Ohio Valley ESC
Bright Beginnings Preschool

Enrollment Application

2021-2022 School Year

We are excited to learn with you!

This packet must be completed and all documentation submitted as soon as possible for your child to be considered for a classroom spot.

Questions?

email: diane.sullivan@ovesc.org - for SOLSD and Washington County

email :cathy.williams@ovesc.org - for Noble Local School District

Thank you for letting us serve your family!

★ ***Application will require extra postage - please use 3 stamps when mailing.***

Ohio Valley ESC
Bright Beginnings Preschool

revised:1/2021

Information:

Thank you for your interest in the Ohio Valley Educational Service Center's Bright Beginnings Preschool for students ages 3 through 5 years old. Children are placed in classes **once ALL required paperwork and documents are submitted.** We place students by date of application, then age of the child (older children are placed first) . We look forward to working with your family!

COST:

Bright Beginnings Preschool offers payment options based upon income and the number of days your child attends class per week/month. **The tuition is a flat rate and refunds are NOT given for absences, holidays and/or calamity days.** The maximum tuition rate possible is $140 for full time enrollment per month. Tuition assistance may be available upon completion of the enrollment application and submission of required proof of income documents. Tuition is due prior to starting preschool and is due on the first day of each month. May's tuition is due April 15.

REQUIRED DOCUMENTS FOR ADMISSION:

- Enrollment Application (all attached pages completed)
- Proof of Income (only if requesting tuition assistance) *please see 3 items needed on page 10
- Birth certificate
- Custody Papers (if applicable)
- Proof of Residency
- Immunization Record

We also require a Valid EMAIL ADDRESS

➔ *Please make sure to sign every signature line with an arrow beside it*

ALL REQUIRED INFORMATION IS MANDATORY to secure your child's spot in a preschool classroom.

Once our Marietta office receives your completed packet, we will notify you if there is an opening for your child.

Medical and Dental Forms(to be completed by a medical professional):

- Students have 30 days from classroom start date to submit both documents
- New forms must be submitted yearly (within 13 months of last visit due to insurance reasons)

MAIL TO:

BRIGHT BEGINNINGS PRESCHOOL 740-373-6669

1338 Colegate Drive, Marietta, OH 45750

Ohio Valley ESC
Bright Beginnings Preschool

N or R

Enrollment Application 2021-2022

CHILD'S NAME: (Please print entire application)

First:	Middle:	Last:

Child's Information:

Date of Birth:	Gender (please circle): Male Female
Foster Child: ____ Yes ____ No	Primary Language Spoken at Home:
Birthplace City:	Citizenship:
Mother's Maiden Name:	Country of Origin:

Racial Group/Local Ethnic Category: (check all that apply)
____ Asian ____ Black/African American ____ Hispanic
_____American Indian/Alaska Native ____ Multi-Racial
____ White ____ Native Hawaiian or Other Pacific Islander

Hispanic/Latino: ____ Yes ____ No

Did your child attend Bright Beginnings Preschool previous school year? : ____ Yes ____ No

Who Child Lives with/Residential Parent is: (circle all that apply): Mother Father Other

Father's Name:	Mother's Name:
Father's Address:	Mother's Address:
Father's Home #:	Mother's Home #:
Father's Cell #:	Mother's Cell #:
Father's Work #:	Mother's Work #:
Father's Email Address:	Mother's Email Address:
District of Residence:	District of Residence:

Is the parent an OVESC employee? _____ Yes _____ No

Preferred School – Please mark - 1st choice, 2nd choice, 3rd choice (Listed by District/School):

___ Belpre- Belpre
___ Fort Frye - Lowell
___ Frontier - Newport
___ Marietta - Marietta
___ Noble - Shenandoah
___ Switzerland of Ohio - Beallsville
___ Switzerland of Ohio - Powhatan
___ Switzerland of Ohio - River
___ Switzerland of Ohio - Skyvue
___ Switzerland of Ohio - Woodsfield
___ Warren - Warren
___ Wolf Creek - Waterford

Office Use Only	**Start Date:**	**SSID #:**
Dis. Condition:	**Services:**	**Preschool:**
Teacher:	**Poverty Level:**	**Typical Itinerant**
Entered EMIS √:	**By:**	

ENROLLMENT PACKET

Child History:

Did mother have any unusual physical/emotional illness during pregnancy? ____Yes ____No
If Yes, Please explain:

Age of mother when child was born: | Child's Birth Weight:

Child was: (please check) ____Full Term ____Early ____Late If applicable how early/late?

