KINDERGARTEN REGISTRATION INSTRUCTIONS

You are receiving this information notice to help you with our kindergarten registration process. Please be sure to read this in full and complete all items in a timely fashion.

-Complete and turn in the registration form. Please be sure to include child's social security number and at least one emergency number that is not a parent. (Parents are always called first so do not list them under the emergency contacts.) We mostly communicate by email, so it is important that you list this on your registration form.

-Complete the Kindergarten Kick off form. This will give us information needed to order shirts and supplies for that evening once the date is set.

-Turn in copies of 3 proofs of residency. If you already have a student in the Millstadt schools, please let me know. I may be able to pull copies from your current student's file. However, if you have a new residence in the school district between the time your original copies were turned in and the first day of school in August, please turn in your new 3 POR's as soon as possible but no later than the first day of school. The normal paperwork accepted is an Occupancy Permit (Mandatory), Lease or Mortgage Statement, and a Utility Bill or Driver's License. I must have all three on file and they must have your name and current address on the documentation. If you need other acceptable options, please call me.

-Provide copy of child's official birth certificate received from the courthouse. This is not the one you may have gotten from the hospital. (Please do not wait until the last minute to check on this as it could take several weeks to get from the court house if you are having it mailed to you.)

-Medical Information/Physicals/Every student needs to have this complete BY THE FIRST DAY OF SCHOOL. The only exceptions to this are the students who don't turn five until between the first day of school and September 1st. For these students, please send a note in on the first day of school as to when your child's appointments are scheduled so she can make note in her records.

-Kindergarten Supply List provided on school website. These items should be obtained and the teachers will let you know when to bring them to school. Normally this will be just before school starts when they come in for the teacher/parent meeting.

NOTE: This is only the first step of the registration process. Here is a heads up on what is to come.... (Please keep this letter so you can refer back to this section.)

1) Your child's Kindergarten Screening will be done the first week of the school year. They will have a temporary teacher assigned before then and then when classes are finalized, you will be notified of who their permanent homeroom teacher is.
2) You will still have to complete the online portion of the registration before school starts, giving permissions and acknowledgements like you did this year. REMEMBER when you log in with your email that you sign in as an EXISTING/RETURNING STUDENT! Also you will need to download an updated proof of residency, like a current utility bill. Do NOT check off that your child is a new student no matter what, this will freeze them out of the system!
3) Please keep an eye out on the school website for the dates of the kick off, the first day of school, and when to sign up for the parent/teacher introduction meeting. You will also receive a letter from your child's teacher the beginning of August when the home rooms are assigned. These lists are not finalized until just before the letters go out. You will receive a communication from MCS when the on-line registration is available for the upcoming school year.

If you have any questions, please contact the school office. Thank you.

FAMILIES ENROLLING IN THE MILLSTADT PRIMARY CENTER

Please present the following items at time of registration:

1. Proof of Parent or Guardian Relationship

   - Driver's License or Other Acceptable Photo ID of parent/guardian.
   - Copy of certified birth certificate of student (the certificate you received from the hospital is not sufficient). A copy can be obtained from the county clerk where the child was born.
   - Proof of guardianship (if applicable).
   - Court Order Agreement, Judgment or Divorce Decree that awards custody of the child to any person (if one exists).

2. Social Security number of student.

3. **Three proofs of residency**. (Follow the guidelines for either **Section A, B, or C** on reverse side):

   A. District residents occupying homes or rental units **before** occupancy permits were required must meet the following criteria.

      1. Provide at least **two** of the following:
         - Current Real Estate Tax Bill
         - Home Ownership Title or Deed
         - Lease showing landlord name and phone number
         - One Current Utility Bill (gas, sewer, water, or electric)
         - Homeowner or Renter Insurance Bill
      2. Plus at least **one** of the following:
         - Driver's License with Address in District
         - Current Paycheck Stub or proof of income with Address in District
         - Documentation of TANF or Approval Letter from Nutrition Program and Support Services
         - Utility Bill (If did not use it as proof of residency in number A1 above.)

   B. District residents occupying homes or rental units **after** occupancy permits were required must meet the following criteria:

      1. **Occupancy Permit** – You will need an occupancy permit from either St. Clair County or the Village of Millstadt if the Parent/Guardian moved into the dwelling according to the following guidelines:

Unincorporated St. Clair County	Village of Millstadt
Renters since January 1, 1998	Renters since November 1, 2007
Homeowner since January 1, 1999	Homeowners since November 1, 2007

      2. Provide at least **one** of the following:
         - Current Real Estate Tax Bill
         - Home Ownership Title or Deed
         - Lease showing landlord name and phone number
         - One Current Utility Bill (gas, sewer, water, or electric)
         - Homeowner or Renter Insurance Bill
      3. Plus at least **one** of the following:
         - Driver's License with Address in District
         - Current Paycheck Stub or proof of income with Address in District
         - Documentation of TANF or Approval Letter from Nutrition Program and Support Services
         - Utility Bill (If did not use it as proof of residency in number B2 above.) (OVER)

C. Requirements of you are living with a District resident:

1. **Affidavit of Residency Requirements**:
   - District Homeowner/renter and the Parent/Guardian must both sign an Affidavit of Residency.

AND

Follow the requirements for **Section A or B** on the front side depending need of an occupancy permit.

- Homeowner/renter must follow Section A1 **or** B1 and B2
- Parent/Guardian must follow Section A2 **or** B3

Any person who knowingly or willfully presents to the district any false information regarding the residency of a student for the purpose of enrolling that student to attend school in the district, or who knowingly enrolls a student who is not a resident of the district, shall be guilty of a Class C misdemeanor, punishable by up to 30 days incarceration in the St. Clair Jail ILCS 5/5-8-3 and/or a fine up to $1500.00 730 ILCS 5/5-9-1. In addition, any nonresident student will be charged tuition for each day of enrollment in accordance with Section 10-20.12a, of the Illinois School Code.

Appeal Procedures: In the event the district denies enrollment, the parent/legal guardian may appeal the decision to the Principal. If the parent/legal guardian is not satisfied with the Principal's decision, he/she may appeal to the Superintendent's decision, he/she may appeal at the next regularly scheduled board meeting. While this decision is being decided, the student may not enroll in the school. As part of the investigation process, the district may require the parent/legal guardian of the student to produce additional proofs of legal residence. If the decision by the Board of Education is that the student does not reside within the district, admission is denied.

MILLSTADT PRIMARY CENTER

NEW STUDENT INFORMATION

GRADE/HR: _____ SCHOOL YEAR: _____

(Please print)
LAST NAME: _____

FIRST NAME: _____

MIDDLE NAME:: _____ Birth Place:

SS#: | | | | DATE OF BIRTH: | | | |

RACE: _____ GENDER: M: _____ F: _____

Birth Certificate	
School ID#	
SID#	
Illinois Transfer Form	
Trans Code:	*AM* / *PM*

Office Use Only

ADDRESS: _____
(street) (city) (zip)

HOME PHONE #: ( ) _____

CELL PHONE #: Mother: _____ Father: _____

Email Address: _____

Name of Mother or Legal Guardian: _____ Maiden Name: _____

Address: _____

Occupation: _____ Federally Employed: Yes _____ No _____

Employer: _____ Phone #: ( ) _____

Name of Father or Legal Guardian: _____

Address: _____

Occupation: _____ Federally Employed: Yes _____ No _____

Employer: _____ Phone #: ( ) _____

Parent (s) are a member of a branch of the Armed Forces? If so, (please list)
Future deployment date Indicated:

Status of Parents or Legal Guardians: Married: _____ Separated: _____ Divorced: _____

Child Living with: Parents: _____ Mother: _____ Father: _____ Legal Guardian: _____ Other: _____

EMERGENCY CONTACT: If student should get ill, in the event parents cannot be reached, call the following:

Name	Relationship to Student	Emergency Phone Number

If a language other than English is spoken in the home, what is the language: _____

Does the student speak a language other than English? Yes: _____ No: _____

If Yes, what is the language? _____

Please list names and birth dates of **all** other children living in your home:

_____

The State of Illinois furnishes, on a loan basis, some of the textbooks used in the various classrooms. (Public Act 79-961 OF 1975) Do we have your permission to let your child use these textbooks? YES NO

My child has permission to go on Field Trips with the students and teachers of Millstadt Grade School District #160, as designated by the School. (Parents will be notified of such designated Field Trips) YES NO

If student is going to a sitter or address other than home - please list:

Name: _____

Address: _____

Phone Number _____

SIGNATURE OF PARENT OR GUARDIAN: _____

MCS PTA
KINDERGARTEN KICKOFF

WHEN: **August (Exact Date and Time will be posted on school website by August 1st, usually two days before first day of school)**

WHERE: **Millstadt Primary Center Multipurpose Room**

Come and join us for a great evening of fun and let your child enjoy an orientation into their first days at MCS. Be sure to check the school website for updated information the first part of August.

