Please feel free to make additional comments in any area. Thank you.

1

Developmental Milestones: Please indicate the age or range when your child performed the following milestones (or indicated "not yet routine")

Crawled	
Took first steps independently	
Spoke first words	
Spoke in 2-3 word phrases	
Speaks in full sentences	
Fully potty trained	
Ascends/decends stairs confidently	
Drinks from an open cup	
Feeds self with fork/spoon	
Washes own hands at sink	

2

Circle which hand your child prefers for eating, coloring, etc. Right Left Undecided

3

Home Behavior: (check how often the following settings are challenging for your child)

Getting ready for bed	☐ Rarely	☐ Sometimes	☐ Frequently
Getting ready to leave the house	☐ Rarely	☐ Sometimes	☐ Frequently
Eating at the dinner table	☐ Rarely	☐ Sometimes	☐ Frequently
Playing alone/independently	☐ Rarely	☐ Sometimes	☐ Frequently
Playing with siblings or peers	☐ Rarely	☐ Sometimes	☐ Frequently
When with a babysitter	☐ Rarely	☐ Sometimes	☐ Frequently
When asked to pick up toys	☐ Rarely	☐ Sometimes	☐ Frequently
In public spaces (store, church etc.)	☐ Rarely	☐ Sometimes	☐ Frequently
In the car	☐ Rarely	☐ Sometimes	☐ Frequently
When asked to do something they don't prefer	☐ Rarely	☐ Sometimes	☐ Frequently

4 **Temperament and Tendencies:** Check all traits that apply to your child

- | | |
|---|---|
| ☐ very quiet/reserved | ☐ has difficulty separating from parent |
| ☐ generally happy | ☐ generally sad |
| ☐ comfortable with change | ☐ prefers consistency/routines |
| ☐ usually follows directions | ☐ easily frustrated/cries easily |
| ☐ has frequent tantrums/meltdowns | ☐ easily distracted/short attention span |
| ☐ trips or falls easily | ☐ choosy/picky eater |
| ☐ enjoys conversations with adults | ☐ avoids physical activity |
| ☐ seeks movement/always active | ☐ aggravated by clothing texture, sticky fingers |
| ☐ bothered by bright lights | ☐ startles easily/covers ears for loud noise |
| ☐ touches everything/loves textures | ☐ dislikes/fears being alone |
| ☐ very outgoing/social | ☐ enjoys sitting with adults to read a book |
| ☐ affectionate/ loves to cuddle | ☐ enjoys having their own space |
| ☐ may wander off | ☐ plays easily with peers |
| ☐ prefers older children over peers | ☐ prefers younger children over peers |
| ☐ prefers adults over other children | |

5 Has your child had any pre-kindergarten or out-of-home daycare? Please indicate below:

	When/What age	Name and Location of Program
Pre-K/Preschool		
Head Start		
Early Intervention		
Day Care		
Other		

6 Please describe who is living in your home at this time: (check appropriate boxes and add ages for children)

Ages:

- | | | |
|--|---|-------|
| ☐ Mother | ☐ Brother(s) | _____ |
| ☐ Father | ☐ Sister(s) | _____ |
| ☐ Step-Mother | ☐ Step/half brother(s) | _____ |
| ☐ Step-Father | ☐ Step/half sister(s) | _____ |
| ☐ Other Adult(s) | ☐ Foster Children | _____ |
| ☐ Other Relative(s) | ☐ Other Children | _____ |
| ☐ Pets? Types: | | |

7 If parents have joint custody, please describe who is living in the other home: (check appropriate boxes and add ages for children)

Ages:

- | | | |
|--|---|-------|
| ☐ Mother | ☐ Brother(s) | _____ |
| ☐ Father | ☐ Sister(s) | _____ |
| ☐ Step-Mother | ☐ Step/half brother(s) | _____ |
| ☐ Step-Father | ☐ Step/half sister(s) | _____ |
| ☐ Other Adult(s) | ☐ Foster Children | _____ |
| ☐ Other Relative(s) | ☐ Other Children | _____ |
| ☐ Pets? Types: | | |

- 8 Are there other adults besides parents who have a significant part in raising your child? ☐ Yes ☐ No
If so, provide name, relationship and what does the child call them.

Name	Relationship	What does your child call them

- 9 Are there any social/family stressors we should be aware of (recent separations, divorce, custody issues, family illness, recent births or deaths, job changes, recent moves, financial struggles) that may be impacting your child at this time?

- 10 What are you child's current "favorites?" (activities, toys, characters, playmates)

- 11 Has your child been evaluated by a specialist?