Did the child have any sickness/problems? ____Yes ____No If Yes, Please explain:

Please indicate at what age the child began the following activities:
Walked alone _____ Was Toilet Trained_____
Spoke in Sentences _____ Dressed Self_____

How does this child's development compare to other children (siblings or playmates)?
(please check) ____About the same as others ____Slower than others ____Faster than others

Please list/describe allergies (to medications, foods, plants, animals) and reactions to these items:

Please list/describe recommended treatment to these reactions:

Please list any severe injuries, illnesses, surgeries you child has had:

Injury/Illness/Surgery	Was the child hospitalized?	Age at time of event?
1.		
2.		
3.		

Please describe any medications, food supplements, modified diet or fluoride supplements, the child takes daily and/or frequently:

Medication/Supplements	Reason taken?	How often?
1.		

Please check ☐ any health conditions the child has/had:

- ☐ Abnormal spinal curvature
- ☐ Allergies/hay fever
- ☐ Anemia
- ☐ Anaphylactic reaction
- ☐ Asthma or wheezing
- ☐ Attention Deficit Disorder
- ☐ Behavior problems
- ☐ Birth/Congenital malformation
- ☐ Cancer – Type_____
- ☐ Chicken pox – date_____
- ☐ Chronic diarrhea/constipation
- ☐ Chronic ear infections
- ☐ Concern about relationships
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eczema/Chronic skin condition
- ☐ Emotional problems
- ☐ Eye problems or poor vision
- ☐ Frequent headaches
- ☐ Frequent sore throats
- ☐ Heart disease – type _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hyperactivity
- ☐ Kidney disease – type _____
- ☐ Measles
- ☐ Meningitis or Encephalitis
- ☐ Mumps
- ☐ Near-drowning/near suffocation
- ☐ Nervous twitches or tics
- ☐ Poisoning
- ☐ Rheumatic fever
- ☐ Seizure disorder/epilepsy
- ☐ Sickle cell disease
- ☐ Speech difficulties
- ☐ Stool soiling
- ☐ Toothaches/dental problems
- ☐ Urinary tract infections
- ☐ Wetting during day or night
- ☐ Other _____

ENROLLMENT PACKET

Emergency Contacts: Please list 3 people to be contacted in the event of an emergency IF the parent cannot be contacted.		
Contact #1:	Contact #2:	Contact #3:
Street Address	Street Address	Street Address
City State Zip	City State Zip	City State Zip
Relationship to Child:	Relationship to Child:	Relationship to Child:
Phone #	Phone #	Phone #
Cell #	Cell #	Cell #
Work #	Work #	Work #

Child's Name: First Middle Last		
Authorization to Release Child: My child may be released to his/her parent/guardian AND the following people only (without prior written authorization).		
Name	Relationship to Child	Phone #
My child may **NOT** be released to the following individuals: Please attach a copy of divorce decree and/or restraining order if applicable.		
Name	Relationship to Child	Please note any special circumstances of which the staff should be aware:

Please indicate if the family is involved with any of the following community services:	
Speech Therapy: __Yes __No If yes, where?	Head Start/Early Head Start: __Yes __No
Occupational Therapy: __Yes __No If yes, where?	Help Me Grow/Early Intervention: __Yes __No
Physical Therapy: __Yes __No If yes, where?	Job & Family Services: __Yes __No If yes, caseworker?
Hearing Services: __Yes __No If yes, where?	Child/Protective Services: __Yes __No If yes, caseworker?
Vision Services: __Yes __No If yes, where?	Preschool/Day Care: __Yes __No If yes, where?
Mental Health/Individual/Family Counseling Services: __Yes __No If yes, where?	
Physician's Name:	Dentist's Name:
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone #	Phone #
Fax #	Fax #

ENROLLMENT PACKET

Things I would like my child's preschool teacher to know:
My child is: ____very active ____normally active ____not very active
My child prefers playing: ____alone ____with other children
My child has become violent or acted out in the following manner towards other children or adults. (please check all that apply) ____Hitting ____Kicking ____Biting ____Fighting ____Scratching ____My child has never become violent or acted out toward others.
If my child becomes upset, they calm themselves by:_____
I have concerns about how my child gets along with other children. ____Yes ____No If yes, please explain:
My child's favorite color is: _____ My child's favorite book is: _____ My child's favorite food is: _____ My child's favorite toy is: _____ My child likes to: ____Listen to stories ____Play inside ____Play outside ____Draw/Color ____Play quite games ____Play pretend/make believe ____Other _____
I would like for my child to be able to:
Please add any comments or concerns that you have about your child's health, development, behavior, family or home life that you would like the school to be aware of.