- ✓ **You and student will take tours of the school and be shown the important aspects of what your child needs to know on the first day of school.**
- ✓ **Every kindergarten child will receive a MCS kindergarten class T-shirt.**
- ✓ **You and your child will enjoy a special treat!**

Please fill out the reservation slip below so that we may prepare for the correct number of people. We hope to have 100% attendance so that our kindergarteners will have a "FEAR FREE and TEAR FREE" experience on their first day of school. Please return this form with your registration today.

✂Please Keep for Your Reference✂

Parents'/Guardians' Name(s):_____

Kindergartener's Name: _____

Phone Number: _____Number Attending_____
(Include Parents)

Kindergartener's T-shirt size (YOUTH SIZES) Please circle one : S(6-8) M (10-12) L (14-16)

Return to: Millstadt Primary Center
Kindergarten Kickoff
105 W. Parkview Dr.
Millstadt, IL 62260

Millstadt Community Consolidated School District #160

Sandi Pegg – Principal
Millstadt Consolidated School
211 West Mill Street
Millstadt, IL 62260
spegg@mccsd160.com
618-476-1681 Fax: 618-476-3401

Dr. Brad Landgraf – Superintendent
District Office
211 West Mill Street
Millstadt, IL 62260
blandgraf@mccsd160.com
618-476-1803 Fax: 618-476-1893

Ed Emge – Assistant Principal
Millstadt Primary Center
105 West Parkview Drive
Millstadt, IL 62260
eemge@mccsd160.com
618-476-7100 Fax: 618-476-7182

Illinois Health Requirements

KINDERGARTEN

Illinois State Law requires all students entering Kindergarten to show proof of the following:

Immunizations- 4 or more doses of DTP/DTaP vaccine

4 or more doses of Polio Vaccine

3 Hepatitis B vaccines

2 MMR (Measles, Mumps, Rubella) vaccines

2 Varicella (Chicken Pox) vaccines

Physical Exam- A complete physical exam and immunization history documented & signed by your doctor on the Illinois school form. Please make sure to fill out and sign the guardian's section of the health history.

Vision/Eye Exam- Required by Illinois for all Kindergarten students. This would include seeing an Optometrist or Ophthalmetrist.

Dental Exam- Required by Illinois for all Kindergarten students.

MCCSD 160 Permission for Treatment/Medical History - guardians must complete the front/back & sign.

All forms are due BEFORE the 1st day of Kindergarten

IMMUNIZATION CLINIC INFORMATION

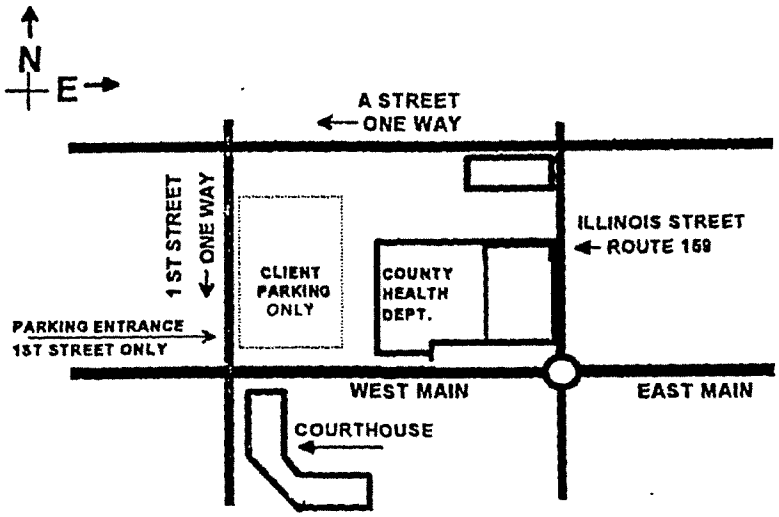
Anyone may go to the St. Clair County Health Department for immunizations. Days for immunizations are Wednesdays. Hours are from 10:00 a.m. to 3:30 p.m., except for the third Wednesday of the month when the hours are 10:00 a.m. – 7:00 p.m.

