SUNSHINE SCHOOL REGISTRATIONS PACKET

Dear Parents,
The following documents are needed to complete your child's preschool folder.

1. ENROLLMENT/EMERGENCY INFORMATION SHEET
2. MEDICAL RELEASE
3. SUNSHINE SCHOOL EMERGENCY CARD (gray card)
4. HOUSEHOLD AND INCOME FORM
5. COMMONWEALTH OF KENTUCKY CERTIFICATE OF IMMUNIZATION STATUS FORM
6. COPY OF BIRTH CERTIFICATE
7. SOCIAL SECURITY CARD (COPY)
8. PREVENTATIVE HEALTH CARE EXAMINATION FORM (Include vision and hearing screening results)
9. KENTUCKY EYE EXAMINATION FORM
10. KENTUCKY DENTAL SCREENING FORM

WE ARE REQUIRED BY LAW TO HAVE THESE PAPERS PLEASE TAKE CARE OF THIS AS SOON AS POSSIBLE.

Student Enrollment/Emergency Information - PLEASE USE BLUE OR BLACK INK

Legal Last Name	First Name	Middle Name	Returning students: Check here if there is any NEW INFORMATION this year.

Grade Level fc 2021/22	Date Of Birth	Social Security Number	Sex	Home Phone	Last School Attended

Physical/911 Address (where student resides)

(Check only if applicable) ☐Shelter ☐Motel ☐Housing shared with friends or family members

Mailing Address (if different)

Student Ethnicity Hispanic/Latino ☐ yes ☐ no

Race Check ALL that apply ☐White ☐Black orAfrican American ☐Asian ☐Native Hawaiian or other Pacific Islander ☐American Indian or Alaskan Native

U S Citizen ☐Yes ☐No If no, country of residence _____ ☐ Migrant ☐ Immigrant ☐ Refugee (Country) _____

County of Origin _____ First language your child began to speak _____

What language does your child speak at home? _____ Primary language used in the home _____

Please Circle Do you have a computer in your home? YES NO	Can you access the internet from your home computer? YES NO	Email Address

Please Circle

1 How will your child arrive at school in the mornings? Bus Car Walker Morning Pick Up Location _____

2 How will your child return home in the afternoons? Bus Car Walker Evening Drop Off Location _____

Please complete IF your child rides the bus

Parents/Guardians Living in the same Household as Student (Student's Primary Household)

Living with (check one) ☐ Both Parents ☐ Father Only ☐ Mother Only ☐ Foster Parent ☐ Guardian
☐ Mother/StepFather ☐ Father/Stepmother ☐ Relative ☐ Other

Father or Male Guardians Name	Birthdate	Place Employed	Work Phone	Cell Phone
Mother or Female Guardians Name	Birthdate	Place Employed	Work Phone	Cell Phone

LIST ALL OTHERS THAT LIVE IN THE HOME

Name	Birthdate	Relationship to Student	School Attending	Grade
1				
2				
3				
4				

Emergency Information List two persons (other than yourself) usually available during the school day who have agreed to care for and pick up (provide transportation) for your student if he/she becomes ill and you cannot be reached We will attempt to contact parents first.

Name	Relationship to student	Daytime Phone Number
Name	Relationship to student	Daytime Phone Number

1 Are there circumstances about the custody of your child which limit the sharing of records, picking up of your child, etc? yes☐ no☐

2 Is there anyone that CANNOT pick up your child? Please list name & explain

(It is the parent's/guardian responsibility to keep the school informed of changes in custody by providing the office current and complete legal documents each year and after any changes)

OTHER IMPORTANT INFORMATION – Please list below any medical conditions, allergies, etc (Students with health problems, food allergies, or taking medications on a regular basis are required to fill out additional forms available in the school nurse's office)

Photo Release. Your child may be photographed or videotaped for inclusion in the district publications and website, or in newspapers or magazines, articles, or letters relating to school activities
Please check ☐ yes, I give my permission ☐ no, I do not give my permission

Residency Verification As the parent/or legal guardian, I understand it is MY responsibility to notify the school of any move or change of physical address Any misrepresentation of the physical (911) address may result in my child losing the privilege of attending Harlan Independent Schools and I will be legally responsible for payment of tuition for the period of misrepresentation

1 Does the student reside in the Harlan Independent School District? ☐yes ☐no

2 If no, in which school district does the student reside?

PARENT/GUARDIAN SIGNATURE _____ Date _____

MEDICAL RELEASE

In the unlikely event that an accident should occur at school, we would not wish to delay medical treatment for your child. However, few doctors or hospitals will treat a child without parental consent. We will need signed permission to have medical treatment rendered to your child.