Authorization for School District Transportation: Please initial on the appropriate line below.
____Yes, I grant permission for my child to be transported to/from school and/or field trips by the school district bus/van, if appropriate. Furthermore, I grant permission for my child to participate in walking field trips that are close to my child's school.
____No, I DO NOT grant permission for my child to be transported to/from school and/or field trips by the school district bus/van, if appropriate. Furthermore, I DO NOT grant permission for my child to participate in walking field trips that are close to my child's school.

Authorization for Annual Class Roster: Each year we prepare a roster for each group of children in our program. This roster will not be shared with any person other than the parents of children enrolled in our program. I authorize the following information to be listed on the Class Roster (please check): My Child's Name: ____Yes ____No Parent/Guardian Home Phone Number ____Yes ____No Parent/Guardian Name: ____Yes ____No Parent/Guardian Cell Phone Number ____Yes ____No

ENROLLMENT PACKET

Authorization for Picture Publication: Please initial on the appropriate line below.

____Yes, I grant permission for my child to have his/her picture taken for possible publication (newspaper, brochure, website, or other social media etc.) Furthermore, I grant permission for my child to be videotaped and understand that it may be used for professional development and/or advertising purposes.

____No, I DO NOT grant permission for my child to have his/her picture taken for possible publication (newspaper, brochure, website, etc.) Furthermore, I DO NOT grant permission for my child to be videotaped and understand that It may be used for professional development and/or advertising purposes.

As the parent/guardian of _____, I authorize the information as listed above *(Authorization to Release Child, Authorization for School District Transportation, Authorization for Annual Class Roster,* and *Authorization for Picture Publication).*

➔ _____
Parent/Guardian Printed Name

➔ _____
Parent/Guardian Signature Date

Authorization for Participation and Release of Information:

My child has permission to participate in any health/developmental/academic screenings and assessments (which may include, but are not limited to physical, dental, vision, hearing, speech, mental health, lead, iron, height, weight, developmental, etc.) that are conducted through the Ohio Valley Educational Service Center, Bright Beginnings Preschool and other community agencies.

The Ohio Valley Educational Service Center has my permission to conduct assessments as required by the Ohio Department of Education (which may include, but are not limited to the Early Learning Assessment, Child Outcomes Summary Process, etc.) I understand that my child's teacher/specialist will provide feedback regarding the assessment to myself and other staff members working with my child. Additionally, I grant permission for the preschool administration to report the results of these assessments electronically, as required by law, to the Ohio Department of Education.

I understand that there may be some screenings/assessments that are not able to be conducted at my child's preschool setting and that I may need to obtain these screenings/assessments through my child's physician, dentist, local health department or other community agencies. I also understand that it may be necessary to obtain follow-up care for my child based on the results of the health/developmental assessments performed and that it will be my responsibility to do so.

As the parent/guardian of _____, by signing, I am verifying that I have read, understand and agree with the above information.

➔ _____
Parent/Guardian Printed Name

➔ _____
Parent/Guardian Signature Date

Ohio Department of Job and Family Services
Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

Tell us about you (the applicant)

First Name	MI	Last Name	
Address			Today's Date
City	State	County	Zip Code
Phone Number ( )	Additional Phone Number ( )	E-mail Address	

Tell us about the people in your home

Name *(First, Middle, Last)*	Relationship to You *(spouse, son, friend, etc.)*	Race	Hispanic or Latino *Y or N*	Spoken Language	Date of Birth	Gender *M or F*	U.S. Citizen *Y or N*
	Self	☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					

ENROLLMENT PACKET

Tell us about your needs for your child(ren)			
Child 1 **Name**	**Provider Name and Address**	**Child's Needs** Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe:	**What hours/days do you need services? (i.e. child care or preschool)** ***Check all that apply*** ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name			**What is the child's home school district?**
Child's City of Birth			
Child 2 **Name**	**Provider Name and Address**	**Child's Needs** Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe:	**What hours/days do you need services? (child care or preschool)** ***Check all that apply*** ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name			**What is the child's home school district?**
Child's City of Birth			
Child 3 **Name**	**Provider Name and Address**	**Child's Needs** Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe:	**What hours/days do you need services? (child care or preschool)** ***Check all that apply*** ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name			**What is the child's home school district?**
Child's City of Birth			

Tell us about your finances

Will you or the people in your home receive income this month? ☐ Yes ☐ No

Income refers to all the money that you and the people in your home receive such as earnings from employment, child/spousal/medical support, disability benefits, retirement benefits, Workers' Compensation, Social Security, SSI, Veterans Benefits, etc.

If yes, please complete the table below.

Name	Type of Income	Amount of Income *(before taxes)*	How Often Received *(weekly, bi-weekly, etc)*	Date Last Received	Work or School Schedule *(please list times)*
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____

Do you or anyone in your household pay Child or Spousal Support? ☐ **Yes** ☐ **No**

How Much?

Signature of Applicant	Date

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

2021 FEDERAL POVERTY GUIDELINES

OHIO VALLEY EDUCATIONAL SERVICE CENTER

1338 Colegate Drive, Marietta, OH 45750 / 740-373-6669

OFFICE USE ONLY

Size of Family Unit	100% Poverty Level	115% Poverty Level	125% Poverty Level	187.5% Poverty Level	200% Poverty Level
1	$12,880	$14,812	$16,100	$24,150	$25,760
2	$17,420	$20,033	$21,775	$32,663	$34,840
3	$21,960	$25,254	$27,450	$41,175	$43,920
4	$26,500	$30,475	$33,125	$49,688	$53,000
5	$31,040	$35,656	$38,800	$8,200	$62,080
6	$35,580	$40,917	$44,475	$66,713	$71,160
7	$40,120	$46,138	$50,150	$75,225	$80,240
8	$44,600	$51,359	$55,825	$83,738	$89,200
Family units with more than 8 members	Add $4,540 for each additional member	Add $5,221 for each additional member	Add $5,675 for each additional member	Add $8,513 for each additional member	Add $9,080 for each additional member

Name of Student (Please Print) _____ DOB:_____

Parents: Due to state reporting requirements, we are required to gather income information for your family. This information in no way will be used to determine if your child qualifies for services and/or what services your child will receive. Simply find the number of family members that are in your household, and determine the dollar amount that is closest to your family's gross income. Please circle the dollar amount in that particular row that most closely reflects the gross income for your family.

Request for Tuition Assistance: Please Provide ONE proof of income.

* 3 most recent pay stubs **OR**
* A statement from Ohio Department of Job & Family Services caseworker stating your poverty level **OR**
* A copy of your most recent tax return

➔ _____Parent/Guardian Signature

OR

If you would like, you may refuse to provide this information. Simply sign at the bottom of this page that you would not like to release this information. If you have any questions, please contact the OVESC office at 740-373-6669. I _____(printed name of parent), am choosing NOT to provide my family's gross income to the OVESC Preschool. I understand that if I were to provide this information, it would not in any way determine the type or amount of services that my child would receive.

Waiver of Tuition Assistance:

◯ I hereby waive my right to be considered for free and reduced tuition. I agree to pay full tuition if accepted in the preschool program. I understand this waiver neither hampers nor enhances the chances of my application being accepted. I understand that if my financial situation changes, I may request a review of my income determination and verification and if my income is eligible, qualify for tuition assistance.

➔ _____ Parent/Guardian Signature

McKinney-Vento

Student Residency Questionnaire

The answers to this residency questionnaire help in determining eligibility of services for families in transition that may be received through the federal McKinney-Vento Assistance Act U.S.C. 11435.

Child's Name: _____

Do you rent or own your home? (Lease or Mortgage is in your name) ☐ **Yes** ☐ **No**

Do you live with another person or persons by choice in housing that is fixed (does not move), regular (always), and adequate (safe, working utilities etc.) ☐ **Yes** ☐ **No**

If you answered No to either of the ABOVE, please complete the remainder of the form.

*If you answered **YES to both** questions you may **stop here and return this form** to the registrar.*

If your answer was ***NO*** to either question above ***PLEASE COMPLETE*** the remainder of this form:

1. **Please check the mark the appropriate answer that indicates your current living arrangement:**
   - **(A) Sheltered:**
     - ☐ In an **emergency/transitional shelter** due to loss of housing, economic hardship, or similar reason
   - **(B) Unsheltered:**
     - ☐ In a **vehicle** of any kind, **campground, park, abandoned building** or **public place** not meant for sleeping
     - ☐ **Substandard housing** (no electricity, running water, health code violation, lack of bathroom or cooking capabilities, etc.)
   - **(C) Doubled Up:**
     - ☐ **Temporarily with another family** due to loss of housing, economic hardship, or similar reason
   - **(I) Doubled Up:**
     - ☐ In a **hotel/motel** due to loss of housing, economic hardship or similar reason
   - **(Y)** ☐ **Unaccompanied youth** not with an adult/legal guardian (couch surfing)

   ☐ **Other (please explain:**

2. **Current nighttime residence:**

3. **How long have you lived in this arrangement?**

List ALL adult caregivers responsible for the above child(ren)	**Relationship to Child(ren)**	**Main Phone Number**	**Other Contact Number**

List ALL children in the family (Including children birth to 18). If more than 4 children in the home, please use reverse side of form.	**Sex**	**Age**	**Grade**	**School where student is currently enrolled or is enrolling into:**	**Last school where student was enrolled:**
	☐M ☐ F				
	☐M ☐ F				

I have answered all questions to the best of my ability and certify the information presented is true and accurate.

➔ _____

Parent/Guardian Signature Date

The medical and dental forms that need completed by your CHILD'S PHYSICIAN are attached.

These forms need to be completed and returned within <u>30 days</u> of your child beginning preschool.

Please detach these two forms and return to the address below WHEN COMPLETE:

Ohio Valley Educational Service Center
1338 Colegate Drive
Marietta, Ohio 45750

Fax: 1-740-376-5809

Thank you!

Ohio Valley ESC
Bright Beginnings Preschool

1338 Colegate Drive, Marietta, Ohio 45750
PH: 740-373-6669, FAX: 740-376-5809

Child Medical Statement

Child's Name:_____ DOB:_____ Child's School_____

I authorize my physician _____ to release the completed medical statement to Bright Beginnings Preschool. Please fax to: 740-376-5809.

➔ _____

Parent/Guardian Signature Date

Required for ALL children enrolled in Preschool Special Education and Early Childhood Education Grant Programs.

Height_____Weight____ Allergies:_____ History:_____

	Normal	Abnormal		Normal	Abnormal
General Appearance			Glands (Lymphatic/Thyroid)		
Posture, Gait			Nose, Mouth Pharynx		
Speech			Teeth, Gums		
Head			Heart		
Skin			Lungs		
Eyes			Abdomen		
*symmetrical light reflex			Genitalia		
*external aspects			Bones, Joints, Muscles		
Development			Extremities		
Ears			Muscular Coordination		
Social/Emotional			Neurological (gross, fine, sensory motor)		

Assessments/Screening	Completed (please circle one)	Date	Assessments/Screening	Completed (please circle one)	Date
Lead	Yes No		Vision screen	Yes No	
Hemoglobin/Hematocrit	Yes No		Hearing screen	Yes No	

Medications:_____

Limitations or health conditions (including food supplements/ modified diets, activity restrictions, health services needed at school):_____

IMMUNIZATION RECORD (Required by Section 3313.671 of Revised Code and for attendance in preschool program) **Please attach a copy**

*Exempt from immunizations: _____ Religious conviction ____ Health concern ____ Other

I have examined this child and found that he/she is in suitable condition for participation in group care.

*_____

Signature Physician/Physician's Assistant/Advanced Practice Nurse **Printed Name** **Date of example**

Ohio Valley ESC
Bright Beginnings Preschool
1338 Colegate Drive, Marietta, Ohio 45750
PH: 740-373-6669, FAX: 740-376-5809

Dental Exam

Parent/Guardian: To ensure good dental health, every child needs to have a dental exam. This checkup may be done by your own dentist. If you/your child do not have a primary dentist, please call 740-373-6669 for the names/phone numbers of local dentists taking new patients.

Child's Name_____ Date of Birth_____

Parent/Guardian Name_____ Phone #_____

Address_____ Child's School_____

I authorize my dental clinic to release this completed form to Bright Beginnings Preschool. Please fax to 740-376-5809.

➔ _____

Parent/Guardian Signature Date

To be completed by the dentist:

This child received the following treatment in my office:

- ☐ **Dental Exam**
- ☐ **X-Rays Taken**
- ☐ **X-Rays Read**
- ☐ **Cleaning**
- ☐ **Topical Fluoride Application**
- ☐ **Sealants**
- ☐ **Fillings**
- ☐ **Emergency Treatment**
- ☐ **Extractions**
- ☐ **Steel Crowns**
- ☐ **Space Maintainers**
- ☐ **Other – Please explain:** _____

_____

_____

☐**ALL TREATMENTS ARE COMPLETE.**

☐**ALL TREATMENTS ARE NOT COMPLETE. THE FOLLOWING IS STILL NEEDED:**

- ☐ **Take X-rays**
- ☐ **Read X-rays**
- ☐ **Topical Fluoride Application**
- ☐ **Sealants**
- ☐ **Fillings**
- ☐ **Extractions**
- ☐ **Steel Crowns**
- ☐ **Space Maintainers**
- ☐ **Other – Please explain:** _____

_____

_____

Dentist's Printed Name **Dentist's Signature** **Telephone #** **Date of Exam**