You must make an appointment for immunizations. Call 233-6170, extension 4428, to make the appointment. Please take your child's immunization record with you to your appointment. If you do not have one, ask the clinic where your child receives medical care for a copy.

There is a $10 charge per immunization. Medical cards are accepted.

ST. CLAIR COUNTY HEALTH DEPARTMENT
19 PUBLIC SQUARE, SUITE 150
BELLEVILLE, IL 62220

618/233-7703 Administration & Health Promotion
618/233-6170 Clinic Services
618/233-7769 Environmental Services



State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments:

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature Title Date

Signature Title Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.

Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease Signature Title

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps** ☐Rubella ☐Varicella **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.

**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes / No	List:	MEDICATION (Prescribed or taken on a regular basis.)	Yes / No	List:

Diagnosis of asthma?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	Yes	No					
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. Parent/Guardian Signature Date			
Bone/Joint problem/injury/scoliosis?	Yes	No					

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI B/P

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes☐ No☐ And any two of the following: Family History Yes ☐ No ☐ Ethnic Minority Yes☐ No ☐ Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ At Risk Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date Result

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ Test performed ☐ Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm_____

Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears		Screening Result:	Gastrointestinal		
Eyes		Screening Result:	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐

Print Name (MD,DO, APN, PA) Signature Date

Address Phone

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten, second, sixth, and ninth grades of any public, private, or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign, and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that require attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy, and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print)

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)
Address: Street	City		ZIP Code
Name of School:	ZIP Code	Grade Level:	
Parent or Guardian: Last Name	First Name		

Select from the below general racial category which most clearly reflects the student's recognition of his or her community or with which the student most identifies.

☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Two or More Races

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To be completed by dentist

Date of Most Recent Examination:_____ (Check all services provided at this examination date)
☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit 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 **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). Please list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Dental Office Address: _____ Office phone number: _____

Signature of Dentist _____ Date _____

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than October 15th of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the child beginning school.

Student Name: _____ Birth Date: _____ Sex: ____ Grade: ____
(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: _____ Phone: _____
(Last) (First) (Area Code)

Address: _____ County: _____
(Number) (Street) (City) (Zip Code)

To Be Completed By Examining Doctor

Case History Date of Exam: _____

Ocular History: ☐ Normal or Positive for: _____
Medical History: ☐ Normal or Positive for: _____
Drug Allergies: ☐ NKDA or Allergic to: _____
Other Information: _____

Examination

Refraction:	Distance			Near
	Right	Left	Both	Both
Unaided Visual Acuity:	20 /	20 /	20 /	20 /
Best Corrected Visual Acuity:	20 /	20 /	20 /	20 /

Was refraction performed with cycloplegic agents? ☐ Yes ☐ No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	☐	☐	☐	
Internal Exam (media, lens, fundus, etc.)	☐	☐	☐	
Neurological Integrity (pupils)	☐	☐	☐	
Binocular Function (stereopsis)	☐	☐	☐	
Accommodation and Vergence	☐	☐	☐	
Color Vision	☐	☐	☐	
IOP (glaucoma)	☐	☐	☐	
Oculomotor Assessment	☐	☐	☐	
Other: _____	☐	☐	☐	

Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other: _____

Recommendations

1. Corrective Lenses: ☐ No ☐ Yes, glasses should be worn for: ☐ Constant Wear ☐ Near Vision ☐ Far Vision ☐ May Be Removed for Physical Education
2. Preferential seating recommended: ☐ No ☐ Yes Comments: _____
3. Recommend re-examination: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other _____
4. _____
5. _____

Print Name: _____
Optometrist or Physician Who Provides Eye Examinations

Address: _____

_____

Signature: _____
Optometrist or Physician Who Provides Eye Examinations

Phone: _____

Consent of Parent or Guardian
I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)