

Big Beaver Falls Area School District's Pre-K Application Instructions & Checklist

Thank you for your interest in Big Beaver Falls Area School District's **FREE Pre-K Counts** program!

Pennsylvania Pre-K Counts provides a high-quality pre-kindergarten experience for eligible 3- and 4-year-old children at **no cost to families**.

We are excited that you are considering Pre-K Counts for your child! Please use the checklist below to help you complete the application process. If you have questions or need help gathering any of the required information, please contact us. **We are happy to help!**

STEP 1: COMPLETE THE PRE-K COUNTS APPLICATION

☐ **Pre-K Counts Application.** Please complete **all sections** of the application. Before submitting, please make sure that:

- ☐ All required questions have been answered
- ☐ Household and income information is complete
- ☐ The application has been signed and dated by the parent/guardian

STEP 2: PROVIDE DOCUMENTATION

Please provide copies of the following documents. **Do not submit original documents.**

Proof of Your Child's Age

☐ **Birth certificate or other acceptable documentation of your child's date of birth.** Your child's age will be reviewed to determine eligibility for Pre-K Counts.

Proof of Household Income

Please provide documentation of **all applicable household income**. Examples may include:

- | | |
|--|---|
| ☐ Recent pay stubs | ☐ Workers' compensation documentation |
| ☐ Most recent federal income tax return/W-2 | ☐ Child support documentation |
| ☐ Social Security or SSI documentation | ☐ TANF/cash assistance documentation |
| ☐ Unemployment compensation documentation | ☐ Documentation of other applicable income |

Not sure what income documentation you need? Contact us! We can help you determine what documents are appropriate for your family's situation.

ADDITIONAL DOCUMENTATION

☐ **Proof of current address/residency.** Examples may include acceptable district residency documentation such as a lease, mortgage statement, utility bill, or other approved documentation.

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☐ **Copy of your child's current immunization record.** If your child's immunizations are not yet complete or you have questions about the documentation needed, please contact us.

☐ **Current health/physical examination documentation.** Please provide your child's most recent health examination information. If an updated examination is needed, we will let you know.

☐ **Current dental examination/documentation.** Please provide your child's most recent dental information. If an updated dental examination is needed, we will let you know.

STEP 3: READY TO SUBMIT?

Before submitting your packet, make sure you have:

☐ Completed Pre-K Counts Application	☐ Immunization Record
☐ Proof of Child's Age	☐ Health/Physical Documentation
☐ Proof of Household Income	☐ Dental Documentation
☐ Proof of Residency	

You can submit your completed application and documents:

IN PERSON Central Elementary School 805 15 th Street, Beaver Falls, PA 15010	BY EMAIL: slappyt@tigerweb.org
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STEP 4: WHAT HAPPENS NEXT?

Once we receive your application:

1. We'll review it. Our Pre-K Counts team will review your application and documentation to determine your child's eligibility.

2. We'll contact you. If we need additional information or documentation, a member of our team will reach out to you.

3. We'll let you know your child's enrollment status. Submitting an application does not guarantee enrollment. Enrollment is based on Pennsylvania Pre-K Counts eligibility requirements, enrollment priorities, and available openings.

QUESTIONS? WE'RE HERE TO HELP!

Applying for Pre-K shouldn't be stressful. If you have questions about the application, aren't sure which documents to provide, or need help completing any part of the process, **please reach out to us.**

Big Beaver Falls Area School District – Pre-K Counts  Phone: 724-843-7470, Option 5  Email: slappyt@tigerweb.org

We look forward to welcoming your family to Pre-K Counts!

2026-27 PA Pre-K Counts Enrollment Form

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

Date Form Completed:						Child's SSN						
	MM		DD		YY		Last 5 digits	#	-	#	#	#

Legal Last Name (Child)	Legal First Name (Child)	Middle Initial
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Street Address		County	
City	State PA	Zip Code	
School District of Residence			
Home Phone	Work Phone	Email Address	

Child's Date of Birth	Age at start of program year ☐ 3 ☐ 4 ☐ 5	Gender ☒ Male ☐ Female
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Race (optional) ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Not Applicable	
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
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Relationship to Child ☐ Father ☐ Mother ☐ Guardian ☐ Other _____ (please specify)	(Select) ☐ Biological ☐ Foster ☐ Adoptive ☐ Other _____ (please specify)
---	--

Role ☐ Primary Guardian ☐ Secondary Guardian	☐ Legal Guardian ☐ Other _____ (please specify)
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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 2 nd 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

Enrollment Priority Criteria (Must check all that apply): These indicators help us learn more about your family and understand what supports may be helpful. Your answers also help us determine enrollment priority so we can serve families with the greatest need first. Every family's situation is unique, and all information is kept confidential.

Risk Factor	Definition
☐ Preschooler with an Individualized Education Program (IEP)-	Defined as a child who is currently enrolled in the Early Intervention program with an active IEP. Verification includes a copy of the IEP or other source of documentation from the parent or the Early Intervention agency.

☐	Migratory (Non-Immigrant) Seasonal Student	Defined as a child who has moved from one school district to another to accompany or join a parent or guardian who is a migratory agriculture worker or 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, or work in nurseries such as Christmas and evergreen tree farming.
☐	English Language Learner	Defined as a child whose first language is not English and who is in the process of learning English. Ask these two questions, as established by the Pennsylvania Department of Education, to determine if a child qualifies as an English language learner: 1) What is/was the child's first language? 2) Does the child speak a language other than English? (Do not include languages learned in school).
☐	Homeless	If any of the situations below apply a family is eligible under McKinney-Vento. Additional guidance is available from the <u>National Center for Homeless Education</u>. - If the family is staying with others, was this a result of a loss of housing, economic hardship, or other similar reason? - Is the family living in a shelter? (Includes youth, emergency, transitional living, domestic violence, etc.) - Is the family living in a motel, hotel, or campground? - Is the family staying in a public or private place not ordinarily used as a regular sleeping accommodation for human beings? - Is the family living in cars, parks, public places, abandoned buildings, transportation stations, or similar settings? - Is the family living in substandard (limited or no utilities, unsafe conditions, etc.) housing?
☐	Child in or Part of Family in Child Welfare System	Defined as a child who is a foster child, a kinship care child, or receiving Children and Youth Services.
☐	Child's Family or Living Structure	Defined as a child with a single parent, divorced parents, or with relatives as guardians.
☐	Child Receiving Behavioral Supports	Defined as a child who is referred to Pennsylvania Pre-K Counts from an appropriately credentialed health or mental health provider (not employed by the Pennsylvania Pre-K Counts program) or a child who is receiving mental health treatment. Additional verification beyond the interview is required.
☐	Teen Parent	Defined as a mother or father who was under the age of 18 when the child was born.
☐	Incarcerated Parent	Defined as a child for whom one or both of the child's parents are currently incarcerated.
☐	Education Level of Guardian	Defined as when the parent or legal guardian of the child does not have a high school diploma, high school equivalency, or postsecondary degree.
☐	Eligible for or Receives the Following Public Assistance: TANF, SSI, SNAP	This risk factor was added in 2024. Defined as a family who can produce documentation of eligibility for or receipt of TANF, SSI, or SNAP. (Categorically eligible for Head Start, please refer to HS program if available.)
☐	Child Enrolled in Infant Toddler Contracted Slots Program (ITCSP)	Defined as a child enrolled in ITCSP and eligible to transition into PA PKC.
☐	Child Lives in Geographic Area of High Poverty	Providers wishing to prioritize specific geographic regions with higher rates of poverty may do so. This might include specific zip codes, school districts, or other factors.