	When?
☐ Speech Pathologist	
☐ Physical Therapist	
☐ Occupational Therapist	
☐ Other:	

- 12 Do you have any developmental concerns for your child? ☐ Yes ☐ No

Explain:

3 Pre-K _____

UPK _____

Fillmore Central School
Pre-Kindergarten Health Form

CHILD NAME: _____ DOB: _____

Custodial Parents/Guardians: _____

Address: _____ Phone #'s Mom home/cell: _____
Mom work: _____
Dad home/cell: _____
Dad work: _____

Name of person completing this form: _____

1	Did your child have a medically normal pre-natal delivery and newborn history?
☐ Yes	☐ No
Explain: _____	

2	Has your child experienced any of the following? Check all that apply/ please describe / give details, dates or age of onset, treatment/resolution.	
☐	Serious Illness	
☐	Seizures/convulsions	
☐	Head Injury	
☐	Surgery/hospitalization	
☐	History of ear infections or tubes	
☐	Allergies	
☐	Asthma	
☐	Vision problems/glasses	
☐	Hearing problems	
☐	Swallowing/chewing difficulties	

3	Is your child currently taking any medications?	☐ Yes	☐ No
If yes, please list medications, dosage and condition it's used for:			

4	Has your child been screened for Lead levels in his/her blood?	☐ Yes	☐ No
If yes, what were the results?			

5 Has your child had dental care? ☐ Yes ☐ No
 Most recent date seen:

6 **Sleep Patterns:**
 Does your child have difficulty:

Falling/staying asleep	☐ Yes	☐ No
Sleeping alone	☐ Yes	☐ No
Nightmares/night terrors	☐ Yes	☐ No
Other sleep difficulties	☐ Yes	☐ No

Please describe:
 What are your child's normal bed/ wake-up times?

7 Does your child typically nap? If yes, how long?
☐ Yes: ☐ No

8 Please list your child's medical professional and address/phone numbers.

	Name	Address	Phone #
Physician			
Eye Doctor			
Dentist			
Specialist and Specialty			
Specialist and Specialty			

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No	☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type	☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental	

Asthma ☐ No	☐ Medication/Treatment Order Attached	☐ Asthma Care Plan Attached
☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : _____	

Seizures ☐ No	☐ Medication/Treatment Order Attached	☐ Seizure Care Plan Attached
☐ Yes, indicate type	☐ Type: _____	Date of last seizure: _____

Diabetes ☐ No	☐ Medication/Treatment Order Attached	☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type	☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____	

Risk Factors for Diabetes or Pre-Diabetes:

Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI _____ kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and >

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	☐ Mental Health: _____
☐ Test Done ☐ Lead Elevated ≥ 10 $\mu\text{g/dL}$				☐ Other: _____
☐ System Review and Exam Entirely Normal				

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____
	_____	_____
☐ Additional Information Attached		

Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision—Near Vision	20/	20/		
Vision—Color ☐ Pass ☐ Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	Negative	Positive	Referral	
	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
☐ Full Activity without restrictions including Physical Education and Athletics.				
☐ Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
☐ No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
☐ No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
☐ Other Restrictions:				
☐ Developmental Stage for Athletic Placement Process ONLY Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports Student is at Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V				
☐ Accommodations: Use additional space below to explain				
☐ Brace*/Orthotic				
☐ Colostomy Appliance*				
☐ Hearing Aids				
☐ Insulin Pump/Insulin Sensor*				
☐ Medical/Prosthetic Device*				
☐ Pacemaker/Defibrillator*				
☐ Protective Equipment				
☐ Sport Safety Goggles				
☐ Other:				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
☐ Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
☐ Record Attached		☐ Reported in NYSIIS		Received Today: ☐ Yes ☐ No
HEALTH CARE PROVIDER				
Medical Provider Signature:				Date:
Provider Name: <i>(please print)</i>				Stamp:
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				

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, 1st, 3rd, 5th, 7th, 9th and 11th grade. 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 year, ask your dentist to fill out section 2. Return the completed form to the school nurse as soon as possible. (Fillmore Central School, Health Office, PO Box 177, Fillmore, NY 14735)

Section 1. To be completed by Parent or Guardian (please print)

Child's Name:

Birth Date: / / Sex: ☐ Male Will this be your child's first visit to the dentist? ☐ Yes ☐ No
 Month Day Year ☐ Female

School: Fillmore Central School Fax# 585-567-2541

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.

Community Eligibility Provision (CEP)/Provision 2 non-base year Household Income Eligibility Form

_____ (name/school) is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete **only one** form for your household, sign your name and return it to the school named above. Call _____ (school phone number), if you need help.

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits: _____
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. Then skip to Part 4.

Name: _____ CASE # _____

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

Name of household member	Earnings from work before deductions Amount / How Often	Child Support, Alimony Amount / How Often	Pensions, Retirement Payments Amount / How Often	Other Income, Social Security Amount / How Often	No Income
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	☐
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	☐
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	☐
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	☐
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	☐
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	☐
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	☐
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	☐

4. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Date: _____

Signature:

Email Address:

Home Phone

Work Phone

Home Address

SNAP/TANF/Foster Income

Free Eligibility

Signature of Reviewing Official

Household Size:

Denied Eligibility

DO NOT WRITE BELOW THIS LINE FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

Household Size: