Morenci Elementary
Pre-School Program

The Morenci pre-school program is a state licensed program. The program is run by a certified preschool teacher and a certified aide. We will be offering a full day program for children ages 3 and 4 years old. Children must turn 3 by September 2019.

**Full-day Program**
Cost: $120 per week 1st child
$105 per week 2nd child
Hours: 7:55 am—3:00 pm

**What will my child be doing?**
- Letter and sound recognition
- Handwriting
- Word families
- Name writing
- Recognize and write numbers
- Social Skills
- Sensory activities
- Transitioning
- Health awareness
- Creative arts

**Registration Process**
- Completed registration packet
- Signed contract
- Non-refundable registration of $15
- Physical completed by physician
- Up-to-date immunization records
- Certified birth certificate
- Proof of residency

**NOW ACCEPTING APPLICATIONS FOR THE 2019/2020 SCHOOL YEAR**

*If you have any questions regarding the program contact Shana Love, Morenci Elementary Principal at 517-458-7504
Sherri White, Executive Assistant at 517-458-7501*
To enroll your child in the preschool program the following documents must be completed before you are accepted into the program. If any documents are missing, you will automatically be put on a waiting list.

1. **REGISTRATION PACKET**
2. **HEALTH APPRAISAL – PHYSICAL COMPLETED BY PHYSICIAN**
3. **$15 REGISTRATION FEE**
4. **SIGNED CONTRACT & PAYMENT AGREEMENT**

5. **IMMUNIZATION RECORD**
   State Law (P.A. 386. sec. 92 or 1978. amended 1992) requires all new school entrants to be immunized against measles, mumps, rubella, polio, DTP, DT, T, Hep B, and Varicella. Upon entering 7th grade or higher students must have the Meningococcal vaccination (PA 386, Section 92 of 1978 as amended). Parents/guardians must provide the school with a record showing that their has received all of these required immunizations or a waiver must be signed. Children who have not completed the required immunizations will be excluded from school until such requirements are met.

The Lenawee County Health Department is located in the Human Services Building located at 1040 S. Winter Street, Adrian, MI. You may contact them at 264-5226 regarding immunizations.

6. **BIRTH CERTIFICATES**
   A person enrolling a student for the first time must provide the school with a **certified** copy of the student’s birth certificate (P.A. 84 of 1987). Failure to comply with the request, or the documents are inaccurate and/or suspicious in nature will result in the school sending notifications of compliance within 30 days or the case will be turned over to the local law enforcement agency.

7. **RESIDENCY**
   Parent/guardian must provide proof of their legal residence. Change of guardianship is not permitted for the purpose of attending a specific school or school district. The courts have stated what constitutes residency.
   “a child is entitled to the benefit of the public schools in the district in which they live if they have gone there in good faith for the purpose of acquiring a home and not for the purpose of taking advantage of school privileges.” (Commonwealth V. School Directors of Upper Swatara Township 26 L.R.A. 581).” Proof of legal residence will be required by the school district of a parent or guardian enrolling a student for the first time. Acceptable forms of proof of residency include:
   - Mortgage documents that prove ownership
   - Copy of property tax statement
   - Copy of a lease agreement
   - Utility bill that provides address and name match up
   - DRIVER’S LICENSE IS NOT ACCEPTABLE
Student Name: ___________________________ Date of Birth: _________________

REGISTRATION REQUIREMENTS

1. The following documents are required with the initial application in order to be accepted into the program. Any missing documents you will be put on a waiting list until all documentation has been received.
   a. Signed contract and payment agreement
   b. Non-refundable registration fee of $15.00
   c. Certified birth certificate
   d. Proof of residency
   e. Up-to-date immunization records
   f. Health appraisal – physical completed by physician within 14 days of fourth birthday.

2. Morenci Area Schools should be notified in writing if your child is withdrawing from the program.

3. Parents/Guardians must escort children to the assigned classroom.

4. It is important that students be dropped off and picked up at designated times.

5. Students leaving early must sign out with the program teacher.

6. No credits or refunds are given if a child is absent.

7. The program will be closed whenever Morenci Area Schools close or delay for inclement weather. **NO** refunds or credits will be given for these types of closures.

8. Morenci Area Schools may close the program at any time due to lack of participation. Pre-paid tuition will be refunded.

THE FOLLOWING ARE GROUNDS FOR DISMISSAL FROM THE PROGRAM:

1. Late tuition payments.

2. Incomplete physical, immunization records, and insufficient proof of certified birth certificate.

3. The child’s behavior is a threat to other children and/or the instructor.

4. It is expected that children are toilet trained.
PAYMENT AGREEMENT

Tuition is due every Monday before preschool begins. Payments not paid by Tuesday will be assessed a $10 late fee for each week payment is late.

Non-payment of tuition is grounds for dismissal from the program.

Tuition fee per week is:

- Full day preschool cost $120 per week
  7:45 am - 3:00 pm (Includes free breakfast and lunch is offered for a fee)

How to view your monthly invoice:

1. Click on School Store
2. Click on School Invoices
3. Select the correct month of the invoice
4. Click on Payment Option
5. Select to pay the remaining amount on that invoice or select pay other amount.
6. All tuition payments are due at the beginning of each month or you will be charged a $10 late Fee.

I agree to the terms of this contract and agree to make my monthly tuition payments. I understand that if I do not make the monthly tuition payment that it is grounds for dismissal from the program.

Parent/Guardian Name (Print): ______________________________ Relationship: _____________

Parent/Guardian Signature: ________________________________
CHILD'S LEGAL NAME (as shown on birth certificate):

Last Name: ___________________________  First Name: ___________  Middle: ___________

Full day Preschool: ____ ($120 per week)  Half day Preschool: ____ ($55 per week)

Birthdate: _______________  City of Birth: ___________________  State of Birth: ______________

SPECIAL EDUCATION
Did your child receive any special education series at a previous school?  Yes  No

If yes, please indicate the types of services he/she received:

________________________________________________________________________

________________________________________________________________________

STUDENT ADDRESS INFORMATION
Physical Address:

House #  Street Name  Apt./Unit #  City  Zip

Mailing Address:

House #  Street Name  Apt./Unit #  City  Zip

Primary PHONE number: _________________  Student Mobile Number: _________________

Student E-mail: _________________

RESIDENCY STATUS

□  Resident  □  School of Choice

School District you live in ______________________________

LANGUAGE

Is your child’s native tongue a language other than English?  Yes  No

□  Yes, Name of language: __________________

□  No

Is the primary language used in your child’s home or environment a language other than English?  Yes  No

□  Yes, Name the language

□  No

OTHER CHILDREN IN THE FAMILY

<table>
<thead>
<tr>
<th>Name (First &amp; Last)</th>
<th>Birthdate</th>
<th>Grade</th>
<th>School of Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>_________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>_________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Updated: July 15, 2019
### Parent/Guardian Information – Living in the Home

<table>
<thead>
<tr>
<th>1st person residing in the home:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td><strong>Relationship:</strong></td>
</tr>
<tr>
<td><strong>Home Phone Number:</strong></td>
<td><strong>Cell Phone Number:</strong></td>
</tr>
<tr>
<td><strong>Place of Employment:</strong></td>
<td><strong>Occupation:</strong></td>
</tr>
<tr>
<td><strong>Work Phone Number:</strong></td>
<td><strong>E-mail Address:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2nd person residing in the home:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td><strong>Relationship:</strong></td>
</tr>
<tr>
<td><strong>Home Phone Number:</strong></td>
<td><strong>Cell Phone Number:</strong></td>
</tr>
<tr>
<td><strong>Place of Employment:</strong></td>
<td><strong>Occupation:</strong></td>
</tr>
<tr>
<td><strong>Work Phone Number:</strong></td>
<td><strong>E-mail Address:</strong></td>
</tr>
</tbody>
</table>

### Parent/Guardian Information – Not Living in the Home

<table>
<thead>
<tr>
<th>1st person NOT in the home</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td><strong>Relationship:</strong></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td><strong>Relationship:</strong></td>
</tr>
<tr>
<td><strong>Primary Home Phone Number:</strong></td>
<td><strong>Cell Phone Number:</strong></td>
</tr>
<tr>
<td><strong>Place of Employment:</strong></td>
<td><strong>Occupation:</strong></td>
</tr>
<tr>
<td><strong>Work Phone Number:</strong></td>
<td><strong>E-mail Address:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2nd person NOT in the home</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td><strong>Relationship:</strong></td>
</tr>
<tr>
<td><strong>Primary Home Phone Number:</strong></td>
<td><strong>Cell Phone Number:</strong></td>
</tr>
<tr>
<td><strong>Place of Employment:</strong></td>
<td><strong>Occupation:</strong></td>
</tr>
<tr>
<td><strong>Work Phone Number:</strong></td>
<td><strong>E-mail Address:</strong></td>
</tr>
</tbody>
</table>

Should this person receive mailings?

Have custody papers been provided to the district? Please provide a copy.

Custody restrictions:
EMERGENCY CONTACT INFORMATION
Please list parent/guardian along with at least 3 additional people to contact in the event your child becomes ill.

<table>
<thead>
<tr>
<th>Calling Order</th>
<th>Name</th>
<th>Relationship</th>
<th>Home Number</th>
<th>Cell Phone</th>
<th>Work Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

RACE ETHNICITY QUESTIONNAIRE:
Please answer BOTH parts A and B.

PART A
Is this student Hispanic/Latino? (Choose only one)
- □ No, not Hispanic/Latino
- □ Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central America or other Spanish culture or origin, regardless of race.)