	Concerns Regarding Child's Physical Development or Existing Medical Condition (Currently Not Receiving EI Services) Concerns Regarding Child's Speech or Language Development (Currently Not Receiving EI Services) Concerns Regarding Child's Social, Emotional, or Behavioral Development (Currently Not Receiving EI Services)	If a family concern is shared that is not covered by any of the other risk factors and the child has not yet been referred to EI for evaluation, the program should share information on EI regardless of enrollment.
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Family Assurances

By signing below, I acknowledge and agree to the following:

- ☐ I understand that my child's eligibility for Pennsylvania Pre-K Counts (PA PKC) is subject to the program's two-year participation limit. My child must be at least three years old by the kindergarten cutoff date set by the school district where we live to assure compliance with receiving only two-years of PKC programming.
- ☐ Once my child reaches the age required to enroll in kindergarten in the public school district where we live, I understand they will no longer be eligible for PA PKC funding.
- ☐ I understand that my child's enrollment is contingent upon meeting the eligibility criteria, including income verification and prioritization based on risk factors.
- ☐ I understand that the PA Pre-K Counts (PKC) program is an educational program with attendance requirements. I agree to ensure my child's regular attendance and to notify the program in case of absences. My program's PA Pre-K Counts hours of operation are:

- ☐ I understand that the PKC portion of the day will be secular (non-religious) in nature and will not include religious instruction during the PKC portion of the day. My program's PA Pre-K Counts hours of operation are:

- ☐ I understand that once an enrollment start date is confirmed, the child's PA Pre-K Counts enrollment status may be shared with other OCDEL-funded programs, such as the Early Learning Resource Center (ELRC) or Early Intervention, to ensure proper coordination of funding and services.

Parent/Guardian Certification

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 give proof of information provided.

I certify that all information provided is accurate. I understand that eligibility is subject to verification and providing false information may result in disqualification.

Parent/Legal Guardian (Signature)

Date



Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:

Complete page one of this form before
student's exam. Take completed form to
appointment.

Student's name _____ Today's date _____
Date of birth _____ Age at time of exam _____
Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other _____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: <i>Has the student...</i>	YES	NO
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: <i>Has the student...</i>	YES	NO
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other: _____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student...</i>	YES	NO
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	YES	NO
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	YES	NO
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other: _____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other: _____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	YES	NO
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

Adapted in part from the *Pre-participation Physical Evaluation History Form*; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: () inches				
Weight: () pounds				
BMI: ()				
BMI-for-Age Percentile: () %				
Pulse: ()				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐			
Physical exam performed at: Personal Health Care Provider's Office ☐	School ☐	Date of exam _____ 20____	
Print name of examiner _____			
Print examiner's office address _____		Phone _____	
Signature of examiner _____		MD ☐ DO ☐ PAC ☐ CRNP ☐	

H514.027 (2/2023)

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 STUDENT			AGE	SEX	GRADE	SECTION/ROOM
Last	First	Middle	M	F		

ADDRESS

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

REPORT OF EXAMINATION

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

Untreated Decay: No Yes

Treated Decay: No Yes

Any Sealants on Permanent Molars: No Yes

Treatment Urgency: None Early Urgent

Date of Dental Examination _____

Signature of Dental Examiner _____ Print Name of Dental Examiner _____

Address of Dental Examiner _____

SCHOOL COUNSELOR REGISTRATION FORM

Student Name: _____ Date: _____ Grade: _____

Check any areas of concern that you have with your child.

<u>BEHAVIOR</u> ☐ Fighting/Aggressive ☐ Acting Out ☐ Impulsive ☐ Withdrawn ☐ Hyperactive ☐ Unusual/Odd Behavior	<u>SCHOOL</u> ☐ Academic Progress ☐ Organizational Skills ☐ Peer Relations ☐ Authority Figure Relationships ☐ Poor Attention
<u>HOME</u> ☐ Death/Loss ☐ Separation/Divorce ☐ Conflict ☐ Other 	<u>EMOTIONAL</u> ☐ Sadness ☐ Nervous/Anxious ☐ Angry ☐ Fearful ☐ Mood Swings ☐ Other

List anything additional you would want the school counselor to know about. _____

Does your child currently receive counseling/therapy services? YES NO

If yes, what is the agency/counselor/therapist or doctor's name? _____

Has a doctor diagnosed your child with any disorders that make it difficult for them to be successful in school?
 YES NO If yes, list diagnosis _____

Is your child on any medications for above diagnosis? YES NO

If yes, list medication, dosage, and what time it is given _____

Please circle if your child has any of the following services: BSC MT TSS FAMILY BASED

Circle any special services that your child receives at school:

IEP (special education/learning support) 504 OT (occupational therapy) SPEECH
 PT (physical therapy) GIFTED EMOTIONAL SUPPORT CLASS LIFE SKILLS CLASS

Has your child ever been placed in an outside facility for behavior or emotional needs? YES NO

If yes, name facility and length of stay _____

Big Beaver Falls Area School District
STUDENT RESIDENCY QUESTIONNAIRE

Dear Parent/Guardian,

Your responses to the following questions will help staff determine what residency documents are necessary for the enrollment of your child(ren.) Thank you for your cooperation.

1. Student's name: _____ Birthdate: _____

2. Person completing form: _____ Relationship to child: _____

3. What type of setting is the student currently living? (Please check one of the boxes below.)
This information will be used to provide support for your child.

SECTION A	SECTION B
☐ In emergency or transitional shelter ☐ Sharing housing of other persons due to loss of housing, economic hardship or similar reason ☐ In a motel, hotel, campsites or cars due to a lack of alternative adequate accommodations ☐ In a park, public spaces, abandoned building, substandard housing, bus/train station or similar settings ☐ Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings Please continue to Question 4, if you checked any box in SECTION A. 	☐ None of the choices in SECTION A apply. If you checked the box above in SECTION B, you do not need to complete the remainder of this form. Please submit the form to school personnel now. 

4. Contact number for the person completing this form: _____

Address where student is currently living: _____

5. The student is currently living with: (Check all that apply.)

- ☐ Parent(s) or legal guardian
☐ Relative, friend(s) or other adult(s)
☐ Alone
☐ Other: _____

Please continue on the back.

MEDICAL HISTORY

A complete health and emotional history enables us to understand your child better, and helps him/her to make a better adjustment to school. Please check, if you child has any of the following conditions:

- | | | |
|--|---|--|
| ☐ Asthma | ☐ Chicken Pox (when) | ☐ Hoarseness |
| ☐ Allergies | ☐ Rheumatic Fever | ☐ Mouth Breather |
| ☐ Diabetes | ☐ Pneumonia | ☐ Speech Difficulty |
| ☐ Bleeder | ☐ Scarlet Fever | ☐ Convulsions/ High Fever |
| ☐ Heart Condition | ☐ Frequent Sore Throat | ☐ Frequent Nose Bleed |
| ☐ Seizures/ Fainting Spells | ☐ Frequent Earache | ☐ Tires Easily |
| ☐ Vision Problems | ☐ Frequent Colds | ☐ Poor Appetite |
| ☐ Hearing Problem | ☐ Clumsiness | ☐ Frequent Headache |
| | ☐ Dental Problems | ☐ Frequent Urination |

Was there a health problem or handicap present at birth? ☐ Yes ☐ No
If yes, please explain

Is he/she presently under care of a physician? ☐ Yes ☐ No
List any injury, operations or hospitalizations – give dates

Is your child on any medication? _____ If yes, name of medication _____
Dosage and time to be give _____

Does your child have special dietary needs? ? ☐ Yes ☐ No

Does your child wear glasses? ☐ Yes ☐ No

Check the following, if it pertains to your child:

EYES

- ☐ Squint
- ☐ Cross Eyes
- ☐ Difficulty Seeing
- ☐ Red Eyes

EARS

- ☐ Difficulty Hearing
- ☐ Frequent Ear Infections
- ☐ Draining Ears

ADDITIONAL COMMENTS:

SIGNATURE OF PARENT OR GUARDIAN _____