I, _____,

parent/guardian of _____,
who is enrolled as a student at the Harlan City School - Preschool Program, authorize a representative of the school to take my child to a doctor or emergency room should medical treatment be required during the time that my child is in attendance at the preschool.

I understand that if medical attention is required that I, or other persons listed below, will be notified by telephone. I further understand that once the notification has occurred, the responsibilities of the school for the medical treatment of my child shall cease.

_____
Parent/Guardian

_____
Emergency Number

Witness _____

Date _____

Persons to notify in the event of an emergency:

Name _____ Phone No. _____

Name _____ Phone No. _____

Name _____ Phone No. _____

Name _____ Phone No. _____

Insurance Firm _____

Medical Card No. (if applicable) _____

It is the parents'/guardians' responsibility to keep all telephone numbers current.

SUNSHINE SCHOOL
EMERGENCY CARD

STUDENT'S NAME _____ BIRTHDATE _____

MAILING ADDRESS _____

STREET ADDRESS (Give exact directions to your home) _____

_____

_____

HOME PHONE _____ CELL PHONE _____

PAGER _____ E MAIL ADDRESS _____

FATHER'S DAYTIME PHONE _____ MOTHER'S DAYTIME PHONE _____

LIST 3 OTHER PEOPLE TO CALL IN CASE OF EMERGENCY:

NAME _____ PHONE _____

NAME _____ PHONE _____

NAME _____ PHONE _____

CHILD'S DOCTOR _____ PHONE _____

LIST ANY PHYSICAL HANDICAP, ALLERGIES OR ILLNESS OF STUDENT _____

_____

SIGNATURE OF PARENT / GUARDIAN _____

(Over)

These People CAN Pick Up My Child:

	Name	Phone Number
1)		
2)		
3)		
4)		

CAN NOT Pick Up My Child:

	Name	Phone Number
1)		
2)		
3)		
4)		

CHILD PHOTO

HARLAN INDEPENDENT SCHOOLS

Dear Parent/Guardian:

Our school is participating in the Community Eligibility Provision (CEP) under the National School Lunch Program. The CEP provision is available to schools with a high percentage of economically disadvantaged students. Under CEP all students receive a breakfast/lunch at no charge for the entire school year. However, to determine eligibility to receive additional benefits for your child(ren) you will need to complete a household and income form.

1. DO I NEED TO FILL OUT A FORM FOR EACH CHILD? No. *Use one Household and Income Form for all students in your household.* We cannot use a form that is incomplete, so be sure to fill out all required information. Return the completed form to: **Emily Clem 420 East Central ST Harlan, KY 40831 606-573-8700 Ext. 6.**

2. MY CHILD(REN) ALREADY RECEIVE MEALS AT NO CHARGE AT **Harlan Independent School.** WHY SHOULD I COMPLETE THIS FORM AS WELL? Many state and federal programs use socioeconomic status (that is, household and income information) to determine eligibility for their programs. In addition, the primary state funding calculation uses socioeconomic status. By completing this form your school is able to determine your child(ren)'s eligibility for additional programs. Regardless, your child(ren) will still receive meals at no charge at **Harlan Independent School.**

3. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD? You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro-rated share of expenses), do not include them.

4. WHAT IF MY INCOME IS NOT ALWAYS THE SAME? List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only made $900, put down that you made $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

5. WE ARE IN THE MILITARY. DO WE INCLUDE OUR HOUSING ALLOWANCE AS INCOME? If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.

6. MY SPOUSE IS DEPLOYED TO A COMBAT ZONE. IS HIS/HER COMBAT PAY COUNTED AS INCOME? No, if the combat pay is received in addition to his/her basic pay because of his/her deployment and it wasn't received before s/he was deployed, combat pay is not counted as income. Contact your school for more information.

If you have other questions or need help, call **606-573-8700 Ext. 6.**

Sincerely,

Emily Clem

INSTRUCTIONS FOR APPLYING

Part 1: All Household Members (**a household member is any child or adult living with you**): All applicants should complete this part. List the name of each household member, the name of the school each child attends, and the child's grade. If the child is a foster child, check the box for foster child. If a household member has no income, check the box for no income. All household members, including foster children, should be included here. If you need additional space, attach a separate piece of paper.

If anyone in your household receives benefits from KTAP or SNAP benefits, please follow these instructions.

Part 2: List the case number for one household member (adult or child) who receives **KTAP** or **SNAP** benefits.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form.

If your child is homeless, a migrant or a runaway, follow these instructions.

Part 2: Skip this part.
Part 3: Check the appropriate category and call **Emily Clem.**
Part 4: Skip this part.
Part 5: Sign the form.

If you have foster child(ren) only, follow these instructions. You do not need to fill out a separate form for each foster child in your household. (If there are both foster children and non-foster children in your household, follow the instructions below for All Other Households).

If all children in the household are marked as foster children in Part 1:
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form.

ALL OTHER HOUSEHOLDS, including WIC households, households with non-foster children and households with both foster children and non-foster children, follow these instructions.

Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Follow these instructions to report total household income from **this month or last month.**

- **Section 1–Name:** List all household members who have income.
- **Section 2 –Gross Income and How Often It Was Received:** List the income for each household member. Check the box to tell us how often the person receives the income—weekly, every other week, twice a month, or monthly.
    - **Earnings from work**: List the **gross income,** not the take-home pay. Gross income is the amount earned *before* taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. Net income should *only* be reported for self-owned business, farm, or rental income.
    - **Welfare, Child Support, Alimony**: List the amount each person receives, and check the box to tell us how often.
    - **Pensions, Retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits**. List the amount each person receives, and check the box to tell us how often they receive it.
    - **All Other Income**: List Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income received weekly, every other week, twice a month, or monthly. Do not include income from KTAP, SNAP, WIC, federal education benefits and foster payments received by your family from the placing agency.
    - If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Part 5: An adult household member must sign the form. Please include your address and phone number in the event the FRAM Coordinator has a question about your information.

HOUSEHOLD AND INCOME FORM

Harlan Independent School is participating in the Community Eligibility Provision (CEP) under the National School Lunch Program. Under CEP, **all** children in the school will receive a breakfast/lunch at no charge regardless of income or completion of this form. However, to determine your child(ren)'s eligibility for various additional state and federal program benefits, please complete, sign and return **a single application per household** to Harlan Independent School.

PART 1: ALL HOUSEHOLD MEMBERS

Names of all people living in your household (First, Middle Initial, Last)	School the child attends, or indicate "NA" if household member is not in school	Grade Level	*Check if a foster child (legal responsibility of the state welfare agency or court). If all children listed below are foster children, skip to Part 5 to sign this form.*	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	

PART 2: BENEFITS – SNAP/KTAP ONLY

If any member of your household receives **SNAP** or **KTAP**, provide the name and case number for the person who receives benefits and **skip to part 5**. If no one receives these benefits, go to Part 3.

NAME: ______________________________

CASE NUMBER (REQUIRED): ______________________________

PART 3: HOMELESS, MIGRANT, RUNAWAY STATUS

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call Emily Clem

HOMELESS ☐ MIGRANT ☐ RUNAWAY ☐

PART 4: TOTAL HOUSEHOLD GROSS INCOME (before deductions). List all income on the same line as the person who receives it. Check the box for how often it is received. Record each income only once. If you provided a case number in Part 2, you do not need to provide income information. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

☐ **DECLINE TO PROVIDE INCOME** – Check this box if you don't wish to provide your income information, your SES status will automatically be "Paid".

1. NAME (List only household members with income, including any students in the home who have income)	**2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED** Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Public assistance, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, Social Security, SSI, VA benefits, All Other Income	Weekly	Every 2 Weeks	Twice Monthly	Monthly
(Example) Jane Smith	$200	☒	☐	☐	☐	$150	☐	☒	☐	☐	$0	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5: SIGNATURE (ADULT HOUSEHOLD MEMBER MUST SIGN)

I certify (promise) that all information on this form is true and that all income is reported. I understand that the school will get state and federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my child(ren) may lose benefits.

Sign here: ______________________ Print name: ______________________ Date: ____________

Address: ______________________ City: ______________________ State: ________ Zip Code: ________

Phone Number: ______________________ Cell Phone Number: ______________________

Non Discrimination Statement: In accordance with Federal Law and U.S. Department of Education policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, gender identity, age, or disability. To file a complaint of discrimination, write U.S. Department of Education, Office for Civil Rights, The Wanamaker Building, 100 Penn Square East, Suite 515, Philadelphia, PA 19107-3323 or call (215) 656-8541 (Voice). Individuals who are hearing impaired or have speech disabilities may contact U.S. DOE through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). The U.S. Department of Education is an equal opportunity provider and employer.

Privacy Notice

The Kentucky Department of Education is requiring schools to collect the information on this form. You do not have to give this information, but if you do not, we cannot determine your child's eligibility for additional benefits under state and federal programs. We will hold the information you provide us as private and confidential to the extent required by law. However, we will share your socioeconomic status with various state and federal programs to help them evaluate, fund, or determine benefits for their programs, with auditors for program reviews, and with law enforcement officials to help them look into violations of program rules. Regardless, all students enrolled in a Community Eligibility Provision school will receive meals at no charge.

HOUSEHOLD CHECKLIST

- ☐ Have you included all your children as household members?
- ☐ For each household member receiving income, is the frequency checkbox checked?
- ☐ Have you signed the form?

DO NOT FILL OUT THIS PART. THIS IS FOR SCHOOL USE ONLY

Annual Income Conversion: Weekly x 52; Every 2 Weeks x 26; Twice A Month x 24; Monthly x 12

Total Income: _____ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice A Month ☐ Month ☐ Year Household size: _____

Categorical Eligibility: _____ Date Withdrawn: _____ SES Code: Free_____ Reduced_____ Paid_____

Reason: _____

FRAM Coordinator: _____ Date: _____

COMMONWEALTH OF KENTUCKY
CERTIFICATE OF IMMUNIZATION STATUS

Certificate Issuing Office Name and Address

Name of Child: _____ (Last) _____ (First) _____ (Middle) _____ (Suffix) Birthdate: _____ (MM/DD/YYYY)

Name of Parent: _____ (Last) _____ (First) _____ (Middle) _____ (Suffix)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

VACCINE	DOSE 1 MM/DD/YYYY	DOSE 2 MM/DD/YYYY	DOSE 3 MM/DD/YYYY	DOSE 4 MM/DD/YYYY	DOSE 5 MM/DD/YYYY
Hepatitis B	/ /	/ /	/ /	/ /	
Alt. Adult Hepatitis B[1]	/ /	/ /			
DTaP/DTP/DT[2]	/ /	/ /	/ /	/ /	/ /
Hib[3]	/ /	/ /	/ /	/ /	
Pneumococcal (PCV13)	/ /	/ /	/ /	/ /	
Polio	/ /	/ /	/ /	/ /	
MMR	/ /	/ /	/ /	/ /	/ /
Varicella	/ /	/ /			
Hepatitis A	/ /	/ /	Had Chickenpox or Zoster Disease Yes No		
Meningococcal	/ /	/ /			/ /
Td	/ /	/ /			
Tdap	/ /	/ /			
Rotavirus	/ /	/ /			
HPV	/ /	/ /	/ /		
Men B	/ /	/ /	/ /		
Pneumococcal (PPSV23)	/ /	/ /	/ /		

[1]Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age. [2]DTaP, DTP, or DT. [3]Hib not required at 5 years of age or more.

☐ This child is current for immunizations until ___/___/____, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

☐ This child is not up-to-date at this time. This certificate is valid until ___/___/____, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

Reason child is not up-to-date:

☐ Provisional Status - Child is behind on required immunizations.

☐ Medical Exemption - The following immunizations are not medically indicated: _____

If Medical Exemption, can these vaccines be administered at a later date? No: _____ Yes: _____ Date: ___/___/___

☐ Religious Objection

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

_____ _____

(Signature of physician, APRN, PA, pharmacist, LHD administrator, RN or LPN designee) (Date)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

Kentucky

EPID-230 (Rev 1/2017)

KDE/DDS

KDESHS002

PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE INDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____ **Gender:** M F **Grade:** _____

Date of Birth: _____ **Age:** _____ **yrs** _____ **months** **Preferred Language:** _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies: _____

Current Prescribed Medications to be taken daily at school: _____

Significant Historical Information: _____

SCREENING RESULTS:

BP: _____ **Height:** _____ **(ft.)** _____ **(inches)** **Weight** _____ **lbs.** **BMI** _____ **BMI%** _____

Vision	**Right 20/**_____	**Passed** ☐	**Hearing – Right**	**Passed** ☐	**Failed** ☐	**Referred** ☐	
	Left 20/_____	**Failed** ☐ **Referred** ☐	**Hearing - Left**	**Passed** ☐	**Failed** ☐	**Referred** ☐	

Optional: **Hct/HGB:** _____ **Lead:** _____ **Urinalysis:** _____

General appearance	☐ **Normal** ☐ **Abnormal**	_____	**Refer/Tx:** _____
Gross dental (teeth and gums)	☐ **Normal** ☐ **Abnormal**	_____	**Refer/Tx:** _____
Head/scalp/skin	☐ **Normal** ☐ **Abnormal**	_____	**Refer/Tx:** _____
Eyes/Ears/Nose/Throat	☐ **Normal** ☐ **Abnormal**	_____	**Refer/Tx:** _____
Chest/Lungs/Heart	☐ **Normal** ☐ **Abnormal**	_____	**Refer/Tx:** _____
Abdomen/Genitalia	☐ **Normal** ☐ **Abnormal**	_____	**Refer/Tx:** _____
Extremities/back	☐ **Normal** ☐ **Abnormal**	_____	**Refer/Tx:** _____
Neuro	☐ **Normal** ☐ **Abnormal**	_____	**Refer/Tx:** _____

(Over)

This child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

☐ This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

☐ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☐ SCHOOL READINESS
- Establish routines
- After-school care/activities
- Friends
- Bullying
- Communicate with teachers

☐ MENTAL HEALTH
- Family time
- Anger management
- Discipline for teaching not punishment
- Limit T.V., computer

☐ NUTRITION AND PHYSICAL ACTIVITY
- Healthy weight
- Well-balanced diet, including breakfast
- Fruits, vegetables, whole grains, dairy
- 60 minutes of exercise/day

☐ ORAL HEALTH
- Regular dentist visits
- Brushing/Flossing
- Fluoride

☐ SAFETY
- Sexual safety
- Pedestrian safety
- Safety helmets
- Swimming safety
- Fire escape plan
- Smoke/carbon monoxide detectors
- Guns
- Sun
- Appropriately restrained in all vehicles

Additional comments or recommendations: _____

Signed: _____ Date: _____

Physician/APRN/PA/EPSDT Provider

Address: _____ Telephone: _____

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION

Date of student's enrollment: _____ **Date of Vision Examination:** _____

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

CASE HISTORY

Date of Exam: _____

Ocular History: Normal or Positive for: _____

Medical History: Normal or Positive for: _____

Drug Allergies: NKDA or Allergic to: _____

Family Ocular and Medical History: ☐ Amblyopia ☐ Strabismus ☐ Glaucoma ☐ Diabetes

Other: _____

Other Pertinent Information: _____

Refraction with cycloplegic? (Please indicate one.) ☐ YES ☐ NO

	OD	OS
Unaided Acuity	20/	20/
Best Corrected Acuity	20/	20/

Type of Examination	Normal	Abnormal	Notable to Assess
External Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc)			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

Diagnosis:

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

Other: _____

Recommendations:

1 Glasses prescribed: ☐ YES ☐ NO
2 _____
3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

- ☐ Educate (parents/patients) about eye/vision disorders and needed vision care
- ☐ Counsel (parents/patients) regarding eye safety
- ☐ Stress importance of early, preventative eye care
- ☐ Recommend re-examination, as appropriate

Signed: _____ Date: _____
Optometrist/Ophthalmologist

Address: _____ Telephone: ( )

OAS/DSS

Kentucky Dental Screening/Examination Form for School Entry

KDESHS005

Kentucky law, KRS 156.160(l), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanc registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five or six (6) year old is enrolled in public school.

Student Name: _____
Last First Middle

Birth date: ___/___/___ Gender: ☐ 0 Male ☐ 1 Female

Parent or Guardian: _____
Name Relationship

Address: _____ City: _____

Phone Number: _____ School: _____

Date of Exam/Screening ___/___/___

Test Type (check one)

☐ Screening

☐ Exam

Screener's Name: _____

Screener's Address: _____

Phone Number: _____ Screening Date: _____

Screener's Signature: _____

Professional affiliation: (Please check one)

☐ Dentist ☐ Dental Hygienist

☐ Physician Assistant ☐ LHD Registered Nurse with KIDS Smiles training

☐ APRN ☐ Physician

Untreated Decay: (Check one)

☐ 0 No untreated cavities

☐ 1 Untreated cavities

Treated Decay: (Check one)

☐ 0 No treated cavities

☐ 1 Treated cavities

Pattern of Early Childhood Cavities: (Check one)

☐ 0 No Early Childhood Cavities

☐ 1 Early Childhood Cavities Present

Treatment Urgency: (Check one)

☐ 0 No obvious problem

☐ 1 Early dental care needed

☐ 2 Referral for Urgent Care
NOTE: Comment required if marked.

Comments:

OH-12