Part A of the question is about ethnicity, not race. Regardless of what you selected in Part A, please answer Part B by marking one or more boxes to indicate what you consider your student’s race to be.

PART B
What is the student’s race? (Choose one or more)
- □ White
  A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- □ American Indian or Alaska Native
  A person having origins in any of the original peoples of North and South America, including Central America.
- □ Asian
  A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- □ Black or African-American
  A person having origins in any of the black racial groups of Africa
- □ Native Hawaiian or Other Pacific Islander
  A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

NOTE: Both parts A and B MUST be completed. If either part (A or B) is not answered, the U.S. Department of Education requires the school district to supply an answer on your behalf.
HEALTH HISTORY

<table>
<thead>
<tr>
<th>Problem</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies or reaction to food?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, list:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergic to any kind of medication?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, list:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergic to bees?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, does your child need an Epi Pen?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hay Fever, Asthma, wheezing, shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other health issues/physical limitations/restrictions (Please explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MEDICATION

Is your child regularly taking any medications?  □ Yes  □ No
If yes, what medication?  ________________________________
Reason for medication?  ________________________________
Where is medication administered?  □ Home  □ School  □ Both
If medication is administered at school, an “AUTHORIZATION TO ADMINISTER MEDICATION” form must be completed by parent and doctor. Medication will not be dispensed without a completed form.

Does this child have any problems that might influence his school judgment?  □ Yes  □ No
If yes, please describe:  __________________________________________

If you or your spouse cannot be contacted in the case of an emergency, would you want the teacher and or principal to seek medical aid for your child on your behalf?  □ Yes  □ No

The undersigned hereby acknowledges that the information provided on the registration forms is true and accurate.
The undersigned understands
1. that is his/her responsibility to inform the appropriate school office if and when any of the information set in this form changes.
2. will provide the following items before my child attends Morenci Area Schools: certified birth certificate, up-to-date immunization records, proof of residency, and custody papers if applicable.
3. understands that the Morenci Preschool Program is a tuition based program and I am responsible for making the monthly payment and non-payment is grounds for dismissal from the program.

Parent or Guardian Signature: ___________________________ Date: ___________________________
RESIDENCY STATEMENT

Students to be enrolled:
Name: ____________________________ Grade: ______________
______________________________

1. We/I reside at ____________________________
   Address ______________
   City __________________

2. We/I have resided at the address from ______ to present.

3. My address is ________________ School District.
   If your address is in a district other than Morenci Area Schools a “School’s of Choice Application” must be on completed.

4. I certify below that I:
   a. have legal custody of the student (s)
   b. was appointed guardian of the student by the Probate Court
   c. operate a licensed home
   d. am a relative of the student providing a suitable home at the court’s order/child placing agency directive. I will produce a copy of the court/agency directive upon request.

5. Declarative: I hereby declare that the information provided above is true and correct. I understand that enrollment may be terminated upon discovery that any of the residence information provided above was false. I agree to notify school officials within seven (7) days of any changes in residency or telephone numbers.

BIRTH CERTIFICATE

☐ I have provided a certified birth certificate.
☐ I will provide a copy within 30 days.

IMMUNIZATION

☐ I have provided a copy of my child’s immunization records.
☐ I will provide a copy within 5 days.

Parent/Guardian Signature: ____________________________ Date: ______________
PRESCHOOL SCHOLARSHIP REQUEST FORM
2019/2020 School Year

Applications are due to the elementary office no later than Monday, August 15, 2019.

To be considered for a scholarship all required documentation must be completed by the application deadline. The only exception would be the physical if the child does not turn four until after August 15th but will be contingent that the physical is completed no later than 14 days after birthday.

If you do not meet this requirement, you forfeit any scholarship awarded.

Student Name: ___________________________ Birthdate: ____________

Program Offering: _______ Full Day

INCOME:
Number of people living in your household: ______

Do you receive Food Assistance Program (FAP)? ______ If yes, what is your case # ______

What is your monthly household income (before any deductions and taxes)? $ ________________

PLEASE MARK ALL THAT APPLY REGARDING STUDENT:

____ Low birth weight
____ Physical and/or sexual abuse and neglect
____ Nutritionally deficient
____ Long term or chronic illness
____ Diagnosed handicapping condition (Mainstreamed)
____ Lack of stable support system of residence
____ Destructive or violent temperament
____ Substance abuse or addiction
____ Language deficiency or immaturity
____ Limited English speaking household
____ Family history of low school achievement or dropout
____ Family history of delinquency
____ Family history of diagnosed family problems
____ Single parent
____ Unemployed parent/parents
____ Parental/sibling loss by death or parent loss by divorce
____ Teenage parent
____ Child has an IEP

I certify (promise) that all information on this application is true. I understand that if I purposely give false information, my child may lose benefits.

Print Name ___________________________ Signature ___________________________ Date ____________

OFFICE USE ONLY:

1. All required documentation is completed: ____________

____ Approved  ______ Denied

Weekly Discount: ____________  Weekly Tuition: ____________
Dear Parent or Guardian:

The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. (BE SURE TO BRING YOUR CHILD’S IMMUNIZATION RECORDS TO THE EXAMINATION.)

### PERSONAL

<table>
<thead>
<tr>
<th>CHILD’S NAME (Last, First, Middle)</th>
<th>DATE OF BIRTH (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS (Number &amp; Street)</td>
<td>(City) (ZIP Code)</td>
</tr>
<tr>
<td>MI</td>
<td></td>
</tr>
<tr>
<td>PARENT/GUARDIAN (Last, First, Middle)</td>
<td>HOME TELEPHONE NUMBER (   )</td>
</tr>
<tr>
<td>ADDRESS (Number &amp; Street)</td>
<td>(City) (ZIP Code)</td>
</tr>
<tr>
<td>MI</td>
<td>WORK TELEPHONE NUMBER (   )</td>
</tr>
</tbody>
</table>

### SECTION I - HEALTH HISTORY

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Allergies or Reactions (for example, food, medication or other)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Hay Fever, Asthma, or Wheezing</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Eczema or Frequent Skin Rashes</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Convulsions/Seizures</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Heart Trouble</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Frequent Colds, Sore Throats, Earaches (4 or more per year)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Trouble with Passing Urine or Bowel Movements</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Shortness of Breath</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Speech Problems</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Menstrual Problems</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Dental Problems: Date of Last Exam</td>
<td></td>
</tr>
</tbody>
</table>

Other (please describe): 

Does your child take any medication(s) regularly? If yes, list medications:

Reason for Medication:

Was the health history reviewed by a health professional?  

### SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

#### Tests and Measurements

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>VISION</td>
<td>Visual Acuity</td>
</tr>
<tr>
<td>H.E.A.</td>
<td>Height &amp; Weight</td>
</tr>
<tr>
<td>Muscle Imbalance</td>
<td></td>
</tr>
<tr>
<td>MEASUREMENTS</td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>Audimeter</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
</tr>
<tr>
<td>Date: / /</td>
<td>Date: / /</td>
</tr>
<tr>
<td>U.R.A.LYSIS</td>
<td>Sugar</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
</tr>
<tr>
<td>Date: / /</td>
<td>Date: / /</td>
</tr>
<tr>
<td>Blood Lead Level</td>
<td>Level ug/dl</td>
</tr>
</tbody>
</table>

**NOTE:** Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

**Exam Date: / /**
### SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

<table>
<thead>
<tr>
<th>VACCINES (Circle Type)</th>
<th>DATE ADMINISTERED MM/DD/YYYY</th>
<th>VACCINES (Circle Type)</th>
<th>DATE ADMINISTERED MM/DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>1</td>
<td>Hepatitis A (HepA)</td>
<td>2</td>
</tr>
<tr>
<td>(HepB)</td>
<td>3</td>
<td>Influenza (IIV/LAIV)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Meningococcal (MCV4 / MPSV4)</td>
<td>1</td>
</tr>
<tr>
<td>DTaP/DTP/DT/Td</td>
<td>2</td>
<td>Human Papillomavirus (HPV9/HPV4/HPV2)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Tdap</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus Influenza</td>
<td>1</td>
<td>OTHER Vaccines</td>
<td>Type of Vaccine(s) Date of Vaccine(s)</td>
</tr>
<tr>
<td>type b (HIB)</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(IPV/Dpol)</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(PCV7/PCV13)</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus (RV1/RV5)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td>1</td>
<td>Specity Date &amp; Type</td>
<td></td>
</tr>
<tr>
<td>(MMR)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>History of Chickenpox Disease?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
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</tbody>
</table>

I certify that the Immunization dates are true to the best of my knowledge.

Health Professional's Signature: ____________________________

Date: ____________

### SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

- ☐ ☐ Is there any defect of vision, hearing or other condition for which the school could help by setting or other actions? If yes, please explain:

- ☐ ☐ Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s):
  - ☐ Classroom
  - ☐ Playground
  - ☐ Gymnasium
  - ☐ Swimming Pool
  - ☐ Competitive Sports
  - ☐ Other

Other Recommendations: ____________________________________________

### SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined ____________________________’s teeth. As a result of this examination, my recommendation for treatment is: ____________________________

Dentist's Signature: ____________________________

Date: ____________

**PHYSICIAN’S SIGNATURE**

Examiner’s Signature: ____________________________

Date: ____________

Examiner’s Name (Print or Type): ____________________________

Degree or License: ____________________________

Number & Street: ____________________________

City: ____________________________

ZIP Code: ____________________________

Telephone: ____